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OVERSIGHT OF HCFA'S SETTLEMENT POLICIES: DID HCFA GIVE THREE PROVIDERS SPECIAL TREATMENT?

HEARING

BEFORE THE

PERMANENT
SUBCOMMITTEE ON INVESTIGATIONS

OF THE

COMMITTEE ON
GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

ONE HUNDRED SIXTH CONGRESS

SECOND SESSION

MARCH 28, 2000

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OVERSIGHT OF HCFA'S SETTLEMENT POLICIES: DID HCFA GIVE THREE PROVIDERS SPECIAL TREATMENT?

TUESDAY, MARCH 28, 2000

U.S. SENATE,
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS,
OF THE COMMITTEE ON GOVERNMENTAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 9:38 a.m., in room SD–342, Dirksen Senate Office Building, Hon. Susan Collins, Chairman of the Subcommittee, presiding.

Present: Senators Collins, Thompson, Specter, Levin, and Durbin.

Staff Present: K. Lee Blalack, II, Chief Counsel and Staff Director; Mary D. Robertson, Chief Clerk; Karina Lynch, Counsel; Brian C. Jones, Investigator; Claire Barnard, Detailee/HHS; Elizabeth Hays, Staff Assistant; Linda Gustitus, Minority Chief Counsel; Felicia Knight and Steve Abbott (Senator Collins); Robert Shea (Senator Thompson); Erin Quay (Senator Specter); Judy White (Senator Cochran); Erin Sammons and Cathy Bates (Senator Roth); Marianne Upton (Senator Durbin); and Laura Stuber (Senator Levin).

OPENING STATEMENT OF SENATOR COLLINS

Senator COLLINS. The Subcommittee will come to order.

Today, the Permanent Subcommittee on Investigations convenes this hearing to examine the settlement practices of the Health Care Financing Administration (HCFA), the Federal agency responsible for the Medicare program. This hearing is one in a series held by the Subcommittee during the past 3 years to examine instances of waste, fraud, and abuse that siphon money out of the Medicare trust fund, costing billions of dollars and jeopardizing health care for our disabled and elderly citizens.

Previous Subcommittee hearings have focused on Medicare fraud prevention and enforcement efforts, flaws in the enrollment process, and the ability of criminals to bill Medicare for bogus claims. The Inspector General of the Department of Health and Human Services recently found that improper Medicare payments to health care providers rose to $13.5 billion last year. I hope that the IG's report and oversight hearings, such as this one, will prompt HCFA to strengthen its financial controls. Indeed, I would note, as has happened with some of our previous hearings, HCFA last night issued new guidance on settlements, perhaps in response to the

issues we will discuss today. The continuing drain in Medicare is all the more urgent given projections that the trust fund is threatened with insolvency in just 15 years.

Last spring, I asked the General Accounting Office to investigate HCFA's settlement of debts owed to Medicare. Today, GAO officials will discuss the findings of a comprehensive 8-month investigation in which they examined 96 settlements in which HCFA's claims exceeded $100,000. In 93 of those agreements, the GAO found nothing improper. For the three largest settlements, however, the GAO uncovered many irregularities. In these three settlements, HCFA circumvented the normal administrative process for resolving reimbursement disputes. These three claims represented 66 percent of all Medicare overpayment settlements for the 8½-year period reviewed by the GAO.

Moreover, HCFA accepted payment of only $120 million, or 36 percent, of the $332 million owed the Medicare trust fund by the three providers. Equally troubling, GAO found that HCFA agreed to reimburse two of the providers for certain future costs without documentation, special treatment that is contrary to the regulations and not allowed other health care providers.

These findings raise serious concerns about the equity of the settlements. The three settlements also included highly unusual secrecy provisions intended, it appears, to prevent other health care providers from finding out about the special deals.

Several officials involved in the settlement negotiations, including representatives of the fiscal intermediaries and the regional offices of HCFA, told the GAO that the settlements were not in the best interest of the Medicare trust fund. Despite the strong protests of these individuals, HCFA officials in Washington compromised the claims for less than their value. Moreover, in a Subcommittee deposition, the official who negotiated the agreements testified that he knew of no other Medicare provider in the country that had been afforded similar treatment.

Contrary to HCFA's own regulations, no government attorney reviewed or approved the three questionable settlements. In fact, of the 96 overpayment settlements examined by GAO, these three settlements were the only agreements that were never reviewed by HCFA's Office of General Counsel.

The first questionable settlement uncovered by GAO involves the Visiting Nurse Service of New York. In September 1991, the fiscal intermediary determined that VNSNY's average cost per home health visit was about $160, more than three times HCFA's limit of about $50 at that time. The intermediary concluded that VNSNY owed Medicare approximately $98 million for which HCFA ultimately agreed to accept $67 million in settlement in 1995.

The second case involves New York City Health and Hospitals Corporation, HHC. Between 1983 and 1993, the fiscal intermediary disallowed reimbursement for certain costs because HHC lacked the documentation necessary to prove that it had actually incurred the costs. HCFA settled this case in 1996 by accepting $25 million in payment of the $155 million debt.

The third questionable settlement identified by the GAO involves the Department of Health Services, County of Los Angeles, LA County. Between 1987 and 1993, LA County's fiscal intermediary

disallowed its claimed reimbursement for certain costs because, again, of missing documentation. In this case, HCFA agreed to accept $28 million in satisfaction of more than $79 million in overpayments. This agreement was reached in 1997.

The GAO's findings raise serious questions about the three settlements and the conduct of senior HCFA officials. Today, we will attempt to seek the answers to a number of critical questions.

First, why did HCFA officials agree to these settlements in the first place?

Second, why were the standard rules not followed? For example, why did HCFA officials not seek the approval of the Department's own lawyers as well as the Department of Justice before compromising multi-million dollar claims for only 36 percent of what was owed?

Finally, did pressure from the individual then serving as the administrator of HCFA cause settlements to be reached that were not in the government's best interest?

We will hear testimony this morning from the GAO's Office of Special Investigations, various HCFA officials involved in the settlement negotiations, and former HCFA Administrator Bruce Vladeck.

Finally, let me make clear the reasons why I am so concerned about what appeared to be improper settlements that may have cost the Medicare trust fund millions of dollars. As many health care providers and my colleagues know, no one has fought harder than I have to ensure that Medicare adequately reimburses our hospitals and home health agencies for the essential services that they provide to our Nation's elderly. One of my highest priorities last year was reversing excessive cuts in Medicare that were jeopardizing the ability of numerous well-run home health agencies and hospitals to care for our seniors and our disabled citizens. Thanks to a bipartisan effort which involved Senator Thompson and Senator Levin, as well as myself, we were successful in restoring some of these funds.

When HCFA enters into improper settlements involving millions of dollars, it undermines the efforts of those of us advocating better rates of reimbursement. It jeopardizes our ability to afford new and better benefits for our senior citizens. It endangers the integrity and fairness of the entire system and it further strains an already shaky trust fund. For these reasons, I am extremely troubled by the GAO's findings.

I would now like to recognize the Ranking Minority Member, Senator Levin, for his opening statement.

OPENING STATEMENT OF SENATOR LEVIN

Senator LEVIN. Thank you, Madam Chairman. Today, we are looking at how HCFA resolved cost reimbursement disputes in the 1990's with respect to three of the largest health care providers in the Medicare program. Each provider which is a subject of this hearing today is a nonprofit institution providing health care services in most cases to the poorest among us.

The issues involved in these settlements are complex and some of them are legalistically challenging. The Department of Justice, HCFA General Counsel, and the GAO have been wrestling with the

application of the Federal Claims Collection Act for years. In doing so, they have been trying to decide what is a claim, what is a debt, what is a compromise versus a settlement, and so on. These are the issues that lawyers and bureaucrats thrive on, and from all appearances, it does not look like HCFA did a very good job of clarifying these terms and applying them to the procedures required for settling cost reimbursement disputes.

GAO argues that these settlements were improper because HCFA "unilaterally chose not to obtain Justice Department approval of the settlements and ignored its own regulations and internal guidance," arguing that under the Federal Claims Collection Act, HCFA should have referred these settlements to the Justice Department for approval. This finding of GAO gives short shrift to the determination of the Department of Justice itself that settlements of cost reimbursement disputes such as these are not subject to the Federal Claims Collection Act and that in two of these cases, there were no claims by the Federal Government or HCFA against the providers. It was the opposite: The providers were seeking money held by HCFA that they believed HCFA owed them. Now, that is in two of the three cases, HCFA was holding money that the providers claimed was owed to the providers.

GAO also argues that the settlements are improper because the administrator's participation in the settlement involving Health and Hospitals Corporation of New York, or HHC, "raised conflict of interest concerns" despite the lack of evidence, in my judgment, that there was such a conflict. The only fact pointed to by the GAO is that the administrator, Dr. Bruce Vladeck, had served as a volunteer on the board of HHC prior to coming to HCFA about 3 years before he was asked by the appointee of Mayor Giuliani to help HCFA reach a settlement with HHC. I do not think that is a covered relationship or close to it within the meaning of the regulations.

Nor does the GAO explain how it can assert, based on its review of this case and without asking any of the providers for their opinions on the settlements themselves, that "the providers were all able to pay the entire overpayment amount, that," in GAO's words, "HCFA would have prevailed if the matters were litigated." How in the name of fairness and completeness can the GAO reach those conclusions without hearing from the providers about their views of the substance of the settlements?

In fact, Madam Chairman, although given only a few hours to read the report, a written statement from one of the providers, the Visiting Nurses Service of New York, surely a highly respected entity, was submitted to the Subcommittee, and the Visiting Nurses Service has taken strong issue with the conclusions of GAO. For instance, with respect to GAO's strongest conclusion, that "the settlement agreement with HCFA would permit the Visiting Nurses Service's reimbursement for costs for which the Visiting Nurses Service would not otherwise be entitled," the Visiting Nurses Service says, "This conclusory statement is extremely damaging and totally inaccurate"—totally inaccurate.

How in the name of fairness and completeness can the GAO then give us a conclusion that these claims were without merit, could

not have been proven at litigation, without seeking the merit of those claims from the providers, about the basis for their claims?

Now, the GAO report then goes well beyond criticizing HCFA for doing a poor procedural job in this area. The GAO claims that the three biggest settlements were "improper," not only in the way they were reached, but also with respect to the substance of the settlements themselves. But again, they did not ask the providers for their comment about the substance of the settlements.

Then the GAO said this. "It is unlikely that any of the providers could have mounted strong defenses." How on earth, without asking the providers for their defenses, could GAO fairly and objectively conclude that it is unlikely that any of the providers could have mounted strong defenses?

Now, when I asked my staff to do what the GAO had not done, ask the providers for their opinions of the settlements, each provider stated that they perceived the settlements to be "hard fought," and involving the expected "give and take" necessary for settling difficult cases. One provider, Health and Hospital Corporation of New York, told us, "GAO wanted to hear about what we got, not what we gave up, and that is unfair."

Finally, when you look through the list of all the 96 settlements reviewed by the GAO, the percentages that HCFA actually received of monies at issue in these three settlements are well within the ballpark of the percentages received in the other 93 settlements.

So unlike their past work, including work for this Subcommittee which I found on the whole to be thorough and careful, I believe in this case the GAO unfairly omitted the other side of the settlement story, that of the providers, as to the substance. I emphasize "of the settlement," because the GAO report goes far beyond evaluating the procedures, and we will hear much of that this morning, whether the procedures were proper or not. The GAO report goes to the substance of those settlements.

Madam Chairman, I come to this issue as one who has fought the HCFA bureaucracy over the years on numerous occasions on behalf of health care providers in my home State. I have at least two ongoing battles with HCFA right now because I have too often experienced HCFA as a frustrating agency, slow to respond, unwilling at times to make accommodations for the real-life situations of our health care providers, bureaucratic, unwilling even to provide information which is requested, much less other materials.

I believe it is not only the right, but the duty of the head of the health care provider or a political official in an affected area to try to get the attention of HCFA to address longstanding issues. I do not think it is improper for the head of a health care provider to pick up the phone and call the Administrator of HCFA to inform the administrator of a serious financial claim being imposed by HCFA on the provider which the provider thinks is unfair or inappropriate. That is what is supposed to happen.

Moreover, I am not concerned by the fact that the head of HCFA, upon receiving such a phone call, would contact his assistant and direct him to try to resolve the problems identified by the call. The administrator would be remiss if he or she did not do that. But the GAO report implies that there is something improper when that happens.

We are going to hear some confusing testimony today, conflicting versions of what key people have said about the process in these settlements. In the end, however, we are going to also have to deal with GAO's repeated inference that these three providers got more than they should have when I do not believe the GAO ever asked the providers for their side of that issue.

So, Madam Chairman, with those tasks facing us, with the conflicting testimony and the complicated policy questions at issue here, the Subcommittee does indeed have its work cut out for us this morning. Thank you.

Senator COLLINS. I am very pleased to now call on the Chairman of the full Committee, Senator Thompson.

OPENING STATEMENT OF CHAIRMAN THOMPSON

Chairman THOMPSON. Thank you, Madam Chairman. Madam Chairman, you have very ably brought out some very troubling problems. They are a part of a larger problem.

Last November, I released a report by the General Accounting Office that touted the amount of overpayments made by the Federal Government. I found out that only 14 programs in all of the Federal Government even bothered to count their overpayments. Even then, in just 14 programs, we found that in 1998, the Federal Government made overpayments totalling $19 billion. Medicare accounted for $12.6 billion of that number. In 1996, numbers are just coming in, and it looks like overpayments in the Medicare program rose by almost $1 billion. That is no surprise.

Every 2 years, GAO lists the programs in the government most vulnerable to waste, fraud, and abuse. Medicare has been on GAO's high-risk list since its inception. With overpayments in Medicare now estimated at $13.5 billion, the problem is getting worse. In the most recent reports from the Inspector General at the Department of Health and Human Services, I have learned that Medicare is paying millions of dollars for services provided to patients after they have died.

So, as I say, unfortunately, what you have brought out here and will be bringing out today is just a part of a larger problem, and these matters that you have demonstrated, and the GAO I think very ably has demonstrated, is not just procedural. We are talking about millions of dollars here, $332 million that was settled for $120 million. Obviously, after the facts, you can go back and pick at the individual components and elements of any decision that is made, any settlement that is made or not made, but if the merits are so much in dispute and there are two such sides to this matter, why was it done in such secrecy?

Why were procedures not followed? Why was this not approved by the Department of Justice in these large amounts when their practice and the law requires anything over $100,000 to be approved? Why was their own Office of General Counsel not involved in just these three settlements? Only in these three, these three huge settlements that constitute 66 percent of all Medicare overpayment settlements since 1991, in only these three, their Office of General Counsel was not involved. In fact, no government attorney at all reviewed these matters. And why was pressure brought to

bear to get these settlements done and done in a way that apparently would not see the light of day?

We will hear testimony as to whether or not this even fit the settlement criteria. My understanding is a determination has to be made by the people at HCFA as to whether or not it fits the settlement criteria, whether or not the provider can pay, whether or not HCFA could win, whether or not the cost of collection exceeds what they would collect. These determinations have to be made. You do not have to have a trial to determine whether or not they fit the settlement criteria. These are determinations that HCFA has to make based upon the information that they have, and that is the determination that GAO in turn came in and made after the fact.

As I say, these are not just procedural matters. These are matters involving millions of dollars about which lower-level people in these agencies made determinations in secret costing apparently millions of dollars. As I said before, the most disturbing part of this is it seems to be a part of an overall problem where billions of dollars are going down the drain over at the Medicare program, billions of dollars that otherwise could be used for beneficiaries.

Thank you, Madam Chairman.

Senator COLLINS. Thank you, Senator Thompson.

The Subcommittee has received two statements that will be included in the record. One is from the Visiting Nurses Service of New York.[1]

The second statement is a letter from Congressman Rangel.[2] Both will be included in the hearing record, as will other statements that are received during the next 2 weeks.

I would now like to call forth our first panel of witnesses from the General Accounting Office. Our first witness this morning is Robert H. Hast, who is the Acting Assistant Comptroller General of the Office of Special Investigations. Accompanying Mr. Hast this morning is William Hamel, the Special Agent with GAO's Office of Special Investigations, and Robert Murphy, the General Counsel for GAO's Office of General Counsel. These gentlemen will be testifying regarding GAO's 8-month investigation of HCFA's process for settling overpayment claims with Medicare providers.

I would first like to welcome all three of you this morning and to thank you for GAO's comprehensive, thorough and excellent work on this investigation. The work is very much in keeping with the tradition of GAO and this Subcommittee has a very long tradition of working very closely with the GAO.

Pursuant to Rule 6, all witnesses who testify before the Subcommittee are required to be sworn in, so at this time, I would ask that you stand and raise your right hand. Do you swear that the testimony you are about to give to the Subcommittee will be the truth, the whole truth, and nothing but the truth, so help you, God?

Mr. HAST. I do.

Mr. HAMEL. I do.

Mr. MURPHY. I do.

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[1] See Exhibit No. 29 which appears in the Appendix on page 248.

[2] See Exhibit No. 27 which appears in the Appendix on page 245.

Senator COLLINS. Thank you. Mr. Hast, I am going to ask you to proceed with your statement.

TESTIMONY OF ROBERT H. HAST,[1] ACTING ASSISTANT COMPTROLLER GENERAL, OFFICE OF SPECIAL INVESTIGATIONS, ACCOMPANIED BY WILLIAM D. HAMEL, SPECIAL AGENT, OFFICE OF SPECIAL INVESTIGATIONS, AND ROBERT P. MURPHY, GENERAL COUNSEL, OFFICE OF GENERAL COUNSEL, U.S. GENERAL ACCOUNTING OFFICE

Mr. HAST. Madam Chairman and Members of the Subcommittee, thank you for inviting me here today to discuss the results of our investigation into HCFA's improper settlement of its three largest Medicaid overpayments [sic], executed between 1991 and 1999. At this time, I would like to introduce our other representatives seated with me today. They are Special Agent William Hamel from my staff and our General Counsel, Robert Murphy.

As you are aware, the depletion of the Medicare trust fund has been the subject of significant scrutiny in recent years and we have previously reported that fraudulent and abusive practices have raised concerns about the program's vulnerabilities. As recently as March 15 of this year, we testified about HCFA's financial management and its need to further improve its controls and accountability to better ensure that improper payments are not made. HCFA, which administers the Medicare program, is required to ensure that debts owed the program are paid. Historically, rather than collect the entire debt, HCFA often enters into settlement agreements with providers and accepts less than the full amount owed.

Although we found nothing improper with 93 of the 96 settlements for overpayments in excess of $100,000 that HCFA provided us, we did determine that HCFA acted improperly in settling its three largest matters in 1995, 1996, and 1997. These three overpayment matters totaled $332 million, or 66 percent of all Medicare overpayment settlements for which HCFA provided us records. HCFA agreed to accept $120 million of the $332 million in its settlement of these matters.

The first of these three settlements was preceded by just 2 months by a large settlement that was referred to the Department of Justice and Justice refused to allow HCFA to execute. We determined that then-HCFA Administrator Bruce Vladeck had directed the three improper settlements be made and that he had a prior professional association with two of the three providers just prior to being appointed HCFA Administrator.

In the largest settlement, $155 million in overpayments to a hospital that HCFA settled for $25 million, Mr. Vladeck had been on the hospital's board of directors, which raised conflict of interest concerns. In this instance, we learned that Kevin Thurm, then chief of staff to the HHS Secretary and current Deputy Secretary, instructed Mr. Vladeck to inquire about the status of the overpayments. As a result, Mr. Vladeck suggested to Mr. Charles Booth, HCFA's then-Director of Payment Policy who Mr. Vladeck had tasked with making the settlement, that time was more important

[1] The prepared statement of Mr. Hast appears in the Appendix on page 69.

than money and instructed him to move more quickly to settle, this despite Mr. Booth's protest to Mr. Vladeck that quickening the process could cost HCFA an extra $8 million to $10 million.

Remarkably, despite this being HCFA's largest settlement, HCFA kept no records or documentation about the settlement, not even a copy of the settlement agreement itself. We were fortunate that the fiscal intermediary maintained records and furnished them to us.

Mr. Vladeck also failed to disclose his affiliation with the other provider, a home health care agency, on his financial disclosure forms upon his appointment. We could not resolve these issues given his refusal to meet with us.

HCFA's regulations and internal guidance state that HCFA must refer all settlements over $100,000 to the Department of Justice for approval in accordance with the Federal Claims Collection Act. Two months prior to initiating the first of these three improper settlements, HCFA had been notified that a HCFA-proposed settlement that was referred to Justice on another multi-million-dollar overpayment was rejected by Justice. Mr. Booth, the official who negotiated the three improper settlements, chose not to seek Justice approval or HCFA's own Office of General Counsel review because he told us that he was concerned if he did the three large settlements would go up in smoke as they were written. He also told us that he knew that these settlements were not in the best interest of the government.

Concerning the specifics surrounding the three settlements, HCFA appears to have disregarded the permissible settlement criteria established by regulation since evidence suggests that the providers were all able to pay the entire overpayment amount, that HCFA would have prevailed if the matters were litigated, and the amount of recovery would have exceeded the cost of collecting the multi-million-dollar debts.

In addition, the agreements were troubling for other reasons, as they contained several questionable provisions. The terms of two of the settlement agreements, which were to be kept confidential, permit future provider reimbursement for costs for which they would not otherwise be entitled. These provisions do not ensure that the payments made are not improper in that they allow billing without auditable recordkeeping. HCFA also waived interest and required the refunding of interest already paid and permitted repayment in installments for one of the agreements, despite contrary directions in its internal guidance.

Mr. Booth disregarded the objections of knowledgeable HCFA and fiscal intermediary officials who protested the settlements as being bad precedents. Lastly, HCFA officials acted imprudently by executing these settlement agreements which relinquished the government's right to recover tens of millions of dollars without the benefit of any legal counsel review.

Finally, we are disturbed that after we advised HCFA of our specific questions in advance about its collection of overpayment process, such as how does HCFA define a claim, when does a claim become a debt, who is HCFA's appropriate agency official to determine a claim or the applicability of the Federal Claims Collection Act to Medicare overpayments, that neither its Chief Financial Of-

ficer, Michelle Snider, nor its Chief Counsel, Sheree Kanner, could answer these questions. Even more troubling was that after these interviews, we gave HCFA the opportunity to respond in writing to these questions, yet its letter to us from the Deputy Administrator, Michael Hash, was unresponsive to our questions.

The chronologies of the three improper settlement and our legal analysis of the Federal Claims Collection Act to the Medicare program can be found in the report we previously issued to you.

At this time, I would like to submit my statement for the record. Madam Chairman, this completes my prepared statement. I would be happy to respond to any questions you or other members of the Subcommittee may have.

Senator COLLINS. Thank you very much for your statement, and again, thank you for a thorough, well-documented report.

I am particularly troubled by four findings: First, that HCFA violated its own rules and regulations; second, that the agreements included highly unusual secrecy provisions that were intended to prevent anyone from finding out about these deals; third, that the Administrator of HCFA at that time, Bruce Vladeck, pressured subordinates to reach these agreements; and fourth, that the agreements included provisions for special treatment that were not afforded to other health care providers. So I would like to focus on those four points in this first round of questioning.

Mr. Hamel, I want to direct this question to you. One of my chief concerns, as I mentioned, is that HCFA appears to have circumvented its own regulations in approving these settlements. Can you tell us if HCFA ever showed these three settlements to its own lawyers in the Office of General Counsel?

Mr. HAMEL. No, they did not.

Senator COLLINS. And of the 96 settlements that you reviewed data from 1991 through 1999, were there any other HCFA settlements that were never shown to the Department's own lawyers?

Mr. HAMEL. No.

Senator COLLINS. So these three settlements, which constituted the three largest settlements during the past decade, were the only ones that were not shown to HCFA's lawyers or to the Department of Justice, indeed, to any government lawyer, is that accurate?

Mr. HAMEL. That is correct.

Senator COLLINS. As part of your investigation, Mr. Hamel, I understand that you interviewed Charles Booth, who is the official who negotiated the settlements, is that correct?

Mr. HAMEL. Yes, it is.

Senator COLLINS. Did Mr. Booth tell you that he knew at the time that he negotiated the settlements of the requirement within HCFA's own rules to obtain the approval of the Office of General Counsel and the Department of Justice?

Mr. HAMEL. Yes, he told us that.

Senator COLLINS. In explaining why he did not seek this approval, did Mr. Booth also tell you that if he had shown the three agreements to the Department's own lawyers or to the Department of Justice, he feared that "the deals would go up in smoke?"

Mr. HAMEL. Yes.

Senator COLLINS. Is it also your testimony that Mr. Booth told you that if the Department of Justice had objected to the settle-

ments that he would be unable to satisfy Mr. Vladeck, who was then the administrator?

Mr. HAMEL. Yes.

Senator COLLINS. And did he also tell you that he felt at the time he negotiated the settlements that they were not in the best interest of the Medicare trust fund?

Mr. HAMEL. I will clarify. He said that they were not in the best interest of the government.

Senator COLLINS. They were not in the best interest of the government. Is it your conclusion that Mr. Booth agreed to the settlements that he knew were not in the government's best interest because of the pressure he was receiving from Mr. Vladeck?

Mr. HAMEL. That is the impression he gave us.

Senator COLLINS. Mr. Hamel, were you also told by another HCFA official, Mr. Seubert, that giving HHC a waiver from the supporting documentation requirement was "unique and set a terrible precedent"?

Mr. HAMEL. Yes.

Senator COLLINS. And were you also told by an employee of Medicare Empire Services, which I understand was the fiscal intermediary for HHC, that he was not happy that HCFA had excluded HHC from having to document is bad debt costs?

Mr. HAMEL. Yes.

Senator COLLINS. Did he also express the concern that an exception was being made and that HCFA was holding other providers to a different standard?

Mr. HAMEL. Yes.

Senator COLLINS. Mr. Murphy, it is my understanding that you are the General Counsel of GAO, is that correct?

Mr. MURPHY. I am.

Senator COLLINS. I find it very troubling that secrecy provisions were included in these three agreements. Are they not public claims and would they not usually be subject to the Freedom of Information Act?

Mr. MURPHY. Normally they would, Madam Chairman.

Senator COLLINS. Did the GAO discover why HCFA and the providers wanted to keep these claims secret? If you are not the appropriate person to answer that, Mr. Hast or Mr. Hamel maybe?

Mr. HAST. Yes. They felt that if they did not keep them secret, it may set a bad precedent. Other providers would want the same deal.

Senator COLLINS. So the concern was that because there were some unusual provisions in these agreements giving special treatment to these three providers that would not be available to other providers, if that became known, then other hospitals and other home health agencies might cite this as a precedent in settling their own disputes with HCFA, is that fair?

Mr. HAST. Yes, I would say that is fair.

Senator COLLINS. Related to that issue and one of the most disturbing findings of the report, which is really chock-full of disturbing findings, is that two of the settlements actually permit providers to be reimbursed for future costs regardless of whether or not there are documents to support those costs, is that correct, Mr. Hamel?

Mr. HAMEL. Yes.

Senator COLLINS. Now, I do not understand how that can be. Is HCFA actually going to pay claims for which there is no documentation, Mr. Hamel?

Mr. HAMEL. Yes.

Senator COLLINS. So in two of these agreements, HCFA has agreed to pay money out of the Medicare trust fund even if there is no supporting documentation to prove that the services were provided, is that correct?

Mr. HAMEL. That is correct.

Senator COLLINS. Did the fiscal intermediaries find those provisions troubling, Mr. Hamel?

Mr. HAMEL. Yes.

Senator COLLINS. Could you tell us of the concerns that they expressed?

Mr. HAMEL. They were concerned in one instance that, again, as Mr. Hast had said, that other providers who were similarly situated would want to request the same particular benefit that that provider had received. In the other instance, Empire had expressed to us concerns that they have to deal with many providers and hold them to a standard of providing documentation and that they also have to deal with providers who are similarly situated, potentially have cost disallowances, and they feel uncomfortable lying to them, telling them, well, we have to hold everybody to the same standard.

Senator COLLINS. Are you aware of any other provider elsewhere in the country that is receiving this kind of special treatment from HCFA in which they are allowed to be reimbursed for future costs and yet they do not have to prove that they actually incurred the costs?

Mr. HAMEL. No.

Senator COLLINS. Mr. Murphy, the General Accounting Office report raises an issue of whether conflicts of interest, either actual ones or an appearance of a conflict, may have been a factor in the settlement of these cases. Could you please elaborate on what brought forth the conflict of interest issue?

Mr. MURPHY. Well, our OSI investigators came to the Office of General Counsel and asked whether, because the then-head of HCFA, Mr. Vladeck, had at one time been a director of one of the providers, whether that presented a legal problem from the viewpoint of the government's ethics rules, and so that is how we got involved in it.

The bottom line is that with respect to a black letter violation, there is not one here. Mr. Vladeck had not been a director of the provider for 3 years. The issue is whether under the regulations promulgated by the Office of Government Ethics he should have raised the issue and consulted with the ethics officer in HCFA. The provision reads that an employee who is concerned that their dealings would raise a question regarding their impartiality, then they should consult with the ethics officer.

In our view, even though he had not been a director for several years, this would have raised an issue of his impartiality and he should have consulted.

Senator COLLINS. Mr. Vladeck, it is my understanding, served as a director of HHC up almost to the point that he became the HCFA

Administrator. I believe he resigned as a director the month before he was confirmed, is that correct?

Mr. MURPHY. That is right. He resigned in April 1994. He had been a director, I believe, for 2 years prior to that.

Senator COLLINS. So in your judgment, given his previous relationship as a director of HHC and the magnitude of the money involved, it would have been prudent for him to seek advice from the agency ethics officer as to whether or not he had an appearance of a conflict of interest and should have recused himself?

Mr. MURPHY. I agree with your terminology. It would have been prudent for him to have done so.

Senator COLLINS. I will be asking Mr. Vladeck whether he did so. If he did not do so, does it cast a further shadow on the impartiality of this decision, given that the rules were circumvented?

Mr. MURPHY. Well, I think these provisions of the government ethics rules really go to the confidence of the public in public servants. Any time public servants act in ways that raise questions about their impartiality, it seems to me that the underlying purpose of the rules is being constrained.

Senator COLLINS. Mr. Hast, the attorney for Mr. Vladeck yesterday sent me a letter that raises an issue about the propriety of Mr. Hamel's involvement in this investigation given work that he had done on this investigation in a previous capacity with the Office of the Inspector General. Were you aware of that concern and could you comment to us on what actions you took?

Mr. HAST. Yes, I am aware of that concern. When we hired Mr. Hamel approximately a year and a half ago at the Office of Special Investigations, we just sat down and discussed our health care program in our office, and one of the things that Mr. Hamel told me is because of prior investigations he had done with the HHS IG, he had questions as to how HCFA acted in making large settlements. Because of that, we had a meeting with the HHS IG and her staff and discussed large HCFA settlements and they said that they had not investigated any other than the very single settlement that Mr. Hamel had been involved in and they had never gone to HCFA and asked them about all of their settlements and that they did not have it in their work plan for this year and that they saw no reason that Mr. Hamel could not participate in an investigation based on the work he had done.

We then went to the Department of Justice and discussed his prior involvement in work with the Department of Justice when he was with the HHS IG. The Department of Justice and the judicial district in which he worked both said that as long as he followed certain guidelines, there would be no problem in him participating in the investigations.

We then proceeded to discuss this with your staff, and I know that your staff has discussed it with Senate counsel and it was determined that we would be able to proceed, and I feel that we have fulfilled all our obligations to have Mr. Hamel conduct this investigation and I am very, very comfortable with how we handled it.

Senator COLLINS. Thank you. Senator Levin.

Senator LEVIN. Thank you, Madam Chairman.

Mr. Hast, you say in your report that "HCFA would have prevailed if the matters were litigated." Later on in the report, you say

"it is unlikely that any of the providers could have mounted strong defenses." Those are sweeping conclusions on the substance. Your office told us that when you talked to the providers about these settlements, you asked only about the process, not about the substance. In fact, one provider told us "GAO wanted to hear about what we got, not about what we gave up, and that is unfair."

Now, how could you make those conclusions that it is unlikely that any of the providers could have mounted strong defenses without talking to the providers about their views of the substance of the settlements, giving them a chance to tell you why they thought this money was owing to them?

Mr. HAST. When we discussed the settlements with the providers, there was a give and take and the providers did talk about their feelings on the settlements. Our analysis of why we felt they could not prevail is based on what the fiscal intermediary said, what the other HCFA individuals told us, and what the providers told us. In discussing this with our legal counsel, our analysis of that is that it was not likely that they could have prevailed.

Senator LEVIN. Did you put into your report their arguments on the substance?

Mr. HAST. No, we did not.

Senator LEVIN. I want to read you something that the Visiting Nurses wrote us. Now, they only had a few hours to review this report. "The Visiting Nurses Service of New York"—I think you would agree, this is a reputable organization?

Mr. HAST. Yes.

Senator LEVIN. "—is extremely distressed about the March 2000 GAO report. As part of its attack against the Health Care Financing Administration, its allegedly inappropriate settlement of disputes with three providers, inaccurate and very damaging statements are made in the report about the behavior of the Visiting Nurses Service," and then it says, "This statement seeks to correct some of the most egregious and inaccurate allegations in the report."

Jumping down to page 2, and I think the Chairman has put this report in the record, this statement of the Visiting Nurse Service of New York, page 2, "Contrary to the implication in the GAO report, the difference in length between Medicare and non-Medicare visits does not make it inappropriate for VNS to include such visits in its cost report. We resent and take issue with the implication in the report that the settlement agreement with HCFA would permit provider reimbursement for costs for which the provider would not otherwise be entitled. This conclusory statement is extremely damaging and totally inaccurate."

Now, you have given us a report in which you say that they are not entitled to this, that they in their settlement obtained something that they were not entitled to receive. They, a highly reputable outfit, say that that is totally inaccurate, and then they go on and they say this is unfair and it is untrue and they say why they were entitled to this outcome. This is their position on the substance, and yet not one word do we get from the Visiting Nurses Service giving their side of the story in the GAO report. Instead, we have your conclusion that they would not have prevailed, basing that on the fiscal intermediary of HCFA, which of course

takes the same position that HCFA would have taken and HCFA was arguing.

Now, I must tell you, I think that that failure to give to this Subcommittee VNS's argument on the substance as to why they believe they had a good case is unfair. I think it omits one side of the story; it fails to give us the arguments that they make so that we can see whether or not your conclusion, and after all, you base a great deal of your conclusion on a sub-conclusion that they would not have prevailed, and yet their argument as to why their case was meritorious is not even presented to us by the GAO. Why did you not ask them for the substance of their argument and why did you not put the substance of their argument in your report?

Mr. HAST. I think in the interview process, we discussed the substance of their argument, but I would like to point out that they requested the settlement. They are the ones that made phone calls to the Director of HCFA asking for the settlement. They were not interested in litigating. They wanted to settle prior to getting into litigation. Mr. Hamel may have a little bit more on the discussion of the substance.

Mr. HAMEL. Well, on the substance, we had substantial documentation maintained by HCFA and the fiscal intermediary on what VNS's arguments were for why they felt what they did was acceptable. We interviewed them. We heard what they believed was their case. But at the end of the day, they chose not to bring this case forward to the Provider Reimbursement Review Board. Instead, they chose to ask for a settlement.

Senator LEVIN. Are you suggesting that people who propose that a claim be settled do not believe that they have a legitimate claim?

Mr. HAMEL. We did not suggest that they did not have a legitimate claim.

Senator LEVIN. Did you not tell our staff that you did not ask the providers about the substance of the settlements, only the process? Is that correct, that that is what you told our staff?

Mr. HAMEL. I probably did say something to that effect to your staff.

Senator LEVIN. And yet, you concluded in your report that they would have lost on the substance. Even though you did not ask them about their arguments on the substance, you did not present to this Committee their arguments on the substance, you concluded that they would have lost the case on the substance. I find that, frankly, startling. I find it a failure on the part of the GAO to give us the side of the story of the providers here. That is a critical part of the story.

The process issues are important, by the way. I know we are going to be going into the process issues, and we should. But to suggest, to find, as you found in your report, that they would have lost this case without asking them about the merits of their case, without presenting to us what those arguments are, it seems to me is one side of the story and there is a very important other side of the story.

We have two other providers, legitimate groups of hospitals, numerous hospitals, negotiating for years with millions and millions of dollars at stake relative to their survival financially with millions of cases, patients, pieces of paper who would come into them,

and yet the providers are not asked, why is it you thought you were entitled to this? They were not asked, nor were we told their position. Instead, we are given a conclusion, that GAO thinks they would have lost on the merits. Therefore, these settlements are improper. I think that is wrong. I do not think it is consistent with what the GAO has done over the years.

Now, let me ask you some questions, Mr. Hast. Did you conclude that Mr. Vladeck did anything illegal?

Mr. HAST. No.

Senator LEVIN. Did you conclude that Dr. Vladeck did anything criminal?

Mr. HAST. No.

Senator LEVIN. You have also suggested that Dr. Vladeck would not talk to you, that you invited him in and he would not talk to you. His attorney, Dr. Vladeck's attorney, wrote a letter to the Committee saying that in October of last year, he notified Majority counsel that Dr. Vladeck was available for an interview—this is long before your report was completed—and he was told, and this is what he represents to us, I do not know if he was or not, that the train had left the station, that the GAO already was preparing a report.

Now, why would you not take up Dr. Vladeck's offer to talk to him since this was October 1999 and since there was apparently a grand jury proceeding? His attorney wanted that to be completed, as I understand it. It was completed and then he said, OK, we would be happy to have Dr. Vladeck talk to you, and yet you did not take up that offer, and yet conclude repeatedly that his failure to talk to you led to some kind of a negative implication. Why did you not talk to him last October?

Mr. HAST. Between the middle of July and the middle of October, we contacted his attorney 15 times. On several of those occasions, his attorney told us he would set up an interview. The interview was set up. Two weeks would pass. At the 11th hour, he would cancel the interview. That happened on numerous occasions. We asked the Committee to intercede to see if they could get him to come in. The Committee interceded. We continued with negotiations back and forth suggesting he would cooperate and be interviewed and then having him at the last minute decide not to. It appeared to be a delaying tactic.

We also made an offer to Mr. Vladeck because of his concern about the prior case that was a grand jury matter that we would ask absolutely no questions about that settlement. We would just interview him on the other two settlements that surfaced afterwards. He did not come in on that offer.

We had to process the report. We had a deadline to present it to the Committee. We gave him a final offer as to when we were able to interview him. The letter saying that he was available did not make it so. As we know, he did not really come in until a couple days before this hearing, and those were continuing negotiations with the Committee.

Senator LEVIN. So, basically, you disagree, then, with his lawyer's letter that he in October of last year made a clear offer to come in and talk to you?

Mr. HAST. I had no confidence that was a good faith offer.

Senator LEVIN. All right. Now, Mr. Murphy, I am puzzled by your conclusion on the conflicts of interest matter, and I want to read from the letter of the HCFA ethics official to the OGE confirming an element of Dr. Vladeck's ethics agreement, and here is the relevant paragraph.

Senator COLLINS. Senator Levin, I am going to ask you to finish with that question so that we can go on to Senator Thompson.

Senator LEVIN. I am sorry. I did not notice. I will pick that up next round. Thank you.

Senator COLLINS. Senator Thompson.

Chairman THOMPSON. Thank you very much, Madam Chairman.

Could you explain a little bit about how the initial determination was made that these monies were owed by these providers? Were these initial determinations made by the so-called fiscal intermediaries?

Mr. HAMEL. Yes.

Chairman THOMPSON. Such as Blue Cross-Blue Shield? Do you know who the intermediaries were in these cases?

Mr. HAMEL. Yes. United Government Services, which is a part of Blue Cross of Wisconsin, handles Visiting Nurse Service of New York. Empire Blue Cross handles New York City Health and Hospitals. And Blue Cross of California takes care of LA County.

Chairman THOMPSON. All right, and what do they do? Do they go in and do an audit as such or how do they make the determination that these monies are owed by these providers?

Mr. HAMEL. Every year, the providers submit a cost report which sets forth the basis for their reimbursement, and every year, the fiscal intermediary conducts an audit of that cost report and then determines, much like a tax return, sometimes there is money owing back and sometimes there is money owing to. That audit sets forth usually the basis of an overpayment. They are given a notice of program reimbursement, which is like a bill, which says you have to liquidate your debt, and providers have 180 days to file an appeal before the Provider Reimbursement Review Board if they contest it.

Chairman THOMPSON. Do you have any history with regard to these fiscal intermediaries in terms of whether or not their assessments usually hold up or bear out or are challenged or overturned or can you generalize in any way with any degree of accuracy with regard to the reliability of these fiscal intermediaries?

Mr. HAMEL. No. We have never done any review work in that area.

Chairman THOMPSON. Is part of your determination concerning the collectibility of this based upon the analysis of the fiscal intermediaries?

Mr. HAMEL. More so of also the HCFA officials in the regions.

Chairman THOMPSON. All right. So these were not your unilateral determinations. As I understand it, you have to determine, or HCFA has to determine whether or not a particular claim fits the settlement criteria. Some do not even fit the settlement criteria and you cannot settle. One of the criteria for settlement is whether or not the provider can pay the claim, is that right?

Mr. HAMEL. That is correct.

Chairman THOMPSON. And one is whether or not HCFA would probably win, and another is whether it would cost more to collect than you might recover. Those are things that HCFA has to make a determination on before it can even fit a settlement criteria, is that right?

Mr. HAMEL. That is correct.

Chairman THOMPSON. Is that what you relied upon in making your determination?

Mr. MURPHY. Senator, if I could follow up——

Chairman THOMPSON. Yes, go ahead.

Mr. MURPHY [continuing]. Because one of the things, there was a dialogue between the Office of Special Investigations and the lawyers in GAO. We do not know whether, if this were litigated, and we do not even know whether at the review board that HCFA has, whether the providers would have prevailed or not. In the end, we do not know whether this was fair or not, as Senator Levin has pointed out earlier.

What we do know is that there are internal controls imposed by the Social Security Act, by the HCFA regulations and guidelines, and by the Claims Collection Act that are designed to assure the American public that decisions are not made arbitrarily, that they are made in accordance with the law and the regulations as written, and it was those internal controls that we found were not followed. So in the end, nobody knows whether these were fair or whether they were legal or not, and the reason is that the process was not followed.

Now, what we found was that the fiscal intermediaries and HCFA officials pointed out that the providers had not given us documentation that would substantiate their claims. Based upon that and based upon their opinion, we offered the view that they were unlikely to have mounted strong defenses. But in the end, we do not know what the litigation risk was because HCFA did not assess it.

Chairman THOMPSON. That appears to be a reasonable conclusion on your part. You are not obligated to go in and retry the case and give us 600 pages of the merits and the arguments that the lawyers make back and forth. What we are interested in here, essentially, is the operational of governmental agencies.

Mr. MURPHY. That is right. We were not looking at the providers——

Chairman THOMPSON. That is what you are——

Mr. MURPHY [continuing]. To see whether their claims were valid. We were looking at HCFA officials and what they did.

Chairman THOMPSON. With regard to this and these settlements, two of the settlement agreements, as has been pointed out, permitted the providers to obtain reimbursement for future costs that are not otherwise compensable under the Medicare program. HCFA also waived interest on the claims and permitted repayment in installments for one of the agreement despite contrary directions in its internal guidance, is that correct?

Mr. MURPHY. That is correct.

Mr. HAST. In fact, Senator, the president of that home health care agency requested the secrecy agreement, according to Mr.

Booth, because they were worried about bad publicity had that agreement been made public.

Chairman THOMPSON. You say two of the settlements permitted the providers to obtain reimbursement for future costs that you already said would not be documented. Those were the two New York provider, is that correct?

Mr. HAST. Yes.

Chairman THOMPSON. And I noticed here, we have been talking in round numbers, but the New York City Health and Hospital Corporation, the HHC that Dr. Vladeck was associated with before he went to HCFA, that claim was for $155 million and was settled for $25 million.

Mr. HAST. That is correct.

Chairman THOMPSON. Is that correct?

Mr. HAST. That is correct.

Chairman THOMPSON. And in the agreement with VNS, that is the Visiting Nurse Service in New York, HCFA allowed VNS to add a specified number of hours to its Medicare average for all future years regardless of the number of hours that services were actually rendered, is that correct?

Mr. HAST. That is correct.

Chairman THOMPSON. And in the agreement with HHC, HCFA allowed HHC to continue to bill for bad debts without any documentation to support those costs, is that correct?

Mr. HAST. That is correct.

Chairman THOMPSON. And in the case of LA County, HCFA did not require LA County to meet recordkeeping requirements generally required by Medicare?

Mr. HAMEL. Well, they did not specifically say in the agreement that you do not have to, unlike the New York City Health and Hospitals agreement. However, HCFA officials in the regional office had complained that LA County had been "a problem child" for them in their oversight and that they wanted a provision in the settlement that would ensure or at least guarantee that LA County would try to meet those requirements, and they did not get that.

Chairman THOMPSON. In the 96 settlements you reviewed, how many included the kind of provisions referenced in the settlement agreements I mentioned?

Mr. HAST. None of the other ones.

Chairman THOMPSON. And these three settlement agreements constituted 66 percent of all Medicare overpayment settlements since 1991?

Mr. HAST. That is correct.

Chairman THOMPSON. Neither of these three agreements were approved by the Department of Justice?

Mr. HAST. That is correct.

Chairman THOMPSON. Neither of these three agreements was approved even by the Office of General Counsel within HCFA?

Mr. HAST. Not even reviewed by the Office of General Counsel in HCFA.

Chairman THOMPSON. Neither of these three agreements was reviewed by any government attorney at any time?

Mr. HAST. That is correct.

Chairman THOMPSON. I believe that is all.

Senator COLLINS. Thank you, Senator Thompson. Senator Durbin.

OPENING STATEMENT OF SENATOR DURBIN

Senator DURBIN. Thank you, Madam Chair, and I would like to ask that my opening remarks be made a part of the record.

Senator COLLINS. Without objection.

Senator DURBIN. Thank you.

[The prepared opening statement of Senator Durbin follows:]

PREPARED OPENING STATEMENT OF SENATOR DURBIN

Madam Chairman and Senator Levin, thank you. I appreciate the opportunity to join you today. I have supported your continuing efforts, Chairman Collins, to examine weaknesses in the Medicare program which threaten the integrity of this critical safety valve that ensures the delivery of health care to 39 million seniors and disabled individuals in our country—a program which paid out $169.5 billion last year. Under your leadership over the last 3 years, this Subcommittee has undertaken several important inquiries into various deficiencies in how the program operates which make it susceptible to fraud and abuse and to explore solutions to address these problems.

Earlier this month, the HHS Inspector General released new figures about Medicare program losses—funds wasted through fraud, mistakes and other problems. In 1999, such losses inched up to $13.5 billion after falling for 2 consecutive years. Nearly 8 cents out of every dollar paid by Medicare last year was wasted. The program paid out $169.5 billion last year. In 1998, the program lost 7 cents on every dollar, or about $12.6 billion. In 1996, the first year the comprehensive Medicare audit was done, overpayments accounted for 14 cents of every dollar spent, or $23 billion. In 1997, 11 cents on the dollar, or $20 billion, was lost.

I applaud the continued success of Operation Restore Trust, an effective anti-fraud program launched by President Clinton and one of our witnesses today, Dr. Bruce Vladeck when he was at HCFA's helm. When the results of the first comprehensive audit of 1996 payments was published, Dr. Vladeck explained how HCFA worked shoulder to shoulder with the auditors and welcomed their findings as a roadmap for further improvements. In a *USA Today* article Dr. Vladeck then wrote, "In its 31 years, Medicare has vastly improved the health and welfare of seniors and disabled citizens. We are the world's largest health-care insurer, processing 800 million claims a year at a far lower administrative cost than any private company. But only in the last 5 years have modern accounting principles and the standards that go with them been applied—making Medicare run more like a business."

Today's hearing takes a somewhat different tack than some of our previous inquiries, focusing attention on some of the complexities in how this massive program interacts financially with those who provide and deliver health care services to program beneficiaries.

I have reviewed GAO's Report to be released today and the written statements submitted by those who have been invited to testify. GAO's report raises some particular issues about the processes involved in recovering overpayments. I certainly hope today's forum will be an opportunity to hear fully from witnesses and put these issues in context and proper perspective. I wish to associate myself with the concerns outlined in the opening remarks of Senator Levin. I am troubled that the providers in the cases examined are not here to present their perspectives. I am particularly concerned that some of GAO's assertions and conclusions may convey mistaken or inaccurate impressions about the propriety of what actually occurred in these cases and about what happens in the routine administrative cost adjustment procedures used in the course of dispensing Federal funds to providers and recouping overpayment amounts when such are identified.

I hope we can create a clear, accurate, and fair record today and, as a result, examine whether there are any bases for seeking legislative changes or other corrective steps to clarify any legal ambiguities in collecting amounts owed to the government and to improve the processes for prompt recovery of overpayments. Above all, we must ensure that the vital reputation of the Medicare program remains strong and untarnished.

I welcome and look forward to hearing from the panelists.

Senator DURBIN. I would like to ask as a preliminary question, Mr. Murphy, you are General Counsel at GAO, so I am assuming correctly you are an attorney. Mr. Hast and Mr. Hamel, are either of you attorneys?

Mr. HAMEL. No, sir.

Mr. HAST. No.

Senator DURBIN. The reason I ask that is that I found really troubling the line of questioning which my colleague, Senator Levin, has raised. This report is unusual, and I have seen scores or maybe hundreds of GAO reports, particularly in that it focuses on that three largest Medicare overpayment settlements were improper, and yet questioning by Senator Levin has led me to conclude that you are not being as forthcoming as you should in terms of the GAO efforts to fully investigate the merits of these claims before drawing some rather sweeping conclusions as to whether or not they were improper.

There is an instruction given in courts of law across America which says that the jury may take into consideration the failure of the moving party or prosecutor to either call a witness or to bring forward testimony, and the jury may conclude that if they have not called such a witness or elicited such testimony, that it is likely that that testimony or witness would not have helped the government, would not have helped the movant.

I find it interesting that not only did you not question the substance of the agreements and settlements that are the reason for your investigation, but that we are not calling any of those parties today before this Committee to talk about whether or not this was, in fact, fair or proper. How can you draw conclusions as sweeping as saying that had these matters been litigated—let me quote directly—"Providers were all able to pay the entire overpayment amount. HCFA would have prevailed if the matters were litigated. The amount of recovery would have exceeded the cost of collecting each of these multi-million-dollar debts"—if you, in fact, did not get into the substance of the claims that were before you?

Mr. HAST. Well, I think we did get into the substance of the claim, and I would like to just clarify a little bit. When we talk about improper settlements, we are talking about the lack of internal controls by HCFA or following their own internal controls caused these settlements to be made by HCFA improperly, not talking about what the hospitals or the home health care agency did, but the improperness of the settlements is the failure of HCFA to follow its own internal guidance in how they settled the claim——

Senator DURBIN. Oh, but that is not what you say.

Mr. HAST. Let me——

Senator DURBIN. I will let you finish, but that is not what you said.

Mr. HAST. I will go to the second part of it, also. When we talk about litigation risk and we talk about the fact that we believe they would prevail, when we spoke to the health care providers, they basically gave no excuses. Their excuse for not being able to keep documentation is there is just too much of it. We cannot do it. I mean, they did not come up with reasons that we found to be credible.

When we said that we believe they are able to pay the entire amount, in two of them, HCFA had already withheld the money, so they had the money. If they did not give it back, they had been paid in full by those two providers. The home health care agency had set up a reserve of about two-thirds of the money, $56 million, so most of the money to pay it back was either already in HCFA's hands and they would not have had to return it, or it was in the health care——

Senator DURBIN. Mr. Hast, following procedural guidelines is one thing. Going to the substance, and you have raised some questions which I would bet we could have 2 days of hearings with any one of these parties over, whether they had an ability to pay, whether there were underpayments by HCFA that might have been claimed as set-offs. This could go on for a long time. It is a lot of money. One of these cases was pending over 11 years, if I am not mistaken, before HCFA.

And what you have found are, as I can conclude here, three technical and procedural questions which are raised by GAO in their report, and, therefore, you have concluded that had you taken this to court, the government would have won, in your words, if litigated, the government would have succeeded. I just find that very troubling, to reach those conclusions.

This is the Sherlock Holmes barking dog. This dog is nowhere to be found, neither in your investigation nor in this Committee hearing, and for you to reach these conclusions and to really cast a shadow over the efforts of Mr. Vladeck as well as career employees at HCFA I think goes a little bit beyond what the GAO has done in any report that I have seen.

Let me ask Mr. Hamel this question. Mr. Hamel, this has really become kind of a personal crusade for you, as I gather. First, you worked on this case with the Department of Health and Human Services, is that correct?

Mr. HAMEL. First of all, it has not been a crusade. Second of all, there was only one matter which I did have an affiliation with of the three.

Senator DURBIN. But did you not work on this first with the Department of Health and Human Services?

Mr. HAMEL. Well, I take exception to the matter as if GAO's matter was all three combined. I worked on one of the three matters.

Senator DURBIN. Let us stick with that one. Did you not work on that case with the Department of Health and Human Services?

Mr. HAMEL. Absolutely.

Senator DURBIN. And then you took the same case over to the U.S. Attorney's Office in their investigation, is that correct?

Mr. HAMEL. I am not going to comment on that.

Senator DURBIN. Excuse me?

Mr. HAMEL. I cannot comment on that matter. I can talk about the Inspector General's work, but I cannot comment on matters involving the U.S. Attorney's Office.

Mr. MURPHY. Senator, I think he is referring to Rule 6(e) in the Rules of Criminal Procedure and his ability to discuss grand jury matters because of that rule.

Senator DURBIN. OK. Well, I am going to ask Madam Chair, then, that we make as part of the record here a letter from March

27, the year 2000, sent, I believe, to both the Chairman and Senator Levin, and it was sent by the attorney who represented Mr. Vladeck, I hope I pronounce his name correctly, Robert Anello with a New York law firm, Morvillo, Abramowitz. The only reason I make this part of the record, or ask that it be made part of the record, is it states clearly that Mr. Hamel was involved in the investigation of this case with the U.S. Attorney's Office for the Southern District of New York, and if he does not want to comment for whatever reason, that is entirely his prerogative. But I would ask that this be part of the record.

Senator COLLINS. Senator Levin [sic], it has already been marked as an exhibit and will be included in the record.[1]

Senator DURBIN. Then not commenting on whether or not you would confirm or deny what has been said here by this attorney, you pursued this case again with the General Accounting Office, is that correct?

Mr. HAMEL. A portion of it, yes.

Senator DURBIN. OK. Let me ask you this. Are you an attorney?

Mr. HAMEL. No.

Senator DURBIN. I will ask Mr. Murphy then, as an attorney, if you were representing a client before a grand jury and you were asked to submit to an investigation by the GAO while that investigation was underway with the grand jury, would you have any second thoughts about testifying before the GAO while there was a pending grand jury investigation?

Mr. MURPHY. There is no doubt in my mind that I would not want my client testifying in front of GAO.

Senator DURBIN. Neither would I, and I think that is one of the reasons Mr. Vladeck did not, and to use this against him at this point, suggesting that there was something untoward or suspicious, I think is wrong. I think it also should be a matter of record, as noted—let us assume for the record that it is true, we can ask you for your own comments—that in October 1999, Mr. Vladeck's attorney let the GAO know that he was available if they wanted to ask questions and was told, and I quote here from the letter, "the train had left the station." The GAO did not want to hear him. Is that correct? Mr. Hast, do you know?

Mr. HAST. I think I commented before that we had given him a deadline at which time our report was going to be written. By that time, he was negotiating with the Committee and the Committee had told us they would continue to try to interview Mr. Vladeck, which they did, but that we would close out our report with the information we had at that time. But the investigation by the Committee was ongoing. They continued to negotiate with Mr. Vladeck and we would not have been able to write our report until last Thursday had we waited until the time that they finally produced Mr. Vladeck to give any type of deposition.

Senator DURBIN. So you had a publication deadline that you were faced with?

Mr. HAST. Yes.

Senator DURBIN. And you have heard Mr. Murphy's testimony here that, as an attorney, he would not have suggested to Mr.

[1] See Exhibit No. 19 which appears in the Appendix on page 124.

Vladeck to submit to the GAO questioning if there was a case pending before a grand jury. I am just asking, based on that, the suggestion that he was uncooperative by not speaking to the GAO really does not tell the whole story, does it?

Mr. HAST. I would stand by that on two out of the three. I understand that in the one, which I think he knew was already closed, to be perfectly honest with you, but on the other two that had only surfaced through the GAO investigation, there was no pending investigation by the Department of Justice and I could see no reason for him as a former public official not to explain to us his actions in those two settlements.

Senator DURBIN. Can I ask you one other question? You say in your report that you conducted your investigation from May through December 1999, and if Mr. Vladeck's attorney agreed that he was willing to provide information to the GAO in October 1999, apparently that was before you had concluded your investigation.

Mr. HAST. Our investigation concludes once we have finished our vetting process, which as I am sure you know takes a period of time. That period from October to November was moving it through the GAO process.

Senator DURBIN. So you were moving through your internal procedural process——

Mr. HAST. Yes.

Senator DURBIN [continuing]. But again, your procedural process, I do not think, should go to the question of the substance of this issue. I think Mr. Vladeck did the prudent thing. As an attorney, that is what I would have advised him to do, and to suggest that he was not cooperative, I do not believe is altogether accurate.

Can I mention one other thing? This Federal Claims Collection Act, which I do not know much about but I am learning, is apparently controversial. There is a HCFA memo which we have been given where they go to great length to suggest that your conclusion about its application in this case may be wrong. Are you familiar with that, Mr. Murphy?

Mr. MURPHY. Yes. I actually saw that just a few days ago, Senator. I have read it.

Senator DURBIN. Do you understand that even within HCFA, there is some question as to whether the first conclusion of the GAO of impropriety here may not even apply?

Mr. MURPHY. I read that letter, yes, sir, or that memo.

Senator DURBIN. So certainly within HCFA, there is—and perhaps with other agencies—there is some difference of opinion as to whether the Federal Claims Collection Act even applies to this case.

Mr. MURPHY. I cannot argue with that, because I have read that legal memo.

Senator DURBIN. OK.

Senator COLLINS. Senator Durbin, your time has expired, as you can see from the light there.

Senator DURBIN. I am sorry.

Senator COLLINS. The light on the table apparently is not working as it should.

Senator DURBIN. Thank you, Madam Chair.

Senator COLLINS. We have a number of other witnesses to get to. I know there are additional questions. I am going to suggest we do one final very brief round of 3 minutes each.

Mr. HAST AND MR. Murphy, I want to follow up on a point that Senator Durbin just raised. I want to show you Exhibit 1,[1] which is an excerpt from HCFA's own regulations concerning debt collection, its own regulations, and as you can see, it clearly states that HCFA refers all claims that exceed $100,000 or such higher amounts as the Attorney General may prescribe, and that has not happened, to the Department of Justice or the GAO—I realize GAO has been taken out of it now—but for the compromise of claims. As far as you know, was this regulation in effect at the time that the three claims we are discussing were being compromised?

Mr. MURPHY. It was in effect, Madam Chairman.

Senator COLLINS. And was it HCFA's usual practice to refer to the Department of Justice claims over $100,000 for which settlements were being proposed?

Mr. MURPHY. It was their practice to refer claims that had been determined by fiscal intermediaries over $100,000 to the Department of Justice.

Senator COLLINS. And these claims were way over $100,000, correct?

Mr. MURPHY. They were.

Senator COLLINS. Mr. Hast, did GAO's investigation determine that this was, therefore, not in keeping with HCFA's usual practice that these three very large claims, the largest in the last decade, were not referred to the Department of Justice when their own regulations very clearly state that they should be?

Mr. HAST. That is exactly what we found.

Senator COLLINS. Mr. Hast, an issue has been raised about whether it is likely that the providers would have prevailed in litigation had they gone forward. Now, I realize, as Mr. Murphy said, that none of us knows for certain what would have happened had we gone forward, had the claims gone through the normal process and not been circumvented, but would it not have been very unlikely that providers would be able to prevail when they did not have the documentation to support the claims that were in dispute? Mr. Hast?

Mr. HAST. Yes, that was our opinion.

Senator COLLINS. And was that the basis for your conclusion that they were unlikely to prevail?

Mr. HAST. Yes, that was.

Senator COLLINS. And your opinion in this matter was shared by the fiscal intermediaries, is that not correct?

Mr. HAST. By the fiscal intermediaries and by HCFA officials in the regions.

Senator COLLINS. So the lower-level HCFA officials, the regional officials who knew the providers, plus the fiscal intermediaries who handle these kinds of claims at the first level agreed that they thought they could prevail?

Mr. HAST. That is right.

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[1] See Exhibit No. 1 which appears in the Appendix on page 101.

Senator COLLINS. I am going to ask you one final question. Mr. Hast, do you believe that these settlements were in the best interests of the government?

Mr. HAST. Because of HCFA's lack of following their internal controls, there is no way to positively know that. But HCFA, Mr. Booth, who negotiated the settlements for HCFA and did that for a living, told us they were not in the best interest of the government, and individuals that worked in the regions that reviewed overpayments for over 20 years told us they believed they were not in the best interest of the government, as did the fiscal intermediaries. The people that do this for a living believed this was not in the best interest of the government.

Senator COLLINS. Thank you, and thank you very much for your testimony this morning.

Senator Levin.

Senator LEVIN. Thank you, Madam Chairman.

The fiscal intermediaries are agents for HCFA, right?

Mr. HAST. Yes.

Senator LEVIN. And they make certain assessments as to what they believe is owing to HCFA from these providers, is that not correct?

Mr. HAST. That is correct.

Senator LEVIN. And you have given us a chart, I believe you have that in front of you, of all of the HCFA overpayment settlements? [1]

Mr. HAST. Yes, I do.

Senator LEVIN. That is the 96 that have been referred to?

Mr. HAST. I do.

Senator LEVIN. And when you go down all these alleged overpayments by the intermediaries, in most if not all cases, HCFA ended up agreeing that their fiscal intermediaries' assessment of overpayment was not either provable or was not perfect. They ended up settling all these cases, did they not, or just about all these cases?

Mr. HAST. Some of them were bankruptcies and so forth, but yes.

Senator LEVIN. They settled most of them?

Mr. HAST. They settled most of them.

Senator LEVIN. So, for instance, take a look at number nine, Century City Hospital, California. The fiscal intermediary said that there was an overpayment of $239,000, but they ended up paying the hospital $180,000, right?

Mr. HAST. That is correct.

Senator LEVIN. As a matter of fact, was there not a confidentiality agreement in that one? Take a look at your last column there.

Mr. HAST. I would say yes.

Senator LEVIN. Thank you.

Mr. HAST. There were about six other ones that had them, yes.

Senator LEVIN. There were other confidentiality agreements besides these three, were there not?

Mr. HAST. Out of the 96, there were six or seven.

Senator LEVIN. So this was not unique?

Mr. HAST. Unusual, not unique.

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[1] Chart referred to is a GAO work product—not publically available.

Senator LEVIN. Right. Is it not true that there were other confidentiality agreements, just to be straight?

Mr. HAST. It is true.

Senator LEVIN. Thank you. Look at number ten, Cleveland Clinic. The fiscal intermediary said there was an overpayment of $648,000, correct?

Mr. HAST. Yes.

Senator LEVIN. HCFA ended up paying $300,000, right?

Mr. HAST. Yes.

Senator LEVIN. And there was a confidentiality agreement there, right?

Mr. HAST. There was.

Senator LEVIN. And then look at number 13, Howard University. The so-called fiscal intermediary said that Howard owed them $58 million, right, owed the government?

Mr. HAST. That is right.

Senator LEVIN. And then it ended up that Howard paid the government $10 million, is that correct? Is that correct, without going into the whole history, because you have only got 3 minutes.

Mr. HAST. It is correct.

Senator LEVIN. Thank you. Now, take a look at all of these claims, National Medical Enterprises, number 15. The fiscal intermediary said $2.6 million was owing the government, right?

Mr. HAST. Yes.

Senator LEVIN. But the government ended up paying $2.4 million, right?

Mr. HAST. Yes.

Senator LEVIN. So case after case after case, we figure that the amount of payments ended up to be about the same percentage as the payments in these cases. By the way, you can make your own assessment, but I do not want to run out of time here.

Mr. Murphy, I am puzzled by your conclusion on the conflicts of interest issue. The HCFA ethics official asked the OGE to confirm certain elements of Dr. Vladeck's ethics agreement, and here is the relevant paragraph. This is when he was hired, OK, because he had these prior connections. He is required by 5 CFR for a period of 1 year—1 year—following his resignation to consider the need for a recusal from personal and substantial participation in an official capacity in any particular matter. That was approved by the Office of Government Ethics, is that correct?

Mr. MURPHY. Absolutely, yes.

Senator LEVIN. And how many years after his resignation was his involvement, to the extent there was involvement here that had taken place?

Mr. MURPHY. I think it was almost 3 years.

Senator LEVIN. All right.

Senator COLLINS. Senator, your time has expired. Senator Thompson.

Chairman THOMPSON. Well, that being the case, then, why was Mr. Vladeck trying to stay out of this? My understanding was that he was kind of giving instructions as to what to do kind of behind the scenes, but he did not want to be out front on it, is that not correct?

Mr. HAST. That is correct.

Chairman THOMPSON. Well, if there was no conflict of interest problem under the law, then it has to raise the question. Perhaps, just perhaps Mr. Vladeck thought that although there might not be a technical conflict of interest under the law that it might not look too good for an administrator who had been previously on the board of this entity to be pressuring these people to go against their own rules and procedures and secretly cut a deal for $25 million for a claim of $155 million. Perhaps he thought that might not look very good. I agree with Mr. Vladeck. That does not look very good, and I think it is very important that we keep our eye on the ball.

An official in a department, especially a lower-level official in a department, cannot cut a deal on his own behalf with regard to a claim that the government has for a few cents on the dollar in hopes that maybe ultimately when all the trials are conducted, perhaps these people did not owe the government all that much money anyway, or that after we have hearings on the subject, maybe we can attack the GAO because of their motivations or something like that. Government officials cannot do that. They cannot go against their own rules. They cannot hide these deals from the attorneys. They cannot keep these things out of the hands of the Justice Department or their own attorneys. They cannot stand back behind a tree and pressure others to do their work for them when it goes against the interest of the government. That is what all of this is about, and I think you have done a fine job in pointing that out. Thank you very much.

Senator COLLINS. Thank you, Senator. Senator Durbin.

Senator DURBIN. Thank you, Madam Chair.

I tried to read this Federal Claims Collection Act, which is your number one reason for arguing that this whole process by HCFA was unfair and improper, and I will tell you, this is really a challenge for any law student, lawyer, or law professor to try to figure out what this law means. We have seen one paragraph of it, just two or three paragraphs down, completely conflicting instructions in terms of whether or not these matters need to be submitted to the Department of Justice. There is a lengthy memo here from HCFA saying that refers to compromises. This was a settlement before an administrative hearing and it does not apply. So there is clearly a difference of opinion, and you have made your case on this. I really think that if that is what you are relying on to convict or condemn, that it is a thin read.

May I ask specifically, it has been stated in your report and again at this hearing that Mr. Booth said, "the settlements were not in the best interest of the government." I am quoting from your report, not quoting from Mr. Booth because you did not put it in quotation marks. Were those his exact words?

Mr. HAMEL. I have to take a look in the report.

Senator DURBIN. Well, I am anxious for you to do it, because he is going to be here in a little while and he says in his statement that he will give before this Committee under oath, "I believed at the time the settlements were appropriate." So he has either had a change of heart or perhaps what you are representing to the Committee is not what he said.

Mr. HAMEL. No, he said they were not in the best interest of the government. I do not know whether he quoted it with quote marks around it in the report. That is what I was looking for.

Senator DURBIN. But those were his words, they were not in the best interest of the government?

Mr. HAMEL. That is correct.

Senator DURBIN. Was that the extent of his statement? He did not go any further?

Mr. HAMEL. Oh, well, there was substantive discussion about settlements, but we asked him at the end of the day, were these in the best interest of the government and he said no.

Senator DURBIN. In the context of, if we could have received more money from these providers, it would have been better for the government, or in the context that it was illegal or improper to reach these settlements? Give us a context for that statement that has been oft quoted.

Mr. HAST. I think that Mr. Booth told us that he believed he was asked to go outside the normal procedures and he was uncomfortable with being asked to go outside the normal procedures and he did it as an accommodation for Mr. Booth. He said that both he and Mr. Ault were uncomfortable with it and they knew full well that these needed to go to their OGC.

Senator DURBIN. Well, we will have a chance to ask him directly because his statement, which will be under oath, suggests otherwise.

Secondly, the question of who would have prevailed if this case had gone to court, I think has been beaten to death here and need not go any further, but I think the fact that these providers are not here today and they were not brought into this to a level to judge the substance really raises a question about that.

Finally, let me just say, the last point that you make about the ethics here, I am anxious to hear Mr. Vladeck because your conclusion says, "More importantly, his participation in the largest of these settlements raise conflict of interest concerns which we could not resolve given his refusal to meet with us," and I think it has been at least indicated by his attorney that he was prepared to meet with you, and that is the third point that you made of the three.

I think he could have erred on the side of prudence and submitted this to an ethics evaluation because of his past connection and then some conclusion might have been reached. But to base the whole case on that question, or really coming down to that question, really is not what I have seen in the past from the GAO and I certainly hope that subsequent testimony will clarify this. Thank you.

Senator COLLINS. Would you like to respond to that, Mr. Hast, or would you just as soon be excused at this point?

Mr. HAST. No, we stand behind what we have submitted in this report.

Senator COLLINS. Thank you for your testimony.

I would now like to call forth our second panel of witnesses this morning. Both of these witnesses are currently employed in the regional offices of the Health Care Financing Administration.

Our first witness is Jean Ohl, who is a Technical Health Insurance Specialist in HCFA's San Francisco Office. Tony Seubert is a Payment Specialist at HCFA's regional office in New York. Both these individuals participated in the settlement negotiations that resulted in the eventual compromise of Medicare claims in the cases involving LA County and the Health and Hospitals Corporation of New York.

Would you please stand so that I can swear you in. Do you swear that the testimony you are about to give to the Subcommittee will be the truth, the whole truth, and nothing but the truth, so help you, God?

Ms. OHL. I do.

Mr. SEUBERT. I do.

Senator COLLINS. Thank you. First of all, I want to thank you very much for being here today. I realize that this is very difficult for you, and indeed, Ms. Ohl's lawyer has expressed concerns to the Subcommittee staff about possible retaliation for her testimony. I want to give you my personal assurance that if there is any such action taken against either of you for telling the truth before us today, that I will personally get involved. We count on our civil servants to do what they believe is right and to tell the truth to members of Congress, and I just want you to have that personal assurance. I know it is very difficult, nonetheless, to be here today and I appreciate your willingness to help us better understand the circumstances of these settlements.

Ms. Ohl, do you have a statement you would like to make?

Ms. OHL. No, Madam Chairman, I do not have a statement.

Senator COLLINS. Mr. Seubert, do you have a statement you would like to make?

Mr. SEUBERT. No, I do not.

Senator COLLINS. Thank you. I am going to proceed right to questions, then. I am going to ask each of you to be sure the microphone is right in front of you. They are very directional and it is difficult for us to hear you if you are not speaking directly into the microphone.

Ms. Ohl, how long have you worked for HCFA and what is your current position?

TESTIMONY OF JEAN OHL, TECHNICAL HEALTH INSURANCE SPECIALIST, HEALTH CARE FINANCING ADMINISTRATION

Ms. OHL. I joined HCFA in 1978 as an Audit and Reimbursement Specialist in the Division of Medicare. From that position, I moved into Audit and Reimbursement in Medicaid. In 1992, I became Manager over the branch that contains the Audit and Reimbursement Section. And in September 1999, I moved out of management into my current position, which is a technical health insurance specialist specializing in fraud and abuse and other special projects.

Senator COLLINS. So you have been with HCFA for more than 20 years, is that correct?

Ms. OHL. That is correct.

Senator COLLINS. At the time of your involvement with HCFA's settlement with LA County, what was your job title and responsibility?

Ms. OHL. I was Branch Manager over the branch that was Program Safeguards in the Division of Medicare.

Senator COLLINS. How did you first become involved in the negotiations with LA County to resolve the disputed reimbursement claims?

Ms. OHL. In mid-October 1996, one of my staff on my Audit and Reimbursement Section, Gary Terada, was asked by another individual in Medicaid to look at a letter that was sent him by LA County explaining that Medicare had owed LA County Hospital some reimbursement. Mr. Coupar, who was the individual in Medicaid that came to Mr. Terada, because Mr. Coupar did not know any of this, and had asked Mr. Terada to look into this, and as Branch Manager, Mr. Terada kept me informed.

In early November, then, another letter came in from LA County, again as a result of some information that Mr. Terada had passed back to Mr. Coupar, and this early November letter again discussed some of these issues. Then in mid-November, we received in the regional office an E-mail from Mr. Booth in central office HCFA asking us what we were doing about—if we were doing anything, even, with respect to a settlement on LA County.

Senator COLLINS. At some point during the settlement process, did Mr. Booth inform you that he was taking the matter away from the regional office and that he would handle the settlement negotiations from HCFA's central office in Washington?

Ms. OHL. He wrote an E-mail saying that he believed they could move it faster than the fiscal intermediary could because of a lack of documentation.

Senator COLLINS. And this is the issue where LA County provided some documents but they did not support the claims that were in dispute, is that correct?

Ms. OHL. They were not able to provide acceptable documentation to support what they had claimed on their cost report and which they had under appeal at that time with the PRRB.

Senator COLLINS. Was it unusual for you to lose jurisdiction over the settlement of a claim in your region? Was it unusual for it to be taken out of the region and to be handled by Washington?

Ms. OHL. Well, actually, this is an independent appeal process that HCFA is not to interfere in. It is a provider's due process, and HCFA is—tries to stay out of it so it keeps its independence. We are very conscious about the appeals process being independent.

Senator COLLINS. Do you recall in your 22 years working for HCFA any other case in which it was taken out of the region and handled at Washington?

Ms. OHL. I do not.

Senator COLLINS. So this was the only case that you remember in your 22 years at HCFA?

Ms. OHL. This was very unusual, yes, the only one I remember.

Senator COLLINS. And did Mr. Booth ever tell you that he was under direction from Mr. Vladeck, HCFA's Administrator, to resolve the dispute?

Ms. OHL. Yes, he did. He said he was doing this as a personal favor to Mr. Vladeck.

Senator COLLINS. He said that he was handling it as a personal favor to Mr. Vladeck?

Ms. OHL. That is correct.

Senator COLLINS. Did he mention that part of the purpose was to get more money for LA County?

Ms. OHL. Yes, he did.

Senator COLLINS. What is your understanding of the Federal Claims Collection Act? Do you believe that the Justice Department does need to sign off on settlements exceeding $100,000, based on your experience?

Ms. OHL. Yes, they do.

Senator COLLINS. So in your opinion, had you been handling this case in the normal course, had it not been so highly unusual, in fact, unique in your career, the LA County settlement would have been referred to both the Office of General Counsel and the Department of Justice for review and approval?

Ms. OHL. Yes, that is correct.

Senator COLLINS. Ms. Ohl, did you and the other officials in the regional office think that the LA County settlement was a good deal for the Medicare trust fund?

Ms. OHL. No. In fact, I had documented my concerns in an E-mail to our central office and I stated in that E-mail that I did not think this was in Medicare's best interest——

Senator COLLINS. Let——

Ms. OHL. And I was not alone in this. The whole regional office is very much behind me in this position.

Senator COLLINS. So all of your colleagues who are familiar with this case agreed with you that this was not in the best interest of the Medicare trust fund?

Ms. OHL. Those of us working in the Medicare program, that is correct.

Senator COLLINS. And they were upset about what was happening?

Ms. OHL. That is correct.

Senator COLLINS. Could I show you the E-mail that you sent to Mr. Booth responding to his request for comments on the draft of the proposed agreement.[1] Now, again, is it accurate that you sent this E-mail because you wanted to be on record that you were very dissatisfied with this settlement, you thought it was a bad deal for the government?

Ms. OHL. Yes.

Senator COLLINS. And you told my staff that you were shocked when you saw the proposed settlement and the terms of the settlement. Why was that?

Ms. OHL. I was shocked because the original amounts that were claimed on the hospital cost reports for LA County totaled about $12 million that were under appeal with the PRRB. And, additional documentation that LA County had provided to central office had shown various issues that they felt were a little bit higher than that. They had eventually raised that amount to somewhere around $32.5 million. And, I thought that was the last I had heard of what figures we were talking.

So in early March 1997, when we got the proposal to look at the settlement agreement, it had $51 million in there, and I was very

[1] See Exhibit No. 3 which appears in the Appendix on page 103.

surprised—extremely surprised, to say the least. I went back to my staff to ask for an explanation, to see if he could explain it. He was able to come up with some documents to show me that in mid-January 1997, Mr. Booth had sent some documents LA County had provided to the fiscal intermediary to get a background explanation of what the issues were, and in there, the figures actually totaled about $53.6 million. So, actually, further on in this very same E-mail, I asked for an explanation of my assumption being that the $51 million settlement was on the $53.6 million, because that is all I knew about.

Senator COLLINS. Was one of your concerns, and I believe it says in the E-mail that the basic dispute between LA County and the fiscal intermediary is one of recordkeeping and billing requirements or the lack of supporting documentation, rather than a difference in policy interpretation?

Ms. OHL. That is correct. The biggest portion of this was bad debts. LA County had actually several times delayed their hearing on that particular issue because they did not have documentation to support their position, and they had actually sent letters to the PRRB asking for delays because they did not have documentation.

Senator COLLINS. So were you essentially warning Mr. Booth that LA County could not prove its claims for reimbursement under Medicare?

Ms. OHL. They would not be able to, in my opinion or the opinion of the fiscal intermediary, to be able to justify all of what they were claiming.

Senator COLLINS. Did you believe LA County was getting special treatment?

Ms. OHL. Yes, I did.

Senator COLLINS. Are you aware of any other providers in your region that have received this kind of special treatment?

Ms. OHL. No, I am not.

Senator COLLINS. Is that part of the reason why you were so upset about this settlement?

Ms. OHL. I believe that was the major reason. A process like this circumvented the normal procedures and allowed special consideration. If something like that were to get out, it would set very bad precedents and we would be inundated with additional requests, and it was clearly outside the authority we in the regional office would have to deal with these.

Senator COLLINS. Is it fair, Ms. Ohl, to say that you thought HCFA was simply giving LA County the money without regard to whether they were entitled legally to reimbursement under Medicare?

Ms. OHL. I cannot say what documentation LA County finally provided to central office, but all of the documentation that we had seen in the regional office or that our fiscal intermediary had seen clearly did not support the amounts that were being claimed in these numbers.

Senator COLLINS. Thank you. Senator Levin.

Senator LEVIN. Thank you, Madam Chairman.

When we say LA County, is that like a group of hospitals?

Ms. OHL. They have, I am not sure of the number, but it is eight to ten hospitals.

Senator LEVIN. And they have a lot of health care centers?

Ms. OHL. Yes, they do.

Senator LEVIN. Could there be as many as 40 or 50 health care centers?

Ms. OHL. I am not sure what you mean by health care centers, but they have a lot of outpatient departments associated with each of those hospitals and there are probably even more than that number.

Senator LEVIN. The figures we have are that there are about 3 million outpatient visits a year at these facilities and that they total 54. Would that sound within the ballpark?

Ms. OHL. I would not know, sir.

Senator LEVIN. Could that be possible? I mean, could it be millions of outpatient visits a year?

Ms. OHL. It could definitely be. LA County is tremendously large.

Senator LEVIN. And there was a problem, a dispute, whatever you want to call it, a billing difference that covered years starting in the early 1980's?

Ms. OHL. There were actually two different types of problems we were dealing with. We were dealing with LA County's inability to actually submit claims for services provided, and that was actually in another part of the division that I did not have first-hand knowledge on. The part that I was looking at was the audit side, where it talked about the reimbursement and identification of costs involved. With bad debts, that falls under my area, and that would be the coinsurance, the deductible portion of the claims that should have been billed. And yes, they did have problems actually submitting claims.

Senator LEVIN. And this problem that existed for about—since the early 1980's, so there was an ongoing problem about billings and reimbursements with a whole bunch of hospitals here, is that correct?

Ms. OHL. My understanding on that side, on the claims side, is that LA County was developing new computer systems and billing systems that were supposed to be ready in 1992 or 1993. Again, it is not my primary area of responsibility, but those are—I had been told by the contractor rep for Blue Cross of California at the time.

Senator LEVIN. Now, HCFA had actually had money in its hands which the Los Angeles Hospital claimed, is that correct? In other words, was there not, once this process began, a decision by HCFA to hold up on certain reimbursements, to hold back on certain reimbursements, is that correct?

Ms. OHL. HCFA does not hold back on reimbursement. It pays—when the claim comes in, it makes an interim determination and pays that amount. There is a final settlement, and that goes on through the cost report at the end of the fiscal year. Then the fiscal intermediary is responsible for settling that cost report through an audit-type process and that audit process would make adjustments for any costs that the auditors would find to be not Medicare-related, inappropriate, unreasonable, unnecessary, and that would be an adjusted amount. Then there would be a claim that would go out called an NPR, the Notice of Program Reimbursement, and at that point in time is when Medicare, if there was an overpayment, would demand payment back on that.

Senator LEVIN. In addition to demanding payment back, they also would withhold money that would be otherwise owing to the hospitals, is that correct?

Ms. OHL. Only withhold after giving the provider an opportunity to pay or ask for an extended repayment plan, and if neither one of those were met, then they would be put on withhold.

Senator LEVIN. Was about $53 million then withheld here from these hospitals?

Ms. OHL. I could not say. I do not know where the $53 million came from.

Senator LEVIN. You do not know how much money was withheld, if any, from these hospitals?

Ms. OHL. I am trying to understand how to—try to figure out how to explain the process to you, sir. The cost report may have actually even come up with an underpayment and a payment may have been made at that point in time. I do not know. I did not go back in the history and see that process. The $53 million figure came from LA County, I presume. I do not know what it is based on, nor do I know if it was ever even included in the cost report for there ever to have been a withholding on it.

Senator LEVIN. So you do not know whether there was an NPR relative to these hospitals?

Ms. OHL. There is an NPR related to them, but the NPR, in that, there is only $12 million in dispute.

Senator LEVIN. Is it fair to say there were a lot of unresolved reimbursement claims between HCFA and the hospitals?

Ms. OHL. Unresolved reimbursement adjustments on the cost report.

Senator LEVIN. Right, and that they had been outstanding, these differences, disputes, for many, many years?

Ms. OHL. That is correct. In fact, they were actually scheduled to be heard by the PRRB and delayed at the request of LA County.

Senator LEVIN. And the unresolved claims had gone back as far as the early 1980's, is that accurate, do you know?

Ms. OHL. I have heard as early as 1981, but I believe at this point in time things had been settled up until about 1986, 1987, 1988, so there is really only at this point in time going back to the latter part of the 1980's.

Senator LEVIN. Let me read you a letter which was received, I believe yesterday, from Congressman Waxman, that I would ask to be made part of the record.[1]

Senator COLLINS. Without objection.

Senator LEVIN. "It has come to my attention that the Senate Governmental Affairs Subcommittee is conducting a hearing tomorrow concerning how HCFA settled certain Medicare claims in 1996, including some claims relating to public hospitals in LA County. I thought it might be useful to give you some context on this issue."

"During the 1995–96 period, LA County was in a period of severe fiscal crisis with alarming implications for the continued viability of the public hospital system. There were threats of bankruptcy and some were even suggesting that the county would have to walk away entirely from their obligations to serve the poor. There was

[1] See Exhibit No. 28 which appears in the Appendix on page 246.

probably not a member of the LA delegation of either party who was not aware of the serious threat posed to continuing health care services to the many poor and uninsured persons who were served by these providers."

"During that period, the California State administration under Governor Wilson supported and forwarded to HCFA proposals for a waiver of certain Medicaid requirements, and during the discussions of the county and State with HCFA, the severity of the problem facing the LA health system was undoubtedly impressed on HCFA and other officials in the administration. Many members of the delegation, I am sure, urged HCFA officials to act appropriately and responsively in whatever areas were before them to aid the county in avoiding what loomed as a public health disaster. In other words, we wanted to assure that inattention or bureaucratic delays in resolving resolvable issues were avoided to the extent possible."

Were you familiar with the effort on the part of the California delegation and the governor to get this matter resolved because of the financial circumstances of the hospitals?

Ms. OHL. I knew on the Medicaid side of our regional office that they were working in trying to see what could be done, but I did not know the details related to that.

Senator LEVIN. Thank you. Thank you, Madam Chair.

Senator COLLINS. Thank you. Senator Thompson.

Chairman THOMPSON. Thank you very much.

Mr. Seubert, let me ask you some questions, and I have several questions and I will try to get through them as fast as I can here. I understand that you have worked for HCFA since 1976?

TESTIMONY OF TONY SEUBERT, PAYMENT SPECIALIST, HEALTH CARE FINANCING ADMINISTRATION

Mr. SEUBERT. That is correct.

Chairman THOMPSON. You are currently a Payment Specialist in the New York Regional Office?

Mr. SEUBERT. Correct.

Chairman THOMPSON. You previously worked in overpayment review for many years, is that right?

Mr. SEUBERT. I did.

Chairman THOMPSON. You became aware of the settlement negotiations between the New York City Health and Hospital Corporation, HHC, and HCFA. As I understand, in the spring of 1996, Chuck Booth called the regional office to tell you about a meeting that was being set up at your office with Empire, the fiscal intermediary, and HHC to discuss the appeals, is that correct?

Mr. SEUBERT. That is correct.

Chairman THOMPSON. What was the purpose of this meeting?

Mr. SEUBERT. As I understood it, the purpose was to initiate a discussion between the provider, Health and Hospital Corporation, and HCFA to see if there could not be some settlement reached or some breaking of the logjam.

Chairman THOMPSON. When Mr. Booth arrived in New York, did you offer to help him in any way?

Mr. SEUBERT. I did.

Chairman THOMPSON. What was Mr. Booth's response?

Mr. SEUBERT. Mr. Booth cautioned me. I think his words were, "Do yourself a favor, stay away from this."

Chairman THOMPSON. What did you think Mr. Booth meant by that statement?

Mr. SEUBERT. I took it to be a caution that this was highly sensitive in nature and that there would be some rocky shoals and that I might be wise to give it some distance and just sit at the table.

Chairman THOMPSON. Did you attend that first meeting?

Mr. SEUBERT. I did.

Chairman THOMPSON. Did you find the meeting to be unusual in any way?

Mr. SEUBERT. I did, Senator.

Chairman THOMPSON. Why was it unusual?

Mr. SEUBERT. Similar to the situation that I just heard Jean Ohl explain in California, the bad debt issue was a prominent issue under discussion. Bad debt is a relatively straightforward issue. It is a matter of producing documentation to substantiate a provider's claim for reimbursement. Essentially, it is to show that there was, in fact, treatment made and that that claim for payment had gone unpaid and that all necessary action had been made to collect that debt.

It became apparent during the course of discussion that the fiscal intermediary, Empire Blue Cross, felt very strongly that the documentation requirements had not been met. At some point during the discussion, Mr. Booth offered a suggestion that something called the disproportionate share percentage be inserted in lieu of actual hard documentation for bad debts, and that was very unusual.

Chairman THOMPSON. And why was that unusual?

Mr. SEUBERT. Well, it would be a proxy in lieu of documentation. Normally, Medicare, we work as an entitlement program——

Chairman THOMPSON. In other words, was he suggesting a settlement on behalf of HCFA that was based on no empirical data?

Mr. SEUBERT. That is correct, no supportable document, or no supportable, auditable documentation.

Chairman THOMPSON. Did anyone else find that meeting to be unusual?

Mr. SEUBERT. Yes, Senator.

Chairman THOMPSON. Who?

Mr. SEUBERT. Well, the auditors I spoke to at Empire Blue Cross and the Director of Audit and Reimbursement were somewhat disturbed by it.

Chairman THOMPSON. Would this be a Mary Adam from Empire?

Mr. SEUBERT. She was and still is the Director of Audit and Reimbursement at Empire.

Chairman THOMPSON. Was she one of the ones who expressed shock or surprise?

Mr. SEUBERT. Yes.

Chairman THOMPSON. At Mr. Booth's comments and methodology for resolving the bad debt claim?

Mr. SEUBERT. Yes.

Chairman THOMPSON. Is it my understanding that you did not attend additional meetings related to the settlement negotiations?

Mr. SEUBERT. That was the only meeting I attended.

Chairman THOMPSON. Why?

Mr. SEUBERT. To be candid, I was kind of disturbed by the outcome of the meeting and the direction it was taking, and frankly, I did not want to be sitting somewhere like here today. [Laughter.]

Chairman THOMPSON. Well, I would rather be sitting here with your story than some of the other stories that we are going to hear.

Do you believe that HCFA gave HHC special treatment?

Mr. SEUBERT. I do.

Chairman THOMPSON. Were they trying to cut a special break for HCFA?

Mr. SEUBERT. It appeared so. Well, not for HCFA, but for the Health and Hospital Corporation.

Chairman THOMPSON. I am sorry, for HHC. What has been your experience with regard to HHC?

Mr. SEUBERT. They were a troubled provider chain. At any point in time, there were about a dozen hospitals, sometimes more, sometimes a few less depending on who was still in business, but when I say troubled, their documentation or their ability to produce documents to substantiate costs that were claimed by the Medicare or in the Medicare program were less than good.

Chairman THOMPSON. What is HHC's history at HCFA, how they have been treated?

Mr. SEUBERT. Well, they had a record for appealing almost everything. I think at the time that this settlement was reached, there was somewhat in excess of 100 appeals pending and they were tardy in allowing us in to perform audits and they were tardy in producing documentation. They were a problem provider, which is not to say that they did not have a lot of work to do. In terms of our dealings with them, though, they were unable to substantiate costs with frequency.

Chairman THOMPSON. Did they have a reputation as to how they were treated at HCFA?

Mr. SEUBERT. I think they were treated with kid gloves over the years because they did deal with a large number of inner-city hospitals and a poor population.

Chairman THOMPSON. Were you concerned that the settlement was not proper?

Mr. SEUBERT. I was.

Chairman THOMPSON. Explain that a little bit.

Mr. SEUBERT. I was concerned with two things. We have already talked about the Federal Claims Collection Act, and I think that that was still a factor. My understanding is that under the Federal Claims Collection Act, any time there is in excess of $100,000 in controversy, and HCFA did have a claim substantially in excess of that amount, that the Department of Justice was supposed to sign off on any agreements that were reached.

I do think there was collection made on the original debt and some of that might not have been totally under the Federal Claims Collection Act. But it is my understanding that part of the debt was still outstanding and the part that was collected was under appeal. In fact, the whole amount was under appeal to the Provider Reimbursement Review Board, but as Jean Ohl testified, normally, HCFA's position is one of non-involvement in the process once an

appeal is initiated before the Provider Reimbursement Review Board.

Chairman THOMPSON. But they were involved in the process in this case big-time?

Mr. SEUBERT. Yes.

Chairman THOMPSON. Do you think HCFA has the authority to agree to compensate HHC for bad debts in the past or into the future without requiring HHC to provide proof of the costs that they were claiming?

Mr. SEUBERT. In the past, I would say yes, as long it is under the threshold of $100,000 because there was precedent for settlements being reached based on secondary evidence. Into the future, I would say absolutely not.

Chairman THOMPSON. Have you ever seen the actual settlement agreement with HHC?

Mr. SEUBERT. I did, subsequently.

Chairman THOMPSON. From what you know of the settlement, do you think it was a good deal for the Medicare trust fund?

Mr. SEUBERT. I will only address the bad debts, because that is the only thing I had a discussion about with the folks at Empire Blue Cross, and that was the largest part of the settlement. I spoke to the Empire auditors at length about it, and based upon the discussions I had with them, I would say resoundingly, no, it was not a good deal.

Chairman THOMPSON. Did HHC have any proof whatsoever for bad debts?

Mr. SEUBERT. My understanding is they had some and they were compensated for the proof that they presented. The issue revolved around those debts that were unsubstantiated.

Chairman THOMPSON. Did you think HHC would have prevailed on the merits of its appeals if they had gone before the PRRB?

Mr. SEUBERT. Well, clearly, no. I have not looked at their audit papers, but if something is unsubstantiated, again, this is an entitlement program and the burden is on the provider in the first instance to submit documentation. If documentation does not substantiate the claim, it cannot be supported upon appeal.

Chairman THOMPSON. There is a provision on page 2 of the settlement agreement,[1] paragraph 1(b), which as I understand it binds HCFA to compensate HHC for a certain percentage of all future bad debt claims without requiring HHC to prove that they incurred those costs. Are you familiar with that part of the agreement?

Mr. SEUBERT. I am. I have read that part of the agreement.

Chairman THOMPSON. What is your view of this clause of the HHC agreement?

Mr. SEUBERT. I find it mystifying. Barring an approved waiver agreement, it basically carves out an exception for Health and Hospital Corporation as opposed to all other providers in the Medicare program.

Chairman THOMPSON. Do you believe this settlement subverts the audit process?

Mr. SEUBERT. I do.

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[1] See Exhibit No. 21b. which appears in the Appendix on page 137.

Chairman THOMPSON. Well, I do not know of anything that I can add to that, other than to thank both of you. We have seen these problems that HCFA has had in times past and now we are understanding why. But we also see that there are some people on the inside trying to do the right thing, and I want to tell you how much I appreciate it and associate myself with the statements of the Chairman.

Senator COLLINS. Thank you, Senator. Senator Durbin.

Senator DURBIN. Thank you, Madam Chair.

I just have a few brief questions. I want to clarify here. The GAO report states that HCFA agreed to accept about 36 percent of the total principal at issue in the LA County case and the Visiting Nurses case. Is that your understanding?

Mr. SEUBERT. Senator, I am unfamiliar with those two cases. The only one I have a familiarity with is the Health and Hospital Corp.

Senator DURBIN. Do you have any familiarity with those?

Ms. OHL. I have not seen the GAO report, so I cannot comment on what it might have said.

Senator DURBIN. Well, the reason I raise that question is that I am told that, according to the numbers in the statement from Mr. Booth, the total amount at issue in Los Angeles County and HHC was $273 million. Is that your understanding?

Ms. OHL. In Los Angeles County, what was claimed on the cost report and that was under appeal was closer to the $12 million figure I referenced earlier. And then as Mr. Booth asked for additional documentation from LA County, those issues grew in numbers and I cannot discuss what made them up because I never saw any documentation.

Senator DURBIN. Then I will pursue this question with Mr. Booth. I do not want to put you on the spot on something you are not familiar with, but it is my understanding that the total amount at issue in LA County and HHC was $273 million and the settlement was for $181 million, recovery of about 67 percent, and that the Visiting Nurses matter was settled for over 70 percent of the disputed claim. I just want to make sure that that is clarified.

But could I ask you this, Ms. Ohl, if you would. I read in the testimony we are going to receive from Mr. Vladeck that this Los Angeles County situation was, he characterized, a potentially massive public health crisis and might have forced hospitals to close and outpatient facilities to close, as well, due to lack of funds. Do you think that is a fair characterization?

Ms. OHL. I am not familiar with the details at that time. LA County, in fact, I mentioned it in my E-mail, that it does a lot of indigent care, a lot of that type of stuff, but I do not understand—from the documentation and discussions I had with Blue Cross of California, there is evidence that some of the amounts in those figures were for patients or individuals who were not Medicare beneficiaries. So I did not understand how we could use Medicare trust fund dollars to pay for those, and I suggested alternatives in my E-mail, such as grant program.

Senator DURBIN. Again, that raises the question about why the GAO did not go into more depth in terms of the substance of this claim, and I do not understand that still, why they did not do so after they made some rather sweeping conclusions about whether

the amount of settlement was adequate. But thank you very much for your testimony.

Senator COLLINS. I want to thank you both for being here today and for your complete and candid responses to questioning.

Senator LEVIN. May I ask one more question?

Senator COLLINS. If it is quick.

Senator LEVIN. Thank you, Madam Chairman.

There was a claim that HHS had against HCFA, is that not correct?

Mr. SEUBERT. HHC, Health and Hospital Corp.

Senator LEVIN. I am sorry. HHC had a claim against HCFA because HCFA had withheld a significant amount of money, is that right?

Mr. SEUBERT. It was an appeal. They had an appeal of monies that they claimed against HCFA.

Senator LEVIN. But that money was basically withheld by HCFA, was it not?

Mr. SEUBERT. I believe it was partially withheld. I believe some was still outstanding and some had been——

Senator LEVIN. Do you know about how much money? Would it be in the $100 million range?

Mr. SEUBERT. I think initially, the amount in controversy was in the $100 million range, but how much was still outstanding, I am not certain of, Senator.

Senator LEVIN. But is it possible that there was $100 million that HCFA had withheld that HHC was claiming? Is that possible?

Mr. SEUBERT. It is.

Senator LEVIN. Because sometimes we talk about overpayments, claims and so forth. In this case, I understand, money, a significant, large amount of money, had been withheld by HCFA which HHC claimed, and that is what the dispute was about. In ordinary parlance, it was a claim that HHC had against HCFA for money which had been withheld by HCFA.

But we talked to Rick Langfelder, of HHC about the documentation. He said that HHC had given HCFA a room full of documents on their bad debts. Did they give a large number of documents on bad debts?

Mr. SEUBERT. My understanding is, yes, it was a—because there were at least 12 hospitals involved and bad debt, by its very nature, particularly on the outpatient side, involves one record for each claim paid, so there was quite——

Senator LEVIN. Does HHC have 11 hospitals, three skilled nursing facilities, and service perhaps 5 million outpatients a year?

Mr. SEUBERT. That sounds accurate.

Senator LEVIN. And the settlement in question here covered about 11 years, is that correct, from 1982 to 1993?

Mr. SEUBERT. My understanding was 1983 to 1993, yes.

Senator LEVIN. Eighty-three to——

Mr. SEUBERT. Eighty-three to 1993 was my understanding.

Senator LEVIN. Thank you both for coming forward.

Senator COLLINS. Again, I very much appreciate your testimony and your coming forward and explaining the circumstances of these cases to us. Thank you.

Mr. SEUBERT. Thank you, Senators.

Senator COLLINS. Our next witness this morning is Charles Booth, who is currently the Director of the Financial Services Group for the Health Care Financing Administration. Mr. Booth executed the three overpayment settlements at the center of the Subcommittee's investigation. He has been an employee of HCFA since 1977, but actually originally joined the Medicare program at its inception in 1965 when he was employed by the Social Security Administration.

I would now like to administer the oath to you. Do you swear that the testimony you are about to give will be the truth, the whole truth, and nothing but the truth, so help you, God?

Mr. BOOTH. I do.

Senator COLLINS. Thank you, Mr. Booth. Mr. Booth, would you like to proceed with your statement?

TESTIMONY OF CHARLES R. BOOTH,[1] DIRECTOR, FINANCIAL SERVICES GROUP, HEALTH CARE FINANCING ADMINISTRATION

Mr. BOOTH. Thank you, Madam Chairman. Madam Chairman and members of the Subcommittee, good morning. My name is Charles R. Booth. I am a career Federal employee and have worked for the Federal Government for 40 years. I am Director of the Financial Services Group, Office of Financial Management in the Health Care Financing Administration. In that position, I am responsible for the management of the agency's current administrative budget and spending. I have held this position since July 1977—1997, excuse me.

From 1984 through 1994, I was the Director of the Office of Payment Policy in the Bureau of Policy Development. In about 1988, the name of the office was changed from the Office of Reimbursement Policy and the name of the bureau was changed from the Bureau of Eligibility, Reimbursement, and Coverage, but the functions were essentially the same.

I directed a staff to determine the administrative policies for reasonable cost reimbursement, reasonable charge payment, and payment under a variety of fee schedules as Congress enacted them over the years. In addition, when disputes arose about the meaning of various policy interpretations, my staff and I responded to those inquiries. Some of those disputes involved the Office of the General Counsel of Health and Human Services. I was the person they consulted about HCFA's views on whether to settle or appeal certain cases, including those that arose from decisions issued by the Provider Reimbursement Review Board.

In November 1994, there was a reorganization within the Bureau of Policy Development and my role changed somewhat. I assumed more responsibilities for hospitals but no longer had the payment policy responsibility for physician services, home health agencies, or skilled nursing facilities. I held that position until July 1997.

A dispute arose in the early 1990's between the Visiting Nurses Service of New York, VNS, and its fiscal intermediary, United Government Services. United Government Services had reviewed certain costs for this home health agency which it wanted to disallow.

[1] The prepared statement of Mr. Booth appears in the Appendix on page 78.

Because the consequences were very significant, United Government Services discussed them with members of my staff and me. Representatives from VNS also met with us. Those meetings occurred in the fall of 1993. There were also a variety of phone calls with United Government Services representatives and other phone calls with an attorney representing Visiting Nurses Services.

Visiting Nurses clearly wanted to reach some compromise with United Government Services before any final decisions were made. United Government Services asked us in late February 1994 if HCFA was in agreement with its proposed action. After checking with Thomas Ault, who at the time was the Director of the Bureau of Policy Development and my immediate superior, we said we were.

United Government Services issued its decisions, those are Notices of Program Reimbursement, at the end of February 1994. Within a few days, Mr. Ault directed me to find a way to settle this issue. He asked me to meet with representatives from Visiting Nurses Services to find some middle ground because the amount at issue was too great. He indicated this needed to be accomplished quickly.

As a result, I met with representatives from Visiting Nurses Service and United Government Services on or about March 10, 1994, and we reached an agreement. The settlement agreement was drafted by United Government Services, was reviewed at length by Visiting Nurses Service, United Government Services, and me, and finally signed in April 1995.

The main issue in this dispute was whether the length of time Visiting Nurses Services claimed for nurses aides' visits was reasonable. Visiting Nurses served a large Medicaid population as well as a large Medicare population. The aides provided services to the Medicaid population that went beyond those for which Medicare would normally pay. These included homemaker services such as food shopping. While the average length of the Medicare visit was a little over 3 hours, the average length of the Medicaid visit was about 12 hours. Visiting Nurses Services claimed that we should average all the aide visit time for all patients and that Medicare should pay the cost based on that average for aide visits provided for Medicare beneficiaries.

United Government Services contended the aide visits for Medicaid beneficiaries were not like those provided to Medicare beneficiaries and that Medicare should pay only for the time the aides spent with Medicare patients, carving those out from the other visits. Costs for several years were at issue. United Government Services was proposing to disallow about $93 million. As a result of the settlement, Visiting Nurses Services paid the Government approximately $67 million.

In late January 1996, Mr. Ault, still my immediate supervisor, gave me a note dated January 19, 1996, from Rick Langfelder to his boss, Maria Mitchell. Mr. Ault told me to look into it, contact Mr. Langfelder, find out what was going on. Mr. Langfelder worked for the New York Health and Hospitals Corporation, HHC, an agency of the New York City Government that operated several hospitals. It was not clear from the January 19 note what the issues were.

I did contact Mr. Langfelder, met with him and others from HHC in February 1996. There were several issues HHC had with its fiscal intermediary, Empire Blue Cross, going back to the early 1980's. We discussed these issues again in May. However, by then, I had heard directly from Bruce Vladeck, the Administrator of the Health Care Financing Administration from May 1993 until September 1997. Dr. Vladeck inquired about what progress was being made to settle the issues raised by HHC. He was obviously disappointed by the lack of progress in settling these issues and expressed his strong desire to see more progress.

I met again with Langfelder and the others from HHC at the HCFA regional office in New York. That meeting took place in June. Representatives from Empire also attended. I had called William Toby, the Regional Administrator in New York, to ask if we could use space in his office as I believed it would be better to meet there than at HHC. Tony Seubert attended the meeting for Mr. Toby. We discussed the issues and HHC's estimate of the value of those issues but made little progress toward resolution.

Dr. Vladeck inquired about the status of the negotiation soon after the June meeting. He advised me that he needed to "report to the 6th floor." I took that to mean the Department's Office of the Secretary, but Dr. Vladeck provided no further description. Parenthetically, it is common within the agency to refer to the 6th floor as meaning the Office of the Secretary.

He was clearly not happy that very little progress had been made at the June meeting. I recall sending him an E-mail saying that I believed that if we moved quickly to settle the issues, we would end up paying more money. His reply was that he wanted it settled very quickly, that it was worth the extra money. I took this to be his clear direction to settle the issues.

An agreement was reached in mid-August. That meeting was also at the regional office. Empire drafted the settlement agreement, which was reviewed by all the parties and signed in mid-September. The issues settled were worth approximately $200 million and Empire paid HHC approximately $130 million.

In November 1996, I received a phone call from an analyst in the Office of Research and Demonstrations of the Health Care Financing Administration advising that Dr. Vladeck wanted me to look into a dispute between the Los Angeles County Hospitals and their fiscal intermediary, Blue Cross of California. I had a short discussion with Dr. Vladeck in late November or early December 1996, when he advised me that the time pressure was not quite so severe. It was very clear to me that this was a directive from Dr. Vladeck that he wanted this matter settled, as well.

I contacted representatives from Los Angeles County, had discussions with representatives from Blue Cross of California, and reached a settlement agreement with county representatives in late February 1997. As with HHC, there were several issues in dispute. I drafted a settlement agreement along similar lines as the HHC agreement and sent it to representative from Los Angeles County, the fiscal intermediary, and the HCFA regional office in San Francisco. The agreement was revised somewhat and signed and Blue Cross paid Los Angeles County about $51 million. The value of the issues in dispute was about $73 million.

I believed at the time and I believe now that I was acting under the express direction of Mr. Ault in the first instance and Dr. Vladeck in the latter two. I believed at the time the settlements were appropriate. I now know that I should not have agreed to or signed those settlements without the involvement of the Department's Office of General Counsel and agreement from the Department of Justice. At no time did I intend to violate any rules, regulations, or laws.

I have spent 33 years of my 40-year career working for the Medicare program, and I have tried to work for the best interests of Medicare beneficiaries and the Medicare program during this period. Thank you. I will try to respond to any of your questions.

Senator COLLINS. Thank you, Mr. Booth.

Mr. Booth, you just mentioned that you have been with the Medicare program since its inception, for more than 30 years. During that time, were there other occasions in which the Administrator of HCFA called you and directed you to settle cases like these three?

Mr. BOOTH. No, Madam Chairman, there were not.

Senator COLLINS. So——

Mr. BOOTH. May I say, there were other situations in which people came to see me saying the administrator sent them. I normally did not believe them. These were the only three where now—in the first instance, in VNS, I dealt only with Mr. Ault until after the agreement was made. In the second 2, I dealt with Dr. Vladeck directly.

Senator COLLINS. In your deposition, you said that the request came from Mr. Ault but clearly he was acting at the behest of Mr. Vladeck, is that correct?

Mr. BOOTH. I thought I said that was my belief.

Senator COLLINS. OK.

Mr. BOOTH. But Dr. Vladeck had no contact with me on the VNS matter until after the VNS matter had been settled.

Senator COLLINS. But did on the other 2?

Mr. BOOTH. But did on the other 2.

Senator COLLINS. On those 2, those were the only times in your more than 30-year career when the direction clearly came from the administrator?

Mr. BOOTH. Yes, but let me say that I was in the policy position from 1984 to basically July 1997. Those are the only times the administrator would have come to me under those circumstances. I had other responsibilities in other aspects of the program prior to that, so I think the characterization that—I mean, other administrators came to me to do other things, but not settlements.

Senator COLLINS. Not settlements? And in your deposition, you said to the Subcommittee that these were clearly outside of our normal practice because of the way in which you were asked to do them. Do you stand by that statement?

Mr. BOOTH. Yes, Madam Chairman, I do.

Senator COLLINS. I would like to ask you some details about the HHC case and to flesh out the testimony that you have given us. Now, it is my understanding, based on your deposition and your testimony, that in the spring of 1996, Mr. Vladeck asked you to look into the outstanding Medicare appeals involving HHC and

that he asked you to give him periodic status reports. Did he explain to you why he wanted status reports?

Mr. BOOTH. Not at first. After about the second one, he said that he needed to report to the 6th floor.

Senator COLLINS. And you have explained that that is where the Secretary's office is?

Mr. BOOTH. Yes, Madam Chairman.

Senator COLLINS. And in the common parlance of HCFA, when you refer to the 6th floor, you are referring to the Secretary's office?

Mr. BOOTH. Normally, yes.

Senator COLLINS. In July 1996, did Mr. Vladeck send you an E-mail commenting on the pace at which the negotiations were moving?

Mr. BOOTH. I thought that E-mail was probably in June, but I would not dispute that it was June or July.

Senator COLLINS. Did he express his hope or his opinion that the pace was too slow and he wanted you to pick up the pace of the negotiations?

Mr. BOOTH. It was clear that he wanted the matter settled and he wanted it settled very quickly.

Senator COLLINS. In response to the concerns that Mr. Vladeck expressed to you about the pace not being fast enough, did you advise him that if you rushed the process, it could end up costing HCFA and additional $8 to $10 million?

Mr. BOOTH. Yes, Madam Chairman, I did.

Senator COLLINS. And what did Mr. Vladeck reply when you expressed this concern that if you hurried the process, the Medicare trust fund could end up paying $8 to $10 million more money?

Mr. BOOTH. I cannot remember the quote exactly, but the essence was that time was more important than money.

Senator COLLINS. Did that exchange leave you with the impression that completing the settlement quickly was more important than the actual amount of the settlement, than trying to maximize the amount that the government would recover?

Mr. BOOTH. Yes, but may I add that the government actually had the money.

Senator COLLINS. Had the money, because it had been withheld.

Mr. BOOTH. Right. In the cost settlements from 1983 through 1992, at least, and in some cases I think 1993, when the costs were settled and the Notices of Program Reimbursement were issued, the fiscal intermediary then took whatever money was owed, if there was money owed, based on the intermediary's assessment of the value of the issues. And so all the money that we were discussing during the settlement negotiations was in the Medicare trust fund.

Senator COLLINS. And after Mr. Vladeck expressed concern to you about the speed of the negotiations, how long was it, approximately, before you reached an agreement with HHC, do you recall?

Mr. BOOTH. The agreement was reached in mid-August——

Senator COLLINS. So it was within a few weeks?

Mr. BOOTH. So within a few weeks, but three to six.

Senator COLLINS. And as a result of the agreement, HCFA agreed to reimburse HHC or to pay HHC for roughly $130 million of the $155 million in dispute, is that correct?

Mr. BOOTH. My recollection is that there was approximately $200 million in dispute, not 155. But we did agree to pay $130 million.

Senator COLLINS. So what you are saying is the amount forgiven may be even more than I realized based on the GAO report, which was an estimate of $155 million? Your recollection is that the total amount in dispute may have been about $200 million, is that correct?

Mr. BOOTH. Yes, but we paid 130 out of 200, not 130 out of 155. So we got a better deal than I think at least the GAO testimony this morning would have led me to believe. And I had given the GAO those numbers when I had met with them as early as May 1999.

Senator COLLINS. Was the primary issue in dispute that HHC did not have the proof to document its claims for reimbursement of bad debts under Medicare?

Mr. BOOTH. Yes.

Senator COLLINS. And did this settlement with HHC essentially cut them a break by reimbursing the hospital for a percentage of the bad debt costs without HHC having to prove that they actually incurred the costs?

Mr. BOOTH. No.

Senator COLLINS. Tell me what the settlement did.

Mr. BOOTH. It was clear that Medicare beneficiaries received both inpatient and outpatient services. When a Medicare beneficiary receives a service for which there is a deductible and the Medicare beneficiary is unable to pay that deductible or unwilling to pay that deductible, then there are some things that the provider, in this case, HHC, needs to do. They need to document whether or not the patient is indigent, and if the patient is not indigent, they are then required to send the patient at least two letters demanding payment of that deductible or coinsurance.

What the issue was, was whether or not Health and Hospitals Corporation in this case, and LA County in the other, could actually produce proof that they had sent those letters or whether they had proof that they had asked the right questions to determine whether or not the patient was indigent. It was not, in my view, a question of whether or not the services had been rendered and the costs had been incurred. The intermediaries in both cases had paid interim payments for the bills as they were processed. That led me to believe, at least, based on my discussions with both of the intermediaries involved and with the providers, that the costs, indeed, had been incurred. It was the question of not being able to prove that all the documentation was available.

Senator COLLINS. Mr. Booth, in your deposition, your sworn deposition before the Subcommittee staff, you said, quote, "In a couple of areas, we allowed past poor practices to be carried into the future, and by basically not requiring documentation, we were giving them a break." Do you stand by that statement?

Mr. BOOTH. Yes, Madam Chairman, I do. The practices were poor because they did not have all the documentation that the intermediary felt was necessary.

Senator COLLINS. Do you feel that Mr. Vladeck pressured you to get the HHC deal done?

Mr. BOOTH. Yes, Madam Chairman, I do.

Senator COLLINS. Did you know that Mr. Vladeck, prior to becoming the Administrator of HCFA, served as a director of HHC?

Mr. BOOTH. I do not know whether I knew that or not. I do not think it would have been relevant one way or the other.

Senator COLLINS. Senator Levin.

Senator LEVIN. Thank you, Madam Chairman.

GAO has said that you told them that you knew at the time that the settlements were not in the government's best interest, is that true?

Mr. BOOTH. No, sir.

Senator LEVIN. Did you believe at the time that these settlements were in the government's best interest?

Mr. BOOTH. Yes, sir, I did.

Senator LEVIN. Did you hear the GAO testify today?

Mr. BOOTH. Yes, Senator Levin, I did.

Senator LEVIN. And you are telling us under oath that you deny that you ever told the GAO that you believed at the time that these settlements were not in the government's best interest, and in fact, you did believe at the time that they were in the government's best interest, is that correct?

Mr. BOOTH. Yes, sir. I told them that, in retrospect, since I did not follow the procedure that I should have to get the Department of Justice lawyers involved, that in retrospect, there were certainly defects in the settlements.

Secondly, I told them that I have never dealt with a settlement of any kind with—no matter who was involved or how many people were involved, that I was ever totally happy with. I still question whether I paid too much for my last car. And it is in that light that I question whether or not we got the best deal for the government. But I have done that with virtually every settlement I have ever been involved in. This is not different from that in terms of the substance of the settlement.

Senator LEVIN. But I want to be real clear, because this is, it seems to me, critical, whether or not you at the time believed that this settlement was in the best interest of the government. You are testifying here today under oath, I believed at the time the settlements were appropriate, is that correct?

Mr. BOOTH. Yes, sir.

Senator LEVIN. And you did not tell the GAO that, at the time, you did not believe that the settlements were appropriate, is that true?

Mr. BOOTH. That is correct.

Senator LEVIN. Did you intentionally not send these settlements to the Department of Justice or the Office of General Counsel at HCFA because if you had, they would have gone up in smoke?

Mr. BOOTH. No, sir.

Senator LEVIN. Did you hear GAO testify that that is what you told them?

Mr. BOOTH. Yes, sir, and what I told them was that had I thought about sending them to the Department of Justice or involving the Office of General Counsel, that we would have probably lost a fair amount of time. I, frankly, did not consider sending them because of the pressure of time to settle them, and it is only in retrospect, when I thought about it, that I told them that had—I think

the question they asked was, well had you sent them to Justice, what would have happened? I said, they may well have gone up in smoke.

Senator LEVIN. But you did not think about sending them at the time and then decide at the time not to because at the time you felt that they would have been rejected?

Mr. BOOTH. I did not think that, that is correct.

Senator LEVIN. Now, did Dr. Vladeck tell you to settle for a specific amount in the HHC case?

Mr. BOOTH. No, sir.

Senator LEVIN. Did he tell you to settle for a specific amount in the LA County case?

Mr. BOOTH. No, sir.

Senator LEVIN. Did he tell you to settle for a specific amount in the Visiting Nurses case?

Mr. BOOTH. No, sir. He did not tell me anything about the Visiting Nurses case.

Senator LEVIN. I want to just make sure I understood what you have told us here this morning. You said there was not a question in your mind then or now as to whether the services were provided or whether the costs were incurred. The question was whether they could prove that the documentation was available for that proof, is that correct?

Mr. BOOTH. In the two hospital cases, yes, sir.

Senator LEVIN. In the two hospital cases, is that correct?

Mr. BOOTH. Yes, sir.

Senator LEVIN. So you do not question that the services were provided or the costs incurred. What was missing was the documentation and the availability of the documentation relative to those two issues, is that correct?

Mr. BOOTH. On the bad debt issue for those two hospitals, or two groups of hospitals.

Senator LEVIN. And you have clarified something which I earlier tried to clarify with a witness and I do not think I succeeded. Let me try again. There was in the hands of HCFA or its agent $200 million, approximately, that belonged to HHC—excuse me, that was claimed by HHC, it did not belong to it—that HHC claimed, is that correct, that had been withheld from HHC?

Mr. BOOTH. Yes. They had filed appeals with the Provider Reimbursement Review Board claiming that we owed them approximately $200 million for the issues we settled. They had other cases before the Provider Reimbursement Review Board that New York Health and Hospitals Corporation either did not want to settle or we said were not worth what they thought they were worth and therefore we took them off the table.

Senator LEVIN. But that money had been withheld from them, is that not correct, the $200 million?

Mr. BOOTH. Yes, sir.

Senator LEVIN. So when there was a settlement for a hundred and—what was the amount——

Mr. BOOTH. One-hundred-thirty million.

Senator LEVIN [continuing]. $130 million. Then $130 million of money which had been withheld from HHC was then transferred to HHC, is that correct?

Mr. BOOTH. Yes, sir.

Senator LEVIN. So that in common parlance, there had been not an overpayment—I am not talking technically here. I am talking in common parlance. HHC claimed there had been an underpayment of $200 million and that was settled for $130 million, is that correct, just in common parlance?

Mr. BOOTH. Yes, sir.

Senator LEVIN. Now, does HHC have approximately 11 hospitals and three skilled nursing facilities, do you know? Does that sound about right?

Mr. BOOTH. I do not know. It sounds about right.

Senator LEVIN. All right. Does it sound about right that they service about 5 million outpatient visits a year?

Mr. BOOTH. Yes. I think we talked about 4.5 million to 4.75 million at the time of the settlement.

Senator LEVIN. All right. So let us round it off, 4 to 5 million outpatient visits a year. And the period of——

Mr. BOOTH. That is total. That is not just Medicare.

Senator LEVIN. That is total?

Mr. BOOTH. Right.

Senator LEVIN. About how many of those visits would be involved in Medicare, in these claims, half of them, a third? Give us a rough idea, a million?

Mr. BOOTH. I would guess 15 to 20 percent.

Senator LEVIN. So maybe a million?

Mr. BOOTH. I would say a little less than a million, but I would not——

Senator LEVIN. Say three-fourths of——

Mr. BOOTH [continuing]. I would not argue you.

Senator LEVIN. All right. Take a million just for the sake of discussion. This period of time that the settlement covered was about 10 years, is that correct?

Mr. BOOTH. Yes, sir.

Senator LEVIN. And so there would have needed to be paper proof, if I understand this, documents, for services which had been provided and you feel were provided for something like a million outpatient Medicare visits per year for about 10 years, does that sound about right?

Mr. BOOTH. Yes, sir, that is correct.

Senator LEVIN. About 10 million documents?

Mr. BOOTH. More or less.

Senator LEVIN. Did anybody tell you to hide what you were doing?

Mr. BOOTH. No, sir.

Senator LEVIN. Did anybody tell you not to go to the General Counsel's office?

Mr. BOOTH. No, sir.

Senator LEVIN. Did anybody tell you not to go to the Department of Justice?

Mr. BOOTH. No, sir.

Senator LEVIN. Did anybody tell you to do anything illegal or unethical?

Mr. BOOTH. No, sir.

Mr. BOOTH. Were you aware of the regional employees' objections to the settlements?

Mr. BOOTH. I was not aware of Mr. Seubert's objections to the settlement. I was aware of Mr. Ohl's objection to the settlement in early March, basically after the settlement agreement had been reached and everybody knew—not everybody, but at least LA County and the administrator knew what the settlement was. What we were dealing with at that point was the paperwork.

Senator LEVIN. Thank you, Madam Chair. Senator Thompson.

Chairman THOMPSON. Mr. Booth, you know Mr. Seubert, do you not?

Mr. BOOTH. Yes, sir.

Chairman THOMPSON. How long have you known him?

Mr. BOOTH. At least 20 years.

Chairman THOMPSON. Twenty years? You heard him testify a few minutes ago, did you not?

Mr. BOOTH. Yes, sir.

Chairman THOMPSON. He said, I do not know if he said it here or in our staff interviews, he said he took some advice that he got from you, fatherly advice from someone that he liked and respected so I assumed that you and he had known each other for some time. Now, you heard him testify that when you went to New York to talk about the HHC settlement, that he initially offered his assistance. Do you remember that?

Mr. BOOTH. I do not quite remember it that way, but he certainly attended the meeting on behalf of the regional office.

Chairman THOMPSON. You do not remember that he offered assistance?

Mr. BOOTH. No, sir.

Chairman THOMPSON. Do you recall his testimony a few moments ago that you told him that this settlement was one that he would be better off staying away from?

Mr. BOOTH. Well, yes, sir, I do recall his testimony. I take issue with the characterizations, at least.

Chairman THOMPSON. What do you remember about that conversation?

Mr. BOOTH. I told him that I had been asked by Dr. Vladeck to settle this matter and that we would handle the substance of the settlement at the central office. There was certainly no intent on my part to warn him in any manner.

Chairman THOMPSON. But you had been told by Dr. Vladeck to settle the case and that central office would handle it, is that what you are saying?

Mr. BOOTH. Yes, sir.

Chairman THOMPSON. But not that it would be best if he stayed away from it? That is a very nuanced kind of position, Mr. Booth. You have been consistent in that respect, anyway. GAO says that you told them that you felt like at the time you needed to go to the Justice Department. You say now that at the time you did not feel that way, but you do now. GAO said that you said if you had gone to the Justice Department for approval, it would have gone up in smoke. You said you did not say that, but you see in retrospect, or you told them that, in retrospect, if you had gone to the Justice Department, that it probably would have or may have gone

up in smoke. You did not see anything wrong with the procedure at the time, but in retrospect, you now see something wrong with the procedure.

You have been around for a long time. I am sure you have performed good service, and a lot of people, I guess, in your position have to be survivors. Now you find yourself here, having allowed yourself to be used by Mr. Vladeck the way you did in conflict in three material ways with not just one, but two GAO people who investigated this case. It is a sad situation.

But even more incredible is the negotiated settlements that allowed health care entities to continue the practices that caused the overpayments in the first place. We are not just talking about the past here. We are talking about things that we are living under now. In the agreement with VNS, HCFA allowed VNS to add a specified number of hours to its Medicare average for all future years, regardless of the number of hours that services were actually rendered. In their agreement with HHC, HCFA allowed HHC to continue to bill for bad debts without any documentation to support those costs. In the case of LA County, HCFA did not require LA County to meet recordkeeping requirements generally required by Medicare.

The impact of these provisions, of course, is immeasurable. It is, of course, sometimes pointed out that these people are serving deserving constituencies. I think other Medicare recipients who are being deprived of these monies are deserving constituents, too, and perhaps we are seeing an evolving of a new concept. We have heard about too big to fail. Now perhaps we are getting into a new concept, too mismanaged to fail. If the situation is bad enough and they are serving a deserving constituency, then we just circumvent the process if we can get by with it.

So we have got a lot of work to do on this side of the table and I am sure that we will be all involved in this matter for some time to come. I want to thank the Chairman again for having these hearings.

Senator COLLINS. Thank you, Senator.

Mr. Booth, you may be excused.

Mr. BOOTH. I am sorry, could I comment on a couple of things that Chairman Thompson said, because, first of all, in the Visiting Nurses Service, while there was the allowance of additional hours for some period of time, the Balanced Budget Act of 1997, which changed the nature of reimbursement for home health agencies, would have abrogated that agreement at that time.

In the New York Health and Hospitals Corporation case, the agreement going forward was very distasteful to the people at New York Health and Hospitals Corporation. They not only—they had to prove their costs, but using the disproportionate share formula, which was a formula that was derived by the Congress to come up with a proxy for low-income patients, would or should have caused them to move rapidly to establish better recordkeeping so that they could prove all of their bad debt costs. I actually thought that was, while it was creative, unusual, unique—I hope unique—I do not think it was the worst deal that we could have made under the circumstances, given the necessity, in my view, to settle the matter.

And there was assurance by the County Hospitals in Los Angeles that they had a system that would go into place in July 1997 for bad debts that would have allowed them to claim those costs properly and be reimbursed for them properly.

I do not dispute the characterization that the Chairman has made, Chairman Thompson has made in the matter, but I did think it important for the completeness of the record to make that comment about the individual cases.

Chairman THOMPSON. Well, you said something very interesting, though, that got right to the heart of it—given the necessity to settle the matter. All this, given the necessity to settle the matter. There was no necessity to settle the matter except for the direction of Mr. Vladeck. That is what all this is about. You cannot take an invalid concept and base anything that you might do after that on the compelling nature of the invalid concept. There was no necessity to settle any more than there was a necessity to settle any other case, this being one of the very, very few that the administrator personally gets involved in, the one that really is shocking to these other career people who take a look at it, and the one that you shepherded through. Now, I respect your need to protect yourself at this stage of the game, Mr. Booth, but that is all I have got to say about it.

Senator COLLINS. Mr. Booth, you are excused. I am eager to get to——

Senator LEVIN. I am hoping, in light of that last comment, could I ask one question of Mr. Booth?

Senator COLLINS. Senator Levin, your time had expired whereas Senator Thompson still had 3 minutes left on his, and I do want to try to conclude the hearing by 1 o'clock. If we have additional questions for Mr. Booth, we can put them in the record and I am sure that he will answer them.

So, Mr. Booth, you are excused.

Mr. BOOTH. Thank you, Madam Chairman.

Senator COLLINS. Thank you for your testimony.

Our final witness today is Bruce C. Vladeck. Mr. Vladeck is currently a professor at the Mount Sinai School of Medicine and a Senior Vice President for its health system. From May 1993 until September 1997, Mr. Vladeck served as the Administrator of the Health Care Financing Administration. HCFA compromised the three overpayment claims that are the subject of our hearing today during Mr. Vladeck's tenure as administrator.

Pursuant to Rule 6, I will ask that you stand and be sworn in. Do you swear that the testimony that you are about to give the Subcommittee will be the truth, the whole truth, and nothing but the truth, so help you, God?

Mr. VLADECK. I do.

Senator COLLINS. Thank you. Mr. Vladeck, you can proceed with your statement.

TESTIMONY OF BRUCE C. VLADECK,[1] FORMER ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. VLADECK. Thank you very much, Chairman Collins, Chairman Thompson, Senator Levin. I am appearing at the invitation of the Subcommittee to discuss the process by which HCFA has negotiated and resolved disputes with Medicare providers. I have submitted a written statement to the Committee and I believe you have also received a letter from my counsel Mr. Anello,[2] and I understand that both of those will be made part of the record for this hearing.

Senator COLLINS. They will be.

Mr. VLADECK. Thank you.

From 1993 until 1997, it was my privilege to serve as Administrator of HCFA. I am proud of my service and proud of what my colleagues and I accomplished during that time. I certainly would not claim that I made no mistakes during my service, nor that the agency, which with very limited resources administers two of the largest and most complex programs of the Federal Government, was without flaw, but we made significant progress. The agency was in much stronger shape when I left than when I arrived, and most important, Medicare and Medicaid were in significantly better financial shape and working better to serve their beneficiaries.

I understand the GAO and perhaps some members of this Subcommittee are questioning some of the settlements undertaken while I was administrator. I am here to answer questions about my role in those settlements and what I understood about the role of others. I also understand this Subcommittee's Chair may recommend changes in the law or changes in regulation to clarify the process by which disputes between HCFA and providers are resolved. If the objective of that effort is to provide greater certainty and a more expeditious and fair handling of disputes, I applaud your efforts and will assist you in whatever way I can.

When I first appeared before the Senate Finance Committee for confirmation in May 1993, I acknowledged that HCFA was an agency that had long been criticized for being unresponsive to health care needs, an agency that was slow to heed problems in the health care system, and one that too often appeared focused on form over substance. As I approached the tasks of administrator, I resolved to be ever mindful of the impact of the agency on actual people. I sought to address charges of bureaucratic inertia that previously had been leveled against the agency.

I repeatedly tried to convey the message, both inside the agency and without, that the primary responsibility of HCFA was to ensure that its beneficiaries had access to high-quality care when they needed it. The only ones who could actually provide that care were not Federal employees or insurance companies, but the doctors, hospitals, and other health care providers who were thus our partners in fulfilling our core missions to meet the basic health care needs of our most vulnerable populations, the poor, the disabled, and the elderly.

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[1] The prepared statement of Mr. Vladeck appears in the Appendix on page 82.
[2] See Exhibit No. 19 which appears in the Appendix on page 124.

We were fortunate at HCFA to have a staff of very talented, knowledgeable, and experienced officials, many of whom had been with HCFA since its creation. The settlement process was overseen skillfully and energetically by Charles Booth, from whom you just heard, a longtime employee of HCFA who had been involved with the program since its inception. He was capable, tough, and I understood then and believe today of the highest integrity. Mr. Booth, in turn, worked directly with HCFA employees in our central and regional offices and contractor employees throughout the country.

I think it is important for the Subcommittee to have some sense of the scope of these activities. Medicare paid close to 40,000 providers each year on a cost-related basis. Each provider filed an annual cost report, triggering a process that included intermediary review and determination and not infrequently a series of appeals and dispute resolution procedures.

The Subcommittee's letter of invitation and the GAO report asked that I address four specific payment disputes, but only three have been discussed today.

As I testified in my deposition, I did not recall the details of any of the settlements because I was not involved in negotiating the settlements, nor was I advised at the time about the details of the negotiation. I did, however, press for timely resolution of those disputes.

In Los Angeles County, we were facing a potential public health crisis precipitated by a change in Medicaid policy. We were faced with the very real prospect of closure of the Nation's largest public hospital, along with service reductions in a trauma system serving millions of people. I believed then and I believe now that lives were literally at stake.

The New York City Health and Hospitals matter involved a potential disruption in services to the primary provider of care for low-income people in many parts of the city which neither the State nor the city were seeking adequately to address. These disruptions would have closed clinics, created intolerable waits in emergency rooms, and led to the reduction of services for premature infants, for AIDS patients, and for the mentally ill.

The Visiting Nurse Service dispute involved a conflict between the requirements imposed on providers by New York State and the services reimbursable by Medicare for dually eligible Medicare-Medicaid beneficiaries. These beneficiaries are among the frailest and most disabled of all Americans and should not have been caught up in a lacunas between two Federal programs. In each of these cases, I was advised and believed that our failure to act promptly could result in an intolerable reduction or loss of medical and health services to some of our most vulnerable citizens. But I left the specific negotiation and resolution of the matters to the good judgment of HCFA staff, who are better equipped than I to settle the matters.

In each of the settlements that has been discussed today, no one on the senior staff expressed to me at the time any reservations as to whether the agreements were in the best interest of the United States. However, as the Administrator of HCFA, I bear ultimate management responsibility for those resolutions.

Let me address at the outset and in the conclusion of my opening statement a number of concerns that have been raised here today. First, concerns have been raised about the fact that in three of the settlements, I received calls from providers and others about the need to expeditiously resolve outstanding reimbursement disputes. During the 4½ years I served as administrator, I received dozens of calls from providers, from members of Congress, from State officials, and others interested in the resolution of outstanding disputes of one kind or another. In each case, I sought to facilitate solutions by passing the matters on to the appropriate staff at HCFA and asking that they develop appropriate responses. I did not direct the staff to come up with a particular result and I did not get involved in reimbursement settlement negotiations.

Second, concerns have been expressed that the three settlements did not involve HCFA's General Counsel or the Department of Justice. As I testified in my deposition, I frankly did not know whether or not they did go through General Counsel or DOJ, or for that matter, what their final resolution was. However, if I had thought about it at the time, my view would have been that DOJ logically would not have been the appropriate body to resolve any of the policy issues or principal concerns in these three settlements, a position, I understand, that is supported by material that has been made available to the Subcommittee both by HCFA and by the Department of Justice.

These matters did not involve claims and litigation or litigation-related concerns which DOJ would be uniquely qualified to handle. In each of these cases, HCFA had the unique ability, and I believe responsibility, to consider the fundamental health care issues involved, to speed the resolution of outstanding reimbursement issues, and to free up funding that was critical to the provision of services. My job as administrator was to act on significant matters involving policy decisions. Also, as a matter of policy, I did not consult with the Department of Justice but did so only on advice of General Counsel.

Third, concerns have been raised about whether the dollar value of three of the settlements was adequate because they involved amounts significantly less than the amounts originally asserted by the fiscal intermediaries. Although I was not involved in these specific negotiations, it is a fact that where a provider disputes an intermediary's determination of an amount owed, that amount is never final until there is an evaluation of the policy issues, either through a settlement with HCFA by the Provider Reimbursement Review Board after a hearing, by the Administrator of HCFA in the case of a review of a PRRB decision, or by a court where the administrator's decision is appealed. Indeed, even after an NPR is issued, providers are instructed that they should attempt to reach a resolution by way of settlement prior to an actual PRRB hearing.

Where complex policy issues are involved, it is fair and accurate to say that the intermediary's number may be viewed as simply the intermediary's number and certainly is not considered a debt owed to the government. In the three settlements at issue, I do not believe the providers think they received sweetheart deals and the Subcommittee can ask the providers about that themselves.

Fourth, it has been suggested that I may have had a conflict of interest in urging resolution of two of these matters because prior to service at HCFA, I twice served as an unpaid board member of the New York City Health and Hospitals Corporation and I may have served very briefly in an advisory role to a subsidiary research organization affiliated with the Visiting Nurse Service. I have been involved in public health issues for over 25 years and have served in numerous paid and unpaid positions and also worked in numerous unpaid efforts for which I held no formal position, all directed at the same objective of delivering health care services to the public, primarily to the poor and the elderly.

Those remained my objectives when I became HCFA Administrator. It should not be a surprise that I have acquaintances and relationships throughout the health care community nationally, including providers. Indeed, I would argue that had I not had such relationships, I would not have been qualified to fill the position. But to suggest that because of prior unpaid service I had any personal interest as opposed to the public interest in mind when I acted on behalf of HCFA is outrageous and untrue and I believe no one who knows me would make that allegation.

Finally, we have already discussed the issue of my being identified as a reluctant witness because I did not talk directly with the GAO investigator when he sought to interview me in the summer of 1999, and we already established the reasons for that, on advice of counsel. We have also made it clear that as of October of last year, we expressed a complete willingness to meet at any time with either the General Accounting Office or with Subcommittee staff, and I was not asked to actually meet with Subcommittee staff until February, when I arranged to appear voluntarily to give a deposition earlier this month.

I answered fully at the time all the questions put to me to the best of my recollection, as I would happily have done in October or November or December. I am here to answer any additional questions the Subcommittee might have today and I appreciate the opportunity to do so. Thank you.

Senator COLLINS. Mr. Vladeck, how did you first become aware of the dispute between HHC and HCFA?

Mr. VLADECK. I am not sure. I was aware back to the time of my service at HHC that as a matter of course, HHC had always had a large number of reimbursement appeals on Medicare issues pending. The issues associated with the settlement in 1996, I became aware of sometime in the early part of 1996.

Senator COLLINS. So as a result of your service on the board, you were aware that there had been ongoing disputes between HCFA and HHC on many payment issues, is that correct?

Mr. VLADECK. That is correct.

Senator COLLINS. But on the specific issue that we are reviewing today, did you first become aware as a result of a call from the Chairman of the Board of HHC?

Mr. VLADECK. I do not believe so, but I really—my recollection is very fuzzy of how the process started.

Senator COLLINS. In your deposition, you stated that you had a conversation with Maria Mitchell, the Chairman of the Board, in the spring of 1996.

Mr. VLADECK. Yes, but I also said in my deposition that I did not recall in that conversation having discussed Medicare appeals issues.

Senator COLLINS. Were you also contacted by union leaders who were concerned and were seeking Federal funds for HHC?

Mr. VLADECK. I was not contacted directly by union leaders, but they had been in contact with some of my colleagues at the Department who informed me of those communications.

Senator COLLINS. Did you personally meet with union leaders, AFSCME officials, at their headquarters in downtown Washington to discuss possible sources of Federal funding for HHC?

Mr. VLADECK. Yes, I did.

Senator COLLINS. Did you or anyone from the Secretary's office subsequently discuss the idea of using the Medicare reimbursement appeals process as a potential funding source for HHC?

Mr. VLADECK. I would not characterize it that way, but we did talk about whether it would be possible to expedite any settlements in a way that would increase the cash flow into HHC, yes.

Senator COLLINS. As I understand it, after deciding to explore this possible remedy for HHC's budget problems, you contacted Mr. Booth and told him that there was a fiscal crisis at HHC, is that correct?

Mr. VLADECK. That is correct.

Senator COLLINS. Did you ask him to look at the pending appeals to see what he could do about it to get some help to HHC?

Mr. VLADECK. Well, I asked him to look at pending appeals to see how much of the backlog he could clear up, which I presumed would also provide some financial assistance, yes.

Senator COLLINS. It is my understanding that you also asked Mr. Booth for periodic updates on his progress related to this matter, is that correct?

Mr. VLADECK. That is correct.

Senator COLLINS. And how often did he report to you?

Mr. VLADECK. I do not recall.

Senator COLLINS. In your deposition, you said that he reported to you every couple of weeks. Does that refresh your memory?

Mr. VLADECK. I have no—that sounds reasonable to me.

Senator COLLINS. Well, that is what you said under oath in your deposition.

Mr. VLADECK. I do not disagree with that.

Senator COLLINS. Why did you ask for these status reports?

Mr. VLADECK. Well, I was receiving inquiries from various other folks in the Congressional delegation and the Department of Health and Human Services about the status of those discussions and I wanted to be able to report to them.

Senator COLLINS. So you wanted to be able to report to whom in the Department?

Mr. VLADECK. Well, most of my communications went through either John Monahan, who was Director of Intergovernmental Affairs, or Kevin Thurm, who I guess was still then the Chief of Staff of the Department.

Senator COLLINS. For the Secretary of HHS?

Mr. VLADECK. That is correct.

Senator COLLINS. So you were essentially reporting to the Secretary, is that correct?

Mr. VLADECK. Yes.

Senator COLLINS. Did you convey to Mr. Booth that there "time constraints and a need to move expeditiously" on this matter?

Mr. VLADECK. Yes, I did.

Senator COLLINS. Mr. Booth testified today that he advised you that if he rushed the process, it would cost the government, cost the Medicare trust fund, an additional $8 to $10 million. Did you hear that testimony today?

Mr. VLADECK. Yes, I did.

Senator COLLINS. Do you dispute that testimony that——

Mr. VLADECK. I do not recall it, but I do not dispute it. I have always found Mr. Booth to be a very honest man.

Senator COLLINS. And Mr. Booth said that your response was, in essence, that time was more important than money. Do you recall giving him that——

Mr. VLADECK. Again, I do not recall saying that directly, but I would not dispute it at all.

Senator COLLINS. Mr. Booth also testified that he felt pressured by you to settle the HHC dispute, and he said in his deposition that HCFA "could have struck a better deal had we not hurried."

Mr. VLADECK. If I can make an analogy—in a medical analogy, sometimes when a patient is desperately ill, you administer a drug with side effects when if the patient were not so ill you would not have to accept the side effects. I thought holding out another 6 months to achieve an additional $5 or $10 million in settlements that had been pending for a decade, when doing so would have meant the closure of important public health services, was not an appropriate position for the agency and appropriate public policy. And so, yes, I believed then and I believe now that it was more important to keep those services available than it was to squeeze every last nickel out of those settlements.

Senator COLLINS. Well, there are many other hospitals and home health agencies in my State and throughout the Nation that are also under very severe fiscal constraints and are having a very difficult time, are operating in the red. Why single out HHC for special treatment? Is that not unfair to other hospitals and other home health agencies that also have payment disputes with Medicare, that also are running in the red, that are also under tremendous pressure and that are also doing the very valuable work of serving our elderly and disabled citizens?

Mr. VLADECK. I would hope as a matter of practice that HCFA would never have payment disputes pending that were 10 years old for any provider, yes, Senator.

Senator COLLINS. I would agree with that, but why should this provider be moved to the head of the line?

Mr. VLADECK. Because this provider came to our attention as one that had already issued layoff notices and at which the data would suggest served as poor and needy a population as any in the United States, except perhaps for that of the LA County Health Department.

Senator COLLINS. All of us agree that the mission of Medicare is essential. None of us wants to see seniors or disabled people or the

poor lose their access to services. But is it fair to give special treatment to one provider when hospitals all across the Nation are providing the kinds of services that you have just described?

Mr. VLADECK. I never directed anyone, nor do I believe that what HHC received in this settlement was special treatment, as you are characterizing it. I do not think they got special treatment.

Senator COLLINS. Well, we have heard from everyone who has testified today that this was an unusual situation. Mr. Booth says it was the only time in his more than 30 years that the administrator asked him to settle a matter. The lower-level HCFA officials from the regions have testified that they were shocked by the terms of the settlement. The GAO reviewed 96 settlements, every settlement over $100,000, and found that these three did, in fact, receive special treatment. So you are contesting that the standard process was followed in these three cases?

Mr. VLADECK. No, I am saying the standard process was not acceptable in these three cases and it is not acceptable in many other cases and that is why we sought to change it, and that is why I, again, as I said in my statement, would be happy to work with the Subcommittee on making further changes in the process.

Senator COLLINS. You mentioned that you served as a member of the board of directors of HHC. Could you tell us what years you served?

Mr. VLADECK. I do not recall exactly without the documents in front of me, but I served, I believe, from approximately 1986 to approximately 1989, and then from sometime in 1991, I guess, until I resigned immediately before joining the Federal Government.

Senator COLLINS. So you were on the board immediately prior to becoming the Administrator of HCFA, is that correct?

Mr. VLADECK. That is correct.

Senator COLLINS. I want to tell you what my concern is about the conflict of interest issue. The whole purpose of our ethics laws and regulations is to foster public confidence in the integrity and the impartiality of decisions made by government officials, and that is why the regulations include provisions that encourage public officials, if they have any doubt about how a reasonable person would pursue their actions, whether it would be perceived as a conflict of interest, whether or not it is an actual conflict of interest, but whether there is a perception of a lack of impartiality, there is a process set up that encourages public officials to avoid the appearance of a conflict by getting advice from the designated agency ethics official.

Did you do that in this case? Did you consider doing it? Did you receive authorization from your agency ethics official to get so involved in a reimbursement dispute that involved a hospital on which you had sat on the board immediately prior to coming to HCFA?

Mr. VLADECK. Madam Chairman, I believe Senator Levin has already entered into the record a document from the ethics office of the Department of Health and Human Services[1] of which I was aware that made it quite explicit that any disqualification on my part on Health and Hospitals Corporation issues would last for 1

[1] See Exhibit No. 35 which appears in the Appendix on page 268.

year after my appointment as administrator, in addition to which I do not believe the question has ever been raised before you have raised it implicitly right now in the course of all these investigations as to whether I consulted with anyone on the appropriateness of my working on this HHC issue.

Senator COLLINS. That is what I am asking.

Mr. VLADECK. And the answer is, yes, I did. And the fact is that a year earlier, on an unrelated New York State policy matter, I had recused myself from working on an 1115 Medicaid waiver application from New York State because of the extent and nature of my involvements with many organizations—permit me to finish, please—in New York State prior to my appointment as administrator, and I was advised in writing by the HCFA ethics officer that my decision to recuse myself in that instance was not justified by the law, was not required, and was an excessive reaction to the issues of appearance. And while it did not speak specifically to the HHC issues, I understood that guidance in the context of the earlier ruling about New York to be pretty clear guidance on whether or not I should disqualify myself on New York State matters.

Senator COLLINS. Senator Levin.

Senator LEVIN. In each of the settlements which were discussed today, in any of them, did you direct anybody as to what the settlement should be, how much, whether it should be handled administratively, or whether it should be settled?

Mr. VLADECK. No, sir. I did not make such directions.

Senator LEVIN. So the details of any agreement or settlement were not ones that you in any way got involved in, is that correct?

Mr. VLADECK. I first became aware of the details of each of these settlements on March 9 of this month when I gave a deposition to the Subcommittee.

Senator LEVIN. So that when the GAO says that you instructed him, being Booth, to settle the hospitals' claims, your instruction was to do what, precisely?

Mr. VLADECK. My instruction was a procedural one, and I believe in the case of my conversations with Mr. Ault in the VNS instance, which—where my memory is somewhat clearer, I was quite explicit, but I think it was implicit in my instructions to Mr. Booth, with whom I worked very closely over a number of years, that he was to use his best judgment on the substance of the matter, but that I wanted the process to come to closure as soon as possible.

Senator LEVIN. Did anybody on your senior staff express to you opposition to the agreements as being not in the best interest of the United States at the time they were made?

Mr. VLADECK. No, sir.

Senator LEVIN. Did anybody inform you that there was a HCFA regional employee who had objected to the settlement with LA County?

Mr. VLADECK. Not at the time, sir.

Senator LEVIN. At the time. Did you know at the time that neither HCFA's General Counsel nor the Department of Justice were involved in the settlement?

Mr. VLADECK. No, sir.

Senator LEVIN. Are you aware of an administrative resolution of Medicare payment disputes document which apparently is an HHS

or a HCFA document which we have now received which says basically that where the money has been withheld, that then it is not a government claim against the provider but a provider claim against the government?

Mr. VLADECK. I became aware of that particular document during the hearing today, sir.

Senator LEVIN. Would you explain to us the difference, because people sometimes, particularly GAO acts as though there was a claim against these hospitals. As a matter of fact, the hospitals had a significant claim against HCFA, is that not correct?

Mr. VLADECK. That is my understanding, yes, sir.

Senator LEVIN. Is it not correct that HCFA had withheld a significant amount of monies which the hospitals claimed?

Mr. VLADECK. That is correct.

Senator LEVIN. And in the case of New York, I believe that was around $200 million?

Mr. VLADECK. That was the number I have heard today, yes, sir.

Senator LEVIN. And that is money that New York claimed?

Mr. VLADECK. That is correct.

Senator LEVIN. And New York settled that with HCFA for $130 million?

Mr. VLADECK. That is what I understand.

Senator LEVIN. And that is claims, as I understand it, that had been in existence or had grown over a 10- or 11-year period, is that correct?

Mr. VLADECK. That is correct.

Senator LEVIN. And these were claims involving, do we know how many visits, how many Medicare outpatient visits?

Mr. VLADECK. Well, again, the conversation and your interchange with Mr. Booth suggests it was many million, and that must have been——

Senator LEVIN. Does that sound about right to you——

Mr. VLADECK. Yes.

Senator LEVIN [continuing]. For that sum of money?

Mr. VLADECK. Yes.

Senator LEVIN. As I said before, I have had my own frustrations with HCFA, trying to get information, answers to, what I consider to be reasonable questions. I have had a major dispute with HCFA recently over a decision that they made relative to a nursing home in my State. I think HCFA is all wet on the subject, and I have said so publicly and I am very critical of HCFA. I have been trying to get information about reimbursements from HCFA for a month, and I cannot get that information from HCFA.

Members of Congress constantly are hopefully representing their constituents, and I want to read to you, something that one of our colleagues said, at the time of your confirmation. Senator Grassley in the Finance Committee asked you the following question. "I wonder if you intend to make it a priority to reduce administrative hassles which providers in my State complain about endlessly, and maybe not just in my State, but I only know about my State." And your answer was that you would try to make the whole system user friendly for providers. Do you remember that question and that answer?

Mr. VLADECK. I do not remember that particular interchange, but certainly the substance, I remember very well.

Senator LEVIN. Do you believe it was important and is important for HCFA to be responsive to, in a fair way and in a timely way and in a non-bureaucratic way and in a reasonable way, to claims of providers, to dispose of them one way or the other? Do you believe that HCFA has a responsibility because of the beneficiaries who are really behind those providers?

Mr. VLADECK. Yes, sir.

Senator LEVIN. I just want to read into the record one paragraph about the Visiting Nurses Service matter, and that is the final paragraph of their statement they gave the Committee today. "Contrary to the GAO report, the agreement with HCFA does not permit Visiting Nurses Services to add a specified number of hours to its Medicare average 'regardless of the number of hours of service actually rendered.' Instead, the agreement caps the non-Medicare home health visits that can be included in the cost apportionment methodology as the lesser of the actual non-Medicare home health aide visit length or the actual Medicare home health visit length plus 1.63 hours." Are you familiar with that portion of the settlement?

Mr. VLADECK. Again, that was contained in a document that was shown me in my deposition. I was not——

Senator LEVIN. Because the GAO treated that as some kind of a special treatment that was given to the Visiting Nurses by HCFA, never asks HCFA their position on the matter, does not tell us the Visiting Nurses' position on the matter, but we are just told by GAO, oh, they get special treatment. Do you consider that, from what you have heard today, to be an appropriate settlement?

Mr. VLADECK. Senator, again, having seen the settlement for the first time only about 3 weeks ago and having been away from the issues for a number of years, I think that Mr. Booth and the people, Mr. Ault and the people he worked with on that settlement, did an excellent job. I think it is not only an eminently reasonable settlement but I think it is very good public policy.

Senator LEVIN. Finally, overall, do you believe that your conduct in taking calls, taking comments, directing Mr. Booth to try to settle the outstanding cost reports, were proper?

Mr. VLADECK. Yes, sir.

Senator LEVIN. Thank you, Madam Chairman. Senator Thompson.

Chairman THOMPSON. Thank you very much, Madam Chairman.

Mr. Vladeck, you certainly accomplished your goal of becoming more user friendly, I think, with regard to three of these entities, anyway. I want to try to see if I can get this right. Mr. Booth testified that he worked out the details of these settlements the way he did because of the pressure he was receiving from you and that there could have been worse deals struck considering the circumstances and the pressure that was being applied. You heard him testify basically to that a few minutes ago, right?

Mr. VLADECK. Yes, sir.

Chairman THOMPSON. And your testimony is that you applied direction, or however you would characterize it, told him you wanted

to get it settled, but you had nothing to do with the details of the settlement?

Mr. VLADECK. That is correct.

Chairman THOMPSON. So we have the perfect demilitarized zone where nobody is really responsible for both the decision to make this particular settlement and, in fact, carrying out the details of the settlement.

Mr. VLADECK. Senator, may I say something in that regard? Again, I saw none of these three settlements prior to this month. I was not involved in the details of the negotiation. I was not aware of the substance of the negotiation. But having seen them within the last month and having had quite a lot of opportunity to think about them and to revisit the circumstances, I think all three of the settlements were reasonable, were in the best interests of the program and of the United States, and I think Mr. Booth and his staff should be commended for the creativity and thoroughness with which those settlements were negotiated.

Chairman THOMPSON. Well, I understand your position, but you can also understand why one might conclude that you are not exactly a disinterested party in this, and we have heard the testimony of some people who I think are basically a disinterested party who have been with HCFA for a long time and they have their own assessments of it.

Mr. Seubert said that, in the first place, HCFA's central office should not single-handedly settle anything that exceeds the amount specified in the FCCA and that HHC was not required to provide any documentation for the costs for which they were compensated. He also said he did not think that HCFA had the authority to agree to compensate HHC for bad debts into the future without requiring HHC to provide proof of the costs that they were claiming. So that is his analysis of it. Do you take issue with his view of that particular point?

Mr. VLADECK. Yes, sir.

Chairman THOMPSON. Ms. Ohl testified—we saw her E-mail with regard to the LA County situation—that because the agreement with LA County did not include a requirement that LA County keep sufficient records, HCFA was likely to be facing another settlement of this type in 8 to 10 years from now. She stated further that unless Medicare can get some agreement that LA County in the future will meet Medicare documentation requirements or not claim the costs, this is not a settlement where both parties realize some benefit. It is more of a grant and should be called that without the compromise being called a Medicare reimbursement settlement under the Medicare regulations. Do you take issue with her analysis on that case?

Mr. VLADECK. Yes, sir.

Chairman THOMPSON. If you were not involved in the details of the settlement of these cases, how can you make an assessment now as to how wise or unwise the settlements were?

Mr. VLADECK. Well, as I said a few minutes ago, Mr. Chairman, I have had quite a lot of opportunity in the last month to review those documents and many associated documents and to talk to—to read the GAO report and to think about the history of this and so forth and I think I now have enough information to form an

opinion on these. The issues raised that you just described are all issues that I am familiar with in generic terms that were policy issues that we dealt with quite frequently during my tenure. In each of the two instances I believe you just cited, the staff person took a position that was, in effect, a policy position where I disagreed at the time and still disagree with the policy view they were enunciating and I think I understand what the issues are and I disagree with their views.

Chairman THOMPSON. Well, it does not seem to me like it is as much a matter of a policy issue. We have already heard testimony about the millions of documents that are involved in these cases. These are people who spent a long, long time dealing with the details and the merits of these cases and these claims. They have their opinions based upon that. You say that when it was all going on, you were not involved in the details. You just knew that these people were on hard times and these settlements had taken too long and you wanted them settled.

So again, I ask you, in terms of sitting down and figuring out—have you gone through all these documents that we have been hearing much about?

Mr. VLADECK. I believe I was shown 20-some-odd documents in my deposition and there have been a number of other documents shared with the Committee and with us and obviously I have had the GAO report for the last 24 hours, so I have seen quite a lot of paper around this.

Chairman THOMPSON. The GAO report has been criticized because it did not get into the substance, so you did not learn much about the substance from that, did you?

Mr. VLADECK. No, I did not. That is correct.

Chairman THOMPSON. OK. I think that we can all sympathize with the notion of cutting red tape and moving settlements along, but the problem that many of us have, obviously, is that whether you are dealing in a court of law, whether you are dealing with an administrative process, a formal one or an informal one involving settlements, that there are procedures. That is why we call ourselves a Nation of laws and not of men. A person cannot look at a situation—even the President cannot look at a situation and say, I feel, based on whatever information I am getting or telephone calls I am receiving, there is an injustice and a problem out there, so I dictate that we cut a check for several million dollars of taxpayers' money, in effect, something like that. We cannot do that.

We are talking about procedures here, and when you are talking about settling a case, whether we like it or not, we are talking about lawyers. We are talking about lawyers. We all know that they are involved in every aspect of our life, and we regret that in many respects, having been one once upon a time. When you are settling a case, you are talking about essentially the merits of the case on both sides, and there are always two sides, and you cannot do that, you cannot analyze the merits of any case or any matter unless you have someone who is trained, an objective person trained to analyze those merits and come to some determination.

Maybe a bad lawyer will reach the wrong determination, but the American people can see that the right procedure is being followed and somebody is looking at it from a legal standpoint. Is this a de-

cent deal? Maybe it is not the best, but is this a decent and fair deal for the taxpayers of the country? Do you not see the problem?

Mr. VLADECK. Senator, I think it is unacceptable that these three settlements were not reviewed by HCFA's General Counsel. It is astonishing to me that they were not. I do not understand why they were not. I never had any knowledge that they were not until 3 weeks ago. I think that was a very serious violation of procedure and I think whatever steps need to be taken administratively to make sure it never happens again should be taken.

It is inconceivable to me that I personally would have made a major decision involving such an issue when I was at the agency without consulting General Counsel. It was my understanding that as a matter of standard practice, General Counsel always was consulted in these negotiations. I was not aware, again, until 3 weeks ago, that General Counsel had not been consulted in these three incidences. I was astonished to learn it. I was shocked to learn it. I think it is very unfortunate and I think it should not be permitted to happen again. I agree with you entirely.

Chairman THOMPSON. Whose responsibility do you think it was that counsel was not consulted?

Mr. VLADECK. I believe it was Mr. Booth's responsibility.

Chairman THOMPSON. Well, perhaps Mr. Booth will have an opinion on that that we can get at a later time. Thank you, Mr. Vladeck.

Mr. VLADECK. Thank you, Senator.

Senator COLLINS. Senator Levin, I am going to give you the opportunity to either have 3 more minutes of questions or if you want to make a concluding statement, whichever your preference is.

Senator LEVIN. Well, just briefly, I think we have learned a lot this morning about HCFA procedures. It is obvious that a procedure was not followed here. The person who says that he should have followed it, Mr. Booth, said it was an innocent omission on his part. He was not directed by anybody not to go to the General Counsel's office.

But the key question to me, in addition to that, is whether or not these settlements were in the best interest of the United States. That, to me, is the key question, and that question can only be answered, it seems to me, after listening to the providers as well as to the people who opposed this settlement.

The GAO talked to people who opposed the settlement, did not ask—did not ask the providers their position on the substance of the settlement. So what is missing substantively here is the providers' side of the story and I think that is a real omission on the part of the GAO.

We have an expert here who says that, based on his judgment, that those settlements were in the best interest of the United States from what he has seen, although he was not involved in the details. Mr. Booth says over and over again, and I think he is a highly credible witness, that he believed at the time they were in the best interest of the United States. We have situations here where hospitals had hundreds of millions of dollars withheld from payments that they claimed were owing to them, hundreds of millions of dollars, folks, in New York, and that was ultimately settled for $130 million.

So this is not where HCFA was claiming that New York owed it money. This was a situation where, for years, there were festering claims that New York hospitals had against HCFA and finally were settled, $130 million of what turned out to be the hospitals' money that had been withheld by HCFA, and that fact is relevant.

And so on the substance, it is obviously not for us to judge the substance of settlements. But the Visiting Nurses Services, in their letter, it seems to me, is powerfully eloquent about what a mistake it is not to get the other side of the story on the substance, and the GAO did reach a conclusion on the substance because they said that these claims would not have been successful had they been litigated. How they can reach that conclusion when they did not ask the providers for their side of the story on the substance is inexplicable to me. I think it was wrong and I would hope that all of the providers, after they have had an opportunity, which they have had for 24 hours now, to read the GAO report, would be offered the opportunity by our Chairman to submit any statements for the record that they might feel are appropriate.

So this is an appropriate oversight issue on the process and I think there is no doubt that there are procedural omissions here which, if we can correct by law or regulation, we ought to correct. The General Counsel clearly should have been shown these settlements. She was not. If we can correct that, we ought to do it. But we should not, it seems to me, blend that issue with whether or not these were substantively excessive settlements without getting the providers, in two cases who had hundreds of millions or tens of millions of dollars tied up by HCFA, an opportunity to give us their side of the story.

Thank you.

Senator COLLINS. Thank you, Senator Levin.

There is no doubt that HCFA's appeals process is cumbersome, it is expensive, it is complex, it is bureaucratic. Those facts argue for reform of the process to make it more customer friendly, to ensure that decisions are made more expeditiously. Those facts do not argue for subverting the process for three providers who were fortunate enough to have the administrator give personal attention to their overpayment disputes.

When I began this hearing, I said that I was troubled by four findings by the GAO, findings that were substantiated by depositions taken by the Subcommittee staff. I remain very troubled by those four findings.

First, it is absolutely clear that HCFA violated its own regulations, its own rules and procedures in the settlement of these three cases. Everyone agrees that there was no review by any government lawyer of the settlement of these claims. That is not in dispute. Most people agree, and HCFA's own regulations make very clear, that it was the rule and the custom of the Department to obtain the approval of the Department of Justice for the settlement of claims over $100,000. Similarly, HCFA's own regulations make very clear that an overpayment is considered a debt and thus is implicated by the Federal Claims Collection Act.

Second, it is indisputable that the agreements contained highly unusual secrecy provisions. If HCFA felt so comfortable with the

results of these settlements, why were they kept secret? Why were confidentiality provisions included so that other providers would not find out about the special treatment given these three providers?

Third, it is indisputable, whatever his motive, that Mr. Vladeck, who was administrator at the time, did pressure subordinates to reach agreements. He did not dictate what should be in those agreements, but the record is replete, and even Mr. Booth under oath said today that he felt pressured to reach the agreements.

And finally, there is no doubt that the agreements included provisions for special treatment that were not given to other health care providers, and I think that is unfair.

The Subcommittee will continue to pursue this issue. I am looking at legislative solutions and I look forward to continuing to work with HCFA, with the GAO and other interested parties.

This hearing is adjourned.

[Whereupon, at 1:15 p.m., the Subcommittee was adjourned.]

APPENDIX

United States General Accounting Office

GAO

Testimony

Before the Permanent Subcommittee on Investigations, Committee on Governmental Affairs, U.S. Senate

For Release on Delivery
Expected at 10:00 a.m. EST
Tuesday,
March 28, 2000

HEALTH CARE FINANCING ADMINISTRATION

Three Largest Medicare Overpayment Settlements Were Improper

Statement of Robert H. Hast
Acting Assistant Comptroller General
for Special Investigations
Office of Special Investigations

GAO/T-OSI-00-7

GAO/T-OSI-00-7

Madame Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the results of our recent investigation of the Health Care Financing Administration's (HCFA) negotiated settlements of large overpayments to three Medicare providers between 1991 and July 1999. (See *HCFA: Three Largest Medicare Payments Were Improper* [GAO/OSI-00-4, Feb. 25, 2000].) These settlements constituted 66 percent of all Medicare overpayment settlements since 1991 for which HCFA provided us records. In these three settlements, HCFA accepted $120 million for debt exceeding $332 million—about 36 percent of the total principal.

The depletion of the Medicare Trust Fund has been the subject of significant scrutiny in recent years. As we have reported previously, fraudulent and abusive practices have raised concerns about program vulnerabilities.[1] HCFA, an agency within the Department of Health and Human Services (HHS) that administers the Medicare program, is required to ensure that debts owed the program—generally caused by overpayments to providers—are paid. Historically, rather than collect the entire debt, however, HCFA often enters into settlement agreements with providers and accepts less than the full amount owed.

HCFA provided us with copies of 96 agreements reflecting Medicare overpayment settlements that it negotiated from 1991 through July 1, 1999, in which the overpayment exceeded $100,000. We found nothing improper in the settlement of 93 of the 96 matters. We did determine, however, that HCFA acted inappropriately in several respects as to the 1995, 1996, and 1997 settlements of the three largest matters.

In brief, we found that (1) former HCFA Administrator Bruce Vladeck's participation in the largest settlement raised conflict-of-interest concerns, (2) HCFA unilaterally chose not to obtain Department of Justice approval of the settlements and ignored its own regulations and internal guidance, (3) HCFA appears to have disregarded permissible settlement criteria established by regulation, (4) the settlement agreements contained questionable provisions, and (5) HCFA executed settlements without the benefit of legal counsel.

[1] See *Medicare: HCFA Faces Multiple Challenges to Prepare for the 21st Century* (GAO/T-HEHS-98-85, Jan. 29, 1998).

Actions by the HCFA Administrator Raised Conflict-of-Interest Concerns

We determined that HCFA Administrator Bruce Vladeck had directed subordinates to settle the three matters and that he had a prior professional association with two of the three providers immediately prior to being appointed HCFA Administrator. Mr. Vladeck's participation in the largest settlement—$25 million accepted for $155 million in overpayments to a hospital—raised conflict-of-interest concerns because he had previously served on the hospital's Board of Directors. In this instance, we learned that Kevin Thurm, then Chief of Staff to the HHS Secretary and the current Deputy Secretary, had instructed Mr. Vladeck to inquire about the status of the overpayments. As a result, Mr. Vladeck suggested to Charles Booth, then Director of Payment Policy, that "time was more important than money" and instructed him to move faster. Mr. Booth had told Mr. Vladeck that quickening the process could cost HCFA an extra $8 million to $10 million. Despite this being HCFA's largest settlement and unlike other settlements we reviewed, HCFA kept no records or documentation about it, not even a copy of the settlement agreement. We were fortunate to obtain records that the fiscal intermediary maintained. Mr. Vladeck also failed to disclose his previous affiliation with the other provider, a home health agency. In this instance, Mr. Vladeck did not reveal on the financial disclosure forms he filed upon his appointment that he had sat on the Advisory Committee to the home health agency. We could not resolve our questions about Mr. Vladeck's involvement in these settlements given his refusal to meet with us.

No Department of Justice Approval Sought

HCFA's regulations and internal guidance state that HCFA must refer all settlements over $100,000 to the Department of Justice for approval, in accordance with the Federal Claims Collection Act. HCFA unilaterally decided to settle the matters without Justice approval. HCFA should have obtained clarification from those charged with implementing the Federal Claims Collection Act, including Justice and/or GAO. Such clarification should have been sought because HCFA's own regulations required any compromise of a claim over $100,000 to be approved by Justice, and those who settled the matter thought approval was necessary. Mr. Booth chose not to seek Justice approval or HCFA's own Office of General Counsel (OGC) review because, as he told us, he was concerned that if he did, the "deals would go up in smoke." He also admitted to us that he knew that the settlements were not in the best interest of the government.

Two months prior to initiating the first of these three improper settlements, HCFA (and Mr. Vladeck) was notified that Justice had rejected a HCFA-proposed settlement for $3 million of a $58-million overpayment to a hospital. Justice rejected the proposal in September 1993 because it was "not sufficient" and "out of line with settlement

amounts from comparable institutions." It then took over the negotiations with the hospital, which continued until March 1994 when the hospital rejected Justice's offer to settle the matter for $12 million. After the hospital's rejection, Justice returned the matter to HCFA for collection. Ultimately, a $10-million settlement was made.

Permissible Claims Criteria Disregarded

Regulations implementing the Federal Claims Collection Act set forth criteria agencies must consider in determining whether to compromise a debt or claim for less than the full amount owed. These regulations permit compromise of claims only if one or more of the following reasons exist: (1) the debtor cannot pay the full amount within a reasonable time, (2) the debtor refuses to pay and the United States is unable to collect the full amount in legal proceedings, (3) there is real doubt that the United States can prove its case in court, or (4) the cost of collecting the claim does not justify seeking full recovery.[3] HCFA's regulations generally mirror the joint regulations.

Although HCFA chose not to seek a clarification or actual approval from Justice, it is not entirely clear that the Federal Claims Collection Act actually required Justice approval. The applicability of the Federal Claims Collection Act to the three settlements that we investigated depends upon whether the amount of overpayments determined by the fiscal intermediaries constitutes a "claim" or "debt" within the meaning of the act. The Federal Claims Collection Standards,[4] which implement the act, make clear that Justice approval is required only when a debt or claim is compromised.[5] In the claims context, we have previously said that "compromise" means accepting less than the full amount owed in full satisfaction of the claim.[6] Based upon the facts in the three improper settlements, we believe it is clear that HCFA accepted less than the full amount of the overpayments. It is not, however, as clear whether such overpayments constituted a claim or debt within the meaning of the act. The standards use the terms "claim" and "debt" interchangeably and define them as "an amount of money or property which has been determined by an appropriate agency official to be owed to the United States...."[7] The term "appropriate agency official" is not defined in the standards.

[3] 4 C.F.R. pt. 103.

[4] 4 C.F.R. ch.2.

[5] *Id.* § 103.1(b).

[6] *E.g., In re Economic Development Admin.*, 62 Comp. Gen. 489, 492-93 (1983).

[7] 4 C.F.R. § 101.2(a).

However, the meaning of this phrase is critical to whether the act applied to the settlement agreements under discussion here.

HCFA's regulations and manuals recognize that circumstances may exist in which compromise of a debt is appropriate. HCFA's Guide states,

"[C]ompromise of debts should not be considered until all administrative collection action to collect a debt in full has been exhausted, unless it becomes clear at some point during the collection activity that further action to collect the debt in full is not in the best interest of the Government."[7]

Circumstances that could lead to such a determination include HCFA's inability to collect the debt in full, a legal issue that raises doubts as to HCFA's ability to prove its case in court for the full amount, or the further cost of collecting the debt would exceed the amount of the debt.[8]

Although these provisions were promulgated pursuant to the Federal Claims Collection Act, we believe that government agencies should normally consider elements like these before agreeing to settle significant claims. It does not appear that these settlements, however, were negotiated after careful consideration of these factors. In apparently failing to consider these or similar elements before entering into these multimillion-dollar settlements, HCFA acted improperly, regardless of the applicability of the act and its associated regulations. Moreover, had HCFA considered these factors, it is unlikely that settlement would have been appropriate.

For example, HCFA appeared not to consider that all of the providers were able to pay the amounts owed. One of the providers, the home health agency, had established a reserve fund to pay most of the amount owed; and the fiscal intermediaries had already withheld the amounts owed by the other two providers by offset, so that no additional payment was necessary from them.

Further, it does not appear that there was a substantial risk of loss should HCFA or its intermediaries litigate these claims. In all three cases, the provider either claimed that it provided covered services or incurred bad debts; however all three providers lacked documentation to support any of these claims. Therefore it is unlikely that any of the providers could have mounted strong defenses. Moreover, the fiscal intermediaries, who would

[7] HCFA's Guide, § 0306-1-45(I).

[8] *Id.* § 0306-1-45(B); 42 C.F.R. § 405.376(d).

represent HCFA in any legal action to collect these debts, were confident in their ability to prevail. Although a risk in litigation always exists, consideration of "litigation risk" does not appear to justify settlement. Even if settlement had been appropriate, HCFA regulations require that the amount accepted in compromise be reasonable in relation to the amount that can be recovered by enforced collection proceedings.[9] Since it appears there was little litigation risk to HCFA to collect the full debt, the significant compromise of the amounts owed in these three matters is apparently unjustified.

Consideration of the cost of collection also would not justify these settlements. Under both HCFA and the Federal Claims Collection Standards, costs of collecting should not normally carry great weight in the settlement of large claims.[10] It is unlikely that the cost of collecting these debts, which collectively approximated $332 million, could outweigh their recovery.

Settlement Agreements Contained Questionable Provisions

The agreements contained several provisions that were not in accord with HCFA's guidance for settling claims. For example, HCFA agreed to waive interest in the settlement with the home health agency, despite contrary direction contained in its financial management guide.[11] It also permitted the home health agency to pay part of its debt in installments, which should be considered "only in rare instances."[12]

Moreover, two of the agreements explicitly permitted the providers to continue to be reimbursed for costs regardless of whether they were actually incurred. The settlement with the home health agency permits it to be reimbursed in the future for costs that might not be covered by Medicare, although capped at a specific level. Similarly, the 1996 agreement with the hospital permits it to be reimbursed for bad debts without documentation as otherwise required by regulation.[13] Mr. Booth disregarded the objections of knowledgeable HCFA and fiscal

[9] 4 C.F.R. § 103.4, 42 C.F.R. § 405.378(h).

[10] HCFA's Guide, § 0306-1-45(B)(4).

[11] HCFA's Guide directs HCFA to charge interest on all debts owed the government unless a different rule is prescribed but requires that interest be charged on all debts paid in installments. *Id.* § 0306-1-40(P)(1). Note, however, that HCFA's regulations provide for the adjustments to interest charges for overpayment determinations reversed administratively. 42 C.F.R. § 405.378(h)(2).

[12] HCFA's Guide, § 0306-1-45(E).

[13] 42 C.F.R. § 413.20(d).

intermediary officials who protested the settlements as setting bad precedents.

HCFA Eschewed Legal Review of Settlements

None of the three agreements were reviewed by HCFA's OGC or any other government attorney before they were executed, even though HCFA's internal guidance requires that debts of over $100,000 be referred to Justice through HCFA's central office and OGC.[14] The lack of legal review is further evidence of HCFA's failure to assess the litigation risks and other factors involved before settling these matters. We also believe that legal review is appropriate before government officials sign agreements relinquishing the government's right to recover tens of millions of dollars.

After we advised HCFA in advance of the specific questions we would be asking about its claims collection processes and compliance with the Federal Claims Collection Act, neither Chief Financial Officer Michelle Snyder nor Chief Counsel Sheree Kanner could answer those questions. Even more troubling is that after these interviews, we gave HCFA the opportunity to respond in writing to these questions, but the written response from Deputy Administrator Michael Hash was unresponsive to our questions.

The chronologies of the three improper settlements and our legal analysis of the applicability of the Federal Claims Collection Act to these settlements and the Medicare program can be found in our February 25, 2000, report.

Madame Chairman, this completes my prepared statement. I would be happy to respond to any questions that you or other members of the Subcommittee may have.

[14] HCFA's Guide, § 0306-1-20(C).

GAO Contacts and Acknowledgement

For further information regarding this testimony, please contact Robert H. Hast or Donald Fulwider at (202) 512-7455. William Hamel made a key contribution to this testimony.

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SENATE PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

STATEMENT OF

Charles R. Booth

March 28, 2000

Madam Chairman and members of the subcommittee, good morning. My name is Charles R. Booth. I am a career federal employee and have worked for the federal government for 40 years. I am the Director of the Financial Services Group, Office of Financial Management, Health Care Financing Administration (HCFA). In that position, I am responsible for the management of the Agency's current administrative budget and spending. I have held this position since July 1997.

From 1984 through 1994, I was director of the Office of Payment Policy in the Bureau of Policy Development. (In about 1988, the name of the office was changed from the Office of Reimbursement Policy, and the name of the Bureau was changed from the Bureau of Eligibility, Reimbursement, and Coverage, but the functions were the same.) I directed a staff that determined the administrative policies for reasonable cost reimbursement, reasonable charge payments, and payment under a variety of fee schedules as Congress enacted them. In addition, when disputes arose about the meaning of various policy interpretations, my staff responded to those inquiries. Some of those disputes involved the Office of General Counsel of Health and Human Services. I was the person they consulted about HCFA's views on whether to settle or appeal certain cases, including those that arose from decisions issued by the Provider Reimbursement Review Board.

In November 1994, there was a reorganization within the Bureau of Policy Development. My role changed somewhat. I assumed more responsibilities for policies for hospitals, but no longer had payment policy responsibilities for physician services, home health agencies, or skilled nursing facilities. I held that position until July 1997.

A dispute arose in the early 1990s between the Visiting Nursing Services of New York (VNS) and its fiscal intermediary, United Government Services (UGS). UGS had reviewed certain costs for this home health agency, which it wanted to disallow. Because the consequences were very significant, UGS discussed them with members of my staff and me. Representatives from VNS also met with us. These meetings occurred in the fall of 1993. There were also a variety of phone calls with UGS and other phone calls with an attorney representing VNS. VNS clearly wanted to reach some compromise with UGS before UGS made any final decisions. UGS asked us in late February 1994 if HCFA was in agreement with its proposed action. After checking with Thomas Ault, who at the time was the Director of the Bureau of Policy Development and my immediate superior, we said we were. UGS issued its decisions at the end of February 1994. Within a few days, Mr. Ault, directed me to find a way to settle this issue. He asked me to meet with representatives from VNS to find some middle ground because the amount at issue was too great. He indicated this needed to be accomplished quickly. As a result, I met with representatives from VNS and UGS on or about March 10,1994, and we reached an agreement. The settlement agreement was drafted by UGS, was reviewed at length by the VNS, UGS, and me, and finally signed in April 1995.

The main issue in this dispute was whether the length of time VNS claimed for nurses aides visits was reasonable. VNS served a large Medicaid population as well as a large Medicare population. The aides provided services to the Medicaid population that went beyond those for which Medicare would normally pay. These included homemaker services such as food shopping. While the average length of the Medicare visit was a little over three hours, the average length of Medicaid visits was about 12 hours. VNS claimed that we should average all the aide visit time for all patients and that Medicare should pay the costs, based on that average, for aide visits provided for Medicare beneficiaries. UGS contended the aide visits for Medicaid beneficiaries were not like those provided to Medicare beneficiaries, and that Medicare should pay only for the time

that aides spent with Medicare patients. Costs for several years were at issue. UGS was proposing to disallow about $93,000,000. As a result of the settlement, VNS paid the Government about $67,000,000.

In late January 1996, Mr. Ault, still my immediate supervisor, gave me a note dated January 19, 1996, from Rick Langfelder to his boss, Maria Mitchell. Mr. Ault told me to look into it, contact Mr. Langfelder, and find out what was going on. Mr. Langfelder worked for the New York Health and Hospitals Corporation (HHC), an agency of the New York City government that operated several hospitals. It was not clear from the January 19 note what the issues were. I did contact Mr. Langfelder and met with him and others from HHC in February. There were several issues HHC had with its fiscal intermediary, Empire Blue Cross (Empire), going back to the early 1980s. We discussed these issues again in May. However, by then, I had heard directly from Bruce Vladeck, the Administrator of the Health Care Financing Administration from May 1993 until September 1997. Dr. Vladeck inquired about what progress was being made to settle the issues raised by HHC. He was obviously disappointed by the lack of progress in settling these issues and expressed his strong desire to see more progress. I met again with Langfelder and others from HHC at the HCFA regional office in New York; that meeting took place in June. Representatives from Empire also attended. I had called William Toby, the Regional Administrator in New York, to ask if we could use space in his office, as I believed it would be better to meet there than at HHC. Tony Seubert attended the meeting for Mr. Toby. We discussed the issues and HHCs estimates of the value of those issues, but made little progress toward any resolution. Dr. Vladeck inquired about the status of negotiations soon after the June meeting. He advised me he needed to "report to the sixth floor." I took that to mean the Department's Office of the Secretary, but Dr. Vladeck provided no further description. (It is common within the Agency to refer to "the sixth floor" as meaning the Office of the Secretary.) He was clearly not happy that very little progress had been made at the June meeting. I recall sending him an e-mail saying I believed if we moved quickly to settle the issues, we would end up paying more

money. His reply was that he wanted it settled very quickly—that it was worth the extra money. I took this to be his clear direction to settle the issues. An agreement was reached in mid-August. That meeting was also at the Regional Office. Empire drafted the settlement agreement, which was signed in mid-September. The issues settled were worth about $200,000,000, and Empire paid HHC about $130,000,000.

In early November 1996, I received a phone call from an analyst in the Office of Research and Demonstrations of HCFA advising that Dr. Vladeck wanted me to look into a dispute between the Los Angeles County hospitals and their fiscal intermediary, Blue Cross of California. I had a short discussion with Dr. Vladeck in late November or December of 1996, when he advised me that the time pressure was not quite so severe. It was very clear to me that this was a directive from Dr. Vladeck that he wanted this matter settled as well. I contacted representatives from Los Angeles County, had discussions with representatives from Blue Cross of California, and reached a settlement agreement with the County representatives in late February of 1997. As with HHC, there were several issues in dispute. I drafted a settlement agreement along similar lines as the HHC agreement, and sent it to representatives from Los Angeles County, the fiscal intermediary, and the HCFA regional office in San Francisco. The agreement was revised somewhat and signed, and Blue Cross paid Los Angeles County about $51,000,000. The value of the issues in dispute was about $73,000,000.

I believed at the time and believe now that I was acting under the express direction of Mr. Ault or Dr. Vladeck. I believed at the time the settlements were appropriate. I now know that I should not have agreed to or signed those settlements with out the involvement of the Department's Office of General Counsel and the agreement from the Department of Justice. At no time did I intend to violate any rules, regulations, or laws. I have spent 33 years of my 40 year career working for the Medicare program and have tried to work for the best interests of Medicare beneficiaries and the Medicare program during this period. Thank you. I will try to answer your questions to the best of my ability.

STATEMENT OF BRUCE C. VLADECK
Before the Permanent Subcommittee on Investigations
U.S. Senate Committee on Governmental Affairs
March 28, 2000

Chairman Collins, Senator Levin, and members of the Subcommittee, I am Bruce C. Vladeck. I am appearing at the invitation of the Subcommittee to discuss the process by which the Health Care Financing Administration ("HCFA") has negotiated and resolved disputes with Medicare providers.

From 1993 until 1997, it was my privilege to serve as Administrator of HCFA. I am proud of my service and proud of what my colleagues and I accomplished during that time. I certainly would not claim that I made no mistakes during my service, nor that the agency, which with limited resources administers two of the largest and most complex programs of the Federal Government, was without flaw. But we made significant progress. The agency was in much stronger shape when I left than when I arrived, and – most important -- Medicare and Medicaid were in better financial shape and working better to serve their beneficiaries.

I understand the GAO and perhaps some members of this Subcommittee are questioning some of the settlements undertaken by HCFA while I was Administrator. I am here to answer questions about my role in those settlements and what I understood about the role of others. I also understand this Subcommittee's Chair may recommend changes in the law or changes in regulations to clarify the process by which disputes between HCFA and providers are resolved. If the objective of that effort is to provide greater certainty and a more expeditious and fair handling of disputes, I applaud your efforts and will assist you in whatever way I can.

When I appeared before the Senate Finance Committee for confirmation as Administrator of HCFA in May of 1993, HCFA was an agency that had long been criticized for being unresponsive to health care needs; a body slow to heed problems in the health care system; and one that too often appeared focused on form over substance. As I approached the task of Administrator, I resolved to be ever mindful of the impact of the agency on actual people. I made the following statement before the Finance Committee during my confirmation hearing:

> Medicare and Medicaid are two of the most important things this government does, and represent what the United Sates does best. . . . .We need to maintain strong programs for our disadvantaged and elderly citizens. These beneficiaries must be the clear focus of our efforts. We need to communicate better with our beneficiaries, the providers who serve them, and the States that are our partners in furnishing health care. We need also to listen to and work closely with people on the front lines of health care.
>
> We need to encourage greater experimentation, both by States and providers, in new ways to deliver, manage, and pay for services. . . . .The challenges we face in reforming the health care system require an agency that can balance our responsibilities and obligations to the many people the Health Care Financing Administration serves, while facing a changing environment in the health care community.

In 1993, there was a widespread perception that HCFA was a particularly insular, rigid, and bureaucratic agency, unresponsive to its major constituents and stakeholders. Improving customer service to all our customers – providers and States as well as individual beneficiaries – was a major priority of mine from the outset. I sought to address charges of "bureaucratic inertia" that previously had been leveled against HCFA. I repeatedly tried to convey the message, both inside the agency and without, that the

primary responsibility of HCFA was to insure that its beneficiaries had access to high-quality health care when they needed it. The only ones who could actually provide that care were not federal employees or insurance companies, but the doctors, hospitals, and other health care providers who were thereby our partners in fulfilling our core mission to meet the basic health care needs of our most vulnerable population: the poor, the disabled, and the elderly.

Internally, we emphasized the basics of good customer service -- establishing, for example, for the first time within the agency, quantitative standards on responding to telephone calls and written inquiries -- and we invested significant resources in "benchmarking" our activities against other organizations in both the public and private sectors. For example, we sent a team to Atlanta to learn about customer service from a hotel chain that had won the Baldridge Award of the Department of Commerce for excellence in customer service. Externally, I spoke to all the leading health care provider groups to emphasize our openness to increased communication and dialogue.

In this regard, I was continually concerned about the balkiness and inefficiency of the process through which cost report disputes were appealed, reviewed, and adjudicated. The Provider Reimbursement Review Board ("PRRB") had a backlog of several years and several thousands of cases. As Administrator, I was responsible for reviewing and was routinely provided with PRRB decisions involving cases dating back a decade or more. We devoted considerable energy and attention both to trying to make the PRRB process more efficient and trying to reduce the number of cases that came before the PRRB.

Another priority during my tenure at HCFA was a continuing strategy of trying to move away altogether from cost-based reimbursement. The enormous expenditures of time, energy, and money surrounding the cost-reporting and appeals process could be significantly reduced, and the government could save a lot of money, by moving from cost-based to prospective reimbursement. We thus redoubled our efforts to develop and implement prospective payment systems for hospital outpatient services, skilled nursing facilities, and home care agencies, and similarly sought to move from cost-based reimbursement to fee schedules or competitive pricing for other services – activities that culminated in the bipartisan process of the enactment of the Balanced Budget Act in 1997.

The Resolution of Reimbursement Disputes.

At the time I became Administrator, HCFA had been criticized for being non-responsive and non-timely in resolving pending disputes. In some instances, those disputes were based on a health care provider owing the government money; in others, the dispute involved possible underpayments by the government to the provider.

We were fortunate at HCFA to have a staff of very talented, knowledgeable, and experienced officials, many of whom had been with HCFA since its creation. The settlement process was overseen skillfully and energetically by Charles Booth, a long-time employee of HCFA who has been involved with the Medicare program since its inception. He was capable, tough and, I understood then and believe today, of the highest integrity. Mr. Booth, in turn, worked directly with HCFA employees in our central and regional offices and contractor employees throughout the country. I think it is important for the Subcommittee to have some sense of the scope of these activities; Medicare paid

close to 40,000 providers on a cost-related basis. Each provider filed an annual cost report, triggering a process that included intermediary review and determination and not infrequently a series of appeals and dispute resolution procedures.

The Subcommittee's letter of invitation asks that I address four specific Medicare payment disputes. They are:

a) a settlement between HCFA and the Department of Health Services, County of Los Angeles.

b) a settlement between HCFA and the New York City Health and Hospitals Corporation;

c) a settlement between HCFA and the Visiting Nurse Service of New York;

d) a settlement between HCFA and Howard University Hospital;

At my recent deposition before the Subcommittee staff, I was asked about these matters in great detail and was shown a number of related documents. I testified that I did not recall the details of any of the settlements, because I was not involved in negotiating the settlements, nor was I advised at the time about the details of the settlement negotiations. I did, however, press for timely resolution of three of the disputes. As I will discuss in more detail below, the Los Angeles County matter involved a potential health care crisis precipitated by a change in Medicaid policy; the implications of the crisis brought state and federal officials at the highest level to bear on developing a solution. The New York Health and Hospitals matter involved a potential disruption in services, which neither the State nor the City seemed willing to address. The Visiting Nurse Service dispute involved a conflict between the requirements imposed on providers by New York State and the services reimbursable by Medicare. In each of these cases, I

was advised and believed that our failure to act promptly could result in an intolerable reduction or loss of medical and health services to some of our most vulnerable citizens. But I left the specific negotiation and resolution of the matters to the good judgment of HCFA staff, who were better equipped than I to settle the matters. In each of the settlements we will discuss today, no one on the senior staff expressed to me, at the time, any reservations as to whether the agreements were in the best interest of the United States. However, as the Administrator of HCFA, I bear ultimate management responsibility for the resolution of the matters at issue.

Let me address, up front, what I understand are the primary concerns of the Subcommittee.

First, concerns have been raised about the fact that, in three of the settlements, I received calls from providers and others about the need to expeditiously resolve outstanding reimbursement disputes. During the four and a half years I served as Administrator, I received dozens of calls from providers, members of Congress, state officials, and others interested in the resolution of outstanding disputes of one kind or another. In each case, I sought to facilitate solutions by passing the matters on to experienced staff at HCFA and asking that they develop appropriate responses . I did not direct the staff to come up with a particular result, nor did I get involved in reimbursement settlement negotiations.

Second, concerns have been expressed that three settlements did not involve HCFA's General Counsel or the Department of Justice. As I testified in my deposition, I frankly did not know whether they did or did not go through the General Counsel or DOJ, or, for that, matter, what their final resolution would be. However, if I had thought about

it at the time, my view would have been that DOJ logically would not have been the appropriate body to resolve any of the policy issues of principal concern in those three settlements. These matters did not involve claims in litigation or litigation-related concerns, which DOJ would be uniquely qualified to handle. In each of these cases, HCFA had the unique ability, and I believed responsibility, to consider the fundamental health care issues involved, to speed the resolution of outstanding reimbursement issues, and to free up funding that was critical to the provision of services. My job as Administrator was to act on significant matters involving policy decisions. I did not routinely consult with DOJ on matters of policy.

Third, concerns have been raised about whether the dollar value of three of the settlements was adequate, because those settlements were for amounts significantly less than the amounts originally asserted by the fiscal intermediaries. Although I was not involved in those specific negotiations, it is a fact that, where a provider disputes an intermediary's determination of an amount owed, that amount is never final until there is an evaluation of the policy issues – either through settlement with HCFA, by the PRRB after a hearing, by the HCFA Administrator in the case of a review of a PRRB decision, or by a court, where the HCFA Administrator's decision is appealed. Indeed, even after an NPR is issued, providers are instructed that they should attempt to reach a resolution by way of settlement prior to an actual PRRB hearing. Where complex policy issues are involved, it is fair – and accurate – to say, that the intermediary's number may be viewed as simply the intermediary's number, and certainly is not considered a debt owed to the government. In the three settlements at issue, I do not believe the providers think they

received sweetheart deals, and the Subcommittee may wish to question the providers themselves.

Fourth, it has been suggested that I may have had a conflict of interest in urging resolution of two of these matters, because, prior to my service at HCFA, I twice served as an unpaid board member of the New York City Health and Hospitals Corporation, and I was invited to serve as an unpaid member of an advisory committee for the Center for Home Care Policy and Research, a non-profit center established by VNS. (With respect to that advisory committee, I do not know whether I was ever officially on the committee, although I was invited to join and may have attended one organizational meeting.) I have been involved in public health issues for over 25 years, and have served in numerous paid and unpaid positions (and also worked in numerous unpaid efforts for which I held no formal position) – all directed at the same objective of delivering health care services to the public, primarily to the poor and the elderly. Those remained my objectives when I became HCFA Administrator. It should not be a surprise that I have acquaintances and relationships throughout the health care community nationally, including providers. But to suggest that, because of prior unpaid service, I had any personal interest, as opposed to the public interest, in mind when I acted on behalf of HCFA is outrageous and untrue. No one who knows me would make that allegation.

Finally, I understand that I have been tagged as a "reluctant" witness, because I did not talk directly with a GAO investigator when he sought to interview me in the summer of 1999. I was not reluctant to testify. In a separate letter to the Subcommittee, my attorney, Robert J. Anello, addresses those circumstances. The key point is that Mr. Anello did talk with this Subcommittee's counsel last fall – almost six months ago – and

90

offered to make me available for an interview at that time. That offer was declined; my counsel was told "the train had left the station" because a GAO report already was being prepared. That was almost six months ago. I remained fully prepared to be interviewed, but we did not hear from the Subcommittee until last month, when I was asked to give a deposition, at which I appeared voluntarily. I answered fully all questions put to me, to the best of my recollection, as I would have done if Mr. Anello's offer of last fall had been accepted.

At the deposition, and again in this testimony, I describe my involvement to the best of my recollection. My recollection of these matters may not be clear in terms of the details and timing. Indeed, some of the documents shown to me at my deposition are inconsistent with my memory of the sequence of events, which has increased my uncertainty as to specific chronologies. But my lack of clarity on the details in no way affects, or qualifies, my view that each of the settlements at issue was arrived at fairly and was in the best interests of the United States and the people HCFA serves.

Department of Health Services, County of Los Angeles.

In late 1995 or early 1996, I was advised that Los Angeles County was facing a potentially massive public health crisis and might be forced to close hospitals and outpatient facilities due to a lack of funds. Approximately five million individuals relied on the Los Angeles system as their sole access to healthcare. The potential closure of facilities and cutbacks in services was a source of great concern – to the public health community, local officials, my colleagues in the Clinton Administration, and me. As a result, there were meetings in the Secretary's office, as well as at the White House,

involving, at one time or another, Administration officials, HHS officials, HCFA's General Counsel, and others – all focused on seeking ways to avert this potential crisis.

The problem in Los Angeles County was caused, in part, by HCFA's implementation of a change in Medicaid legislation that I supported and advocated. On a number of occasions, I was asked whether it was possible for HCFA to waive or change its regulation in order to keep the LA County Hospital system afloat. I believed, and expressed the view, that the Medicaid regulation represented sound public policy and that HCFA did not have the legal authority to waive the regulation.

Thus, the discussion at these meetings turned to other potential means to alleviate the pressures on LA County. I recall that each unit of HHS, as well as other federal agencies, was directed by the White House to explore whether there were any funds properly available to help keep the Los Angeles County Hospitals open.

One of the alternatives proposed and later adopted was what is known as a Section 1115 Medicaid waiver or a Medicaid Demonstration Project. These waivers, which have been granted to numerous states, often permit, under rigorous budget neutrality rules, short-term expenditure increases to support programmatic changes that will eventually save money. In the case of the LA County Hospital system, the hospitals received increased reimbursement for outpatient services in the fiscal years beginning July 1, 1996, pursuant to a five-year plan designed to overhaul operation of the public hospital system and to recoup the additional expenditures before the end of that period.

While this demonstration project was to be the cornerstone of the LA County Hospital remedy, it was not alone sufficient to resolve the LA County crisis. Accordingly, additional measures were considered, including the potential resolution of

outstanding LA County Hospital Medicare appeals. I recall that the issue of resolving pending Medicare claims was raised at the time when details of the Medicaid waiver were being negotiated in the first half of 1996. I also had the recollection that the LA County Medicare settlement was discussed prior to June 30,1996, the end of the LA County Hospitals' fiscal year.

At my deposition, I was advised that my recollection regarding the timing of the Medicare aspect of the LA County situation was not consistent with various documents and Mr. Booth's recollection. While I still believe that the possibility of settling outstanding Medicare appeals was raised in early 1996, the documents make clear that Mr. Booth addressed the Medicare appeals in the late 1996/early 1997 time frame, and that the Medicare settlement did not occur until March 1997.

I know that, at some point, Mr. Booth was asked to investigate and evaluate any pending Medicare appeals involving LA County Hospitals and to attempt to resolve the outstanding disputes. Because the hospital system was in crisis, I recall telling Mr. Booth that he should move quickly towards a resolution of the appeals so that any funds due to the county would be available. I recall that Mr. Booth initially expressed the view that he believed there would not be a significant amount of money involved. He later informed me, however, that resolution of the pending appeals could result in the LA County Hospitals receiving as much as $35 million. I never discussed with Mr. Booth the specifics of the appeals, although it was my impression at the time that most of the appeals involved medical education issues.

Mr. Booth handled the settlement negotiations on behalf of HCFA, determined the final settlement amount of $51 million, and signed the settlement agreement. I was

informed of the final settlement number after Mr. Booth had concluded his evaluation process. While counsel for the Subcommittee has informed me that Mr. Booth recently has expressed concerns that the settlement with LA County was not a good one from HCFA's standpoint, I do not believe that was his view at the time, and in any case, he did not express that view to me in 1997. Additionally, I understand that the head of LA County Hospital believes the settlement was professionally negotiated, and believes that LA County may have received a more favorable outcome had it gone through the lengthy appeals process.

Until my deposition, I also was unaware that a HCFA regional employee had objected to the settlement with LA County. I saw her e-mail to Mr. Booth for the first time at my deposition. When I read the e-mail, I testified that I believed that the view expressed was an overly rigid interpretation of HCFA's regulations regarding the documentation of claims for bad debts. Procedures for documenting Medicare bad debts have long been a nettlesome issue in Medicare payment policy. The e-mail ignored the fact that both the PRRB and various fiscal intermediaries have accepted alternative methods of documentation; more importantly, it did not take into account the central fact that HCFA's statutory mission was to assist providers and beneficiaries, within the confines of the relevant regulations.

I also have been told recently that Mr. Booth did not discuss the LA County settlement with counsel for HCFA and that DOJ was not involved. Mr. Booth and I never discussed whether the General Counsel or DOJ were involved. I did not know then, and only recently learned, that HCFA General Counsel was not involved. I had no reason to believe he would not be consulted. Indeed, Mr. Booth frequently had direct

dealings with HCFA's General Counsel. I certainly never instructed Mr. Booth or any other staff member not to involve the General Counsel. The decision as to whether DOJ should have been involved in this settlement process appropriately would have been made by the General Counsel.

New York Health and Hospital Corporation

The New York Health and Hospital Corporation provides medical services for millions of low income and impoverished individuals in New York City. As a former health policy official in New York, I was familiar with HHC and twice served as an unpaid board member.

I believe that sometime during the spring of 1996, I was advised by someone from the Secretary's office that HHC was facing drastic service cuts and the layoff of thousands of employees. Although I thought that this HHC matter arose after the LA County Medicaid waiver and settlement were accomplished, it is possible that the sequence of events differs from my recollection.

It was my understanding that, as with LA County, a Section 1115 Medicaid waiver was the first option explored with HCFA to provide additional funds to HHC. The Medicaid waiver was initially requested by the unions whose employees would be affected by the upcoming layoffs. They and others expressed concern that the layoffs would cripple full and effective delivery of medical services. Union representatives made this request at a meeting in Washington, D.C., which was attended, as I recall, by me, other HCFA employees, various union representatives, and officials of the HHS Secretary's office. My response to their request was that a Medicaid waiver could only be granted if New York City or State asked for assistance.

I recall that after this meeting in Washington, D.C., others communicated with New York City and State officials in an attempt to persuade them to request a Medicaid waiver on behalf of HHC. In that regard, I believe I had a conversation with Ms. Maria Mitchell, Mayor Giuliani's senior health care advisor, about a potential demonstration project. My impression after this conversation was that the Medicaid waiver under consideration did not sound promising and would not significantly alleviate HHC's problems. I conveyed this impression to the Secretary's office.

With the Medicaid waiver essentially off the table, someone (I do not recall who) suggested that HCFA inquire about the possibility of resolving existing HHC Medicare disputes. A document I was shown at my deposition (which I do not recall specifically) seems to indicate that Maria Mitchell had been discussing the potential resolution of Medicare disputes with HHS employees as early as January 1996. However, I do not recall the Medicare issue coming up that early in the process, nor do I recall discussing any Medicare-related issues with Ms. Mitchell.

Once the possibility of resolving HHC Medicare claims was raised, I called Mr. Booth and asked about outstanding Medicare appeals. Mr. Booth responded that HHC always had pending Medicare disputes. I then explained to Mr. Booth that HHC was having severe financial problems and requested that he look into the possibility of expeditiously resolving those HHC appeals where the facts were not substantially in dispute and the arguments were clear. It was my understanding from the Secretary's office that this Medicare settlement had to be accomplished quickly to avoid the layoffs and closures.

When Mr. Booth had started his evaluative process, I also asked him to give me an estimate of the total amount of dollars that would be involved in the settlement. Apparently, New York City, which receives and distributes Medicare funds to HHC, had committed that it would not cut hospital services if a certain amount of funds was received. My directions to Mr. Booth, however, were not that he needed to obtain a particular settlement, but that he should look into the outstanding claims, resolve the substantive issues involved, and let the chips fall as they may.

Initially, Mr. Booth reported to me that the Medicare settlement with HHC was likely to be in the $50 million range. At some point later in the process, Mr. Booth informed me that the HHC negotiations were almost concluded and that the settlement was going to be over $100 million. I conveyed this message to the Office of the Secretary. While I did not see the final agreement between HCFA and HHC until my deposition, I understand that the final settlement was in excess of $100 million.

As in the LA County resolution, I was involved neither in assessing the merits of the underlying appeals nor in negotiating the terms of the settlement with HHC. I thought that the Medicare disputes being resolved primarily involved graduate medical education costs and the reimbursability of ambulance costs. Because I was not involved in the merits of the disputes, I had no information at the time that a central issue appears to have been HHC's inability to document its bad debt claims.

With respect to the settlement itself, it has always been my understanding that it was in the best interests of both HCFA and HHC. While Mr. Booth may now feel that there was pressure to conclude the HHC settlement and that this pressure might have costs HCFA some money, at the time the settlement was concluded he never informed

me that he believed the settlement was not in the best interest of HCFA. This is not to say that time pressure was not a factor in the HHC settlement. My belief was that these Medicare appeals had to be resolved quickly to avoid substantial adverse health care consequences in New York City, and I, in turn, alerted Mr. Booth to the time constraints. Nevertheless, I had no reason to believe that HCFA's basic mission was being compromised to achieve a settlement with HHC. The settlement with HHC not only provided much needed funds to HHC but also resolved hundreds of outstanding appeals, the outcome of which could not be predicted with any level of certainty.

It has also come to my attention that Mr. Booth has stated that he did not seek the approval of HCFA's General Counsel and DOJ in connection with the HHC settlement because he believed it would delay the process. I did not know then, and only recently learned, that Mr. Booth did not share the agreement with HCFA General Counsel or DOJ. I clearly did not tell him not to involve either party.

Visiting Nurse Service of New York

VNS was the largest non-profit home health care agency in the country and one of HCFA's largest providers, serving tens of thousands of Medicare and Medicaid patients in the greater New York area. At some time in either late 1993 or early 1994, I had two conversations with Ms. Carol Raphael, who served as CEO of VNS, in which she informed me that VNS was in the midst of a significant dispute with HCFA and wanted to resolve the dispute (At my deposition, the Subcommittee staff suggested that there was an initial conversation with Ms. Raphael in New York in late 1993, when I was in New York to speak at a conference sponsored by VNS. It is possible that this is, in fact, when I first talked with Ms. Raphael about the matter.) I was familiar with VNS prior to

becoming HCFA Administrator and had had professional contacts with its CEO, Ms. Raphael, before she assumed that position and afterwards. (As noted earlier in this statement, prior to becoming HCFA Administrator, I was asked to serve as an unpaid member of an advisory committee of an organization that was affiliated with VNS, but I am not sure that I was ever officially appointed.)

I conveyed information about Ms. Raphael's concerns to Mr. Tom Ault, who served as Director of the Bureau of Policy Development, or to Mr. Booth, who was then Director of the Office of Hospital Policy. I believe I told them that Ms. Raphael expressed a willingness to settle the dispute, and I asked one of them to look into it. Alerting my staff to Ms. Raphael's expressed willingness to settle was appropriate, since it would be to HCFA's benefit to resolve a large dispute quickly, without going through a lengthy appeals process. Indeed, HCFA's instructions to fiscal intermediaries and providers require settlement negotiations. I would also note that VNS serviced a large number of needy elderly beneficiaries.

In what I recall as a second conversation with Ms. Raphael, she expressed concern that there had been no follow up to our initial conversation . At that point, I called either Mr. Ault or Mr. Booth to ask why they had not acted on my initial request to look into the matter.

Following my call with Ms. Raphael, I believe I learned that there was a policy issue involving the interplay of certain Medicare payment criteria and New York State regulations. I also believe that resolution of this policy issue may have had an impact on the VNS dispute. At a meeting with Mr. Ault, Mr. Booth, or perhaps both of them, I was advised that a program memorandum was being prepared to address this policy issue.

Upon reading a draft of the memorandum, I remember being concerned that it did not reflect a full understanding of New York State's unique regulatory requirements, and I urged one or both of them to study the matter further. I did not see the final HCFA policy memorandum that was issued, and I am unsure what relationship that policy memorandum had to the VNS dispute.

Although I pressed to get the VNS matter resolved, I had no view as to what an appropriate resolution would be, nor did I express a view to Mr. Booth or Mr. Ault on how the matter should be resolved, or even whether it should be settled as opposed to being pursued administratively. I knew Mr. Booth negotiated the settlement, because he later advised me that the VNS dispute had been settled. I did not know then, and only recently was advised, that neither HCFA's General Counsel nor the DOJ were involved in the settlement. Frankly, based on my understanding of the DOJ approval process at the time, I would not have thought that the VNS settlement required DOJ approval, because HCFA was not in litigation with VNS, and the matter with VNS involved HCFA policy and was not being resolved based on litigation considerations.

Howard University Hospital

Shortly after I was appointed HCFA Administrator, I was informed of a dispute between HCFA and Howard. I recall that the dispute generally involved issues of graduate medical education costs. I believe HCFA had determined that Howard had significantly overstated these costs, and a repayment schedule had been agreed upon. Shortly thereafter, however, Howard informed HCFA that it was unable to comply with the payment schedule and wished to renegotiate the schedule. I believe most of the negotiations between HCFA and Howard had occurred before I became Administrator. I

may have been informed about some of the aspects of the negotiations at the time, but I did not recall the settlement until I recently was shown a copy of the settlement document with my signature on it.

At my recent deposition before the Subcommittee staff, I was asked about my knowledge of the involvement of the Department of Justice in negotiating the Howard settlement. Frankly, I do not recall any specific discussion about DOJ's position (including any reservation that DOJ might initially have had regarding the settlement) although at some point I understood that DOJ was involved, because Howard had a unique status vis-à-vis the Federal government. Since Howard was subsidized by the Department of the Interior, any money not paid to it by HCFA would ultimately be paid by the Federal Government in another form. I recently have been informed that Darrel Grinstead, who was HCFA General Counsel at the time, believes he discussed the Howard settlement with me and that he likely discussed with me the reasons why DOJ was involved. I do not recall such a specific conversation, but have no reason to question Mr. Grinstead's recollections. My general understanding was that DOJ became involved in settlements if litigation-related matters were involved – in contrast to policy interpretations or considerations of the merits of a claim, which are the exclusive province of HCFA.

I hope this written statement has been helpful to the Subcommittee. I would be pleased to answer any questions and to work with the Subcommittee as it considers these important issues in the future.

Senate Permanent Subcommittee
On Investigations
EXHIBIT # 1

§ 401.601 Basis and scope.

(c) Amount of claim. HCFA refers all claims that exceed $ 100,000 or such higher amount as the Attorney General may from time to time prescribe, exclusive of interest, to the Department of Justice or the General Accounting Office for the compromise of claims, or the suspension or termination of collection action.

§ 401.603 Definitions.

For purposes of this subpart --

Claim means any debt owed to HCFA.

Senate Permanent Subcommittee
On Investigations
EXHIBIT # 2

Senate Permanent Subcommittee
On Investigations

EXHIBIT # 3

>>> Alysson Blake 03/06/97 04:10pm >>> 1 C
Chuck, Alysson is not here, so this is Jean Oh responding to your request for comments on the proposed settlement.

Thanks for the opportunity to comment on the draft settlement agreement with LA County.

As we discussed earlier in our phone call with you, we have some major concerns with an agreement of this type. It appears this is a political action on the part of L.A. County to circumvent Medicare requirements and undermine the Medicare's administrative resolution process. It sets a bad precedence especially since the County has been a "problem child" for years and years. Furthermore, based on our discussions with Blue Cross about some of these appeal issues, the basic dispute between the County and the FI is one of record keeping and billing requirements (or the lack of supporting documentation), rather than a difference in policy interpretation. There is a good likelihood that Blue Cross will prevail on most of these issues, if and when the issues are heard by the PRRB (LA County keeps postponing the hearing, we believe because they know they do NOT have documentation and know they will not prevail).

Therefore, we believe this agreement is not in Medicare's best interest. If a settlement is in HCFA's best interest, we strongly encourage you to have the PRRB appeals moved forward to resolve these issues. If it is in HCFA's best interest to get Federal funding to LA County, we suggest you consider a block grant, ORD project or some other means that does not require Blue Cross of California contractor or Medicare staff to subvert, or circumvent, Medicare regulations. We also do not believe all of the payment should be made with Medicare Trust Funds as some amount of it, which no one is able to substantiate but we believe is significant (see point #1 below), appears to be for non-Medicare services. We believe this is not consistent with our fiduciary responsibility to protect the interests of our customers, the Medicare beneficiaries.

We also do not believe the settlement will permanently resolve the underlying issue that LA County cannot ~~not~~ will not, maintain the records required of all other Medicare providers. What will happen to costs and claims for subsequent periods of time? This settlement does not require LA County to meet Medicare record keeping requirements in the future, or lose the resulting Medicare reimbursement. Will HCFA be facing another "settlement" of this type in 8 to 10 years from now? Medicare is offering to pay $51 million in the settlement. What is LA County giving in return -- Ceasing to appeal issues they really don't want the PRRB to hear because they know they don't have documentation and cannot prevail? In our opinion, unless Medicare can get some agreement that LA County in the future will meet Medicare documentation requirements or not claim the costs, this is not a settlement where both parties realize some benefit. It is more of a "grant" and should be called that, without the compromise being called a "Medicare reimbursement settlement" under Medicare regulations.

ΩMSG FROM: XR28 --HCFACOM TO: XC15 --HCFADOM 02/22/94 17:12:28

To: XC15 --HCFADOM Ault, Thomas XS38 --HCFADOM Kuhl, Robert

From: CHARLES BOOTH
Subject: VNS, New York

I talked with Mary Flachner again a few minutes ago. Her boss, Tim Cullen, wants your personal assurance, Tom, that we will support the FI when they issue the NPR's on 2/28. For your info, there was a conference call on 2/22 between the FI and VNS including Liz Dunst. They reached an impasse; VNS wants the FI to just add 5.5 hours to each visit because patients are sicker in New York. The FI says there is no justification; give us something to show any adjustment makes sense, but VNS apparently has nothing. I continue to tell Mary that we agree with their position and to proceed with the NPRs. Cullen is afraid we will point fingers and wants to figuratively hold your hand so you can't. Thanks. Chuck

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Senate Permanent Subcommittee On Investigations
EXHIBIT # 4

Senate Permanent Subcommittee
On Investigations

EXHIBIT # 5

From: CHARLES BOOTH
*** Resending note of 03/16/94 14:25
To: JSTEC --HCFACHI

From: CHARLES BOOTH
Subject: Settlement with Visiting Nurses, New York
We did reach a settlement last Thursday which will result in a substantial
ment to the trust fund. This settlement is for all 6 years and provides
is to set correct interim payments for '94 and beyond. The parties
agreed to keep the results of the settlement quiet since we don't want it to
be a precedent for the other HHAs. I tried to send you a cc of a PROFS note
I sent Bruce Vladeck, but I must have done something wrong. In that note, I
commented that the FI did a great job, and Bruce expressed his thanks to them.
I'd be happy to discuss this further if you wish. Chuck

DISTRIBUTION:
☑ Marva Cheatham
☑ Mary Flaschner
☑ Dick Heesen
☐ Barb Hensley
☐ Dennis Krueger
☑ Larry Pierzchalski
☐ Chuck Schuele
☐ Randy Watkins
☐ Eileen Weller
☐ Alta Werner

Date: 3/17/94

PRIORITY:
☐ 1 ☐ 3
☐ 2 ☒ FYI

ACTION:
☐ Formal Response Required
☐ Review & Implement
☐ Supply Data & Return

* Indicates Primary Responsibility for Response

FROM: Marva
TO:
☐ Tim Cullen
☐ Jenny Donnelly
☐ Steve Banas

Senate Permanent Subcommittee
On Investigations
EXHIBIT # 6

>>> Chuck Booth 11/27/96 01:47pm >>>
I have communicated via E-mail with Tom Coupar, Diane Caradeuc, and Gary Terada on the above subject. I believe Bruce Vladeck hopes we can move this process faster than Blue Cross will because of the lack of good documentation. I believe the next step is to communicate with folks at both Blue Cross and provider representatives.

I will be out the first week in December on vacation, but plan to call Joe Turna as soon as I return. If you have any suggestions for alternate courses of actions, I'd be happy to have them. Thanks. Chuck.

CC: rchambers, SAN FRANCISCO.SFO1(EAbbott),

Senate Permanent Subcommittee
On Investigations
EXHIBIT # 7

From: Alysson Blake
To: BALT2.CO2(CBooth)
Date: 11/29/96 10:58am
Subject: Possible Settlement with L.A. County Hospitals -Reply

Chuck - Can we talk about what you have in mind for moving this along? I've had discussions with Jean and Gary and don't know what can be suggested given what they told me about the lack of documentation by the providers. I'll be in all week the week you are back. Let me know when would be convenient for you and I'll arrange for Richard Chambers, Thom and Gary to be available as well. Thanks

From: Alysson Blake
To: eabbott, rchambers
Date: 11/29/96 10:27am
Subject: Possible Settlement with L.A. County -Reply -Forwarded -Forwarded

This goes with a note from Chuck Booth that I sent a reply to and copied you. This is a really complicated issue I've been talking with Gary and Jean about. I don't know what Chuck thinks we can "negotiate" but Gary and Jean feel pretty strongly without additional documentation from providers BCCA cannot go further. I have asked Chuck to get in touch to schedule a call with me (us) and I will ask Jean and Gary to give me the realtilty long version of the issues before I talk to him Do you want to be involved in either their briefing or the call.

CC: johl, gterada

Senate Permanent Subcommittee
On Investigations
EXHIBIT # 8

From: Jean Ohl
To: SAN FRANCISCO.SFO1(ABLAKE), BALT2.CO2(CBooth)
Date: 3/7/97 11:59am
Subject: Settlement with L.A. County Hospitals -ACTION -Reply -Reply -Reply

1R

Chuck, thanks for hearing us out. One more piece of information: I understand that California passed a law a year or two ago that prohibits local goverment entities from holding closed door (secret) meetings. I do not know if this concept also applies to agreements. But, it would not be fair to place LA County in a position of going against a State law with the item #9 non-disclosure statement. Could you please have OGC ensure this is ok with State laws? Thanks.

Senate Permanent Subcommittee
On Investigations

EXHIBIT # 9

MAR-03-2000 12:43

MARK FINUCANE, Director

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
313 N. Figueroa, Los Angeles, CA 90012
(213) 240-8101

File LA County

HHS, HCFA
DIVISION OF MEDICARE
REGION IX
MAY 13 97 0000

RECEIVED
MAY 14 1997
JANDERSON
MEDICARE

Board of Supervisors
Gloria Molina
First District
Yvonne Brathwaite Burke
Second District
Zev Yaroslavsky
Third District
Don Knabe
Fourth District
Michael D. Antonovich
Fifth District

April 28, 1997

cc: Jerri Dill
Gary T

Bruce Vladeck, Ph.D, Administrator
Health Care Financing Administration
Hubert H. Humphrey Building, Room 314G
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Dr. Vladeck:

LETTER OF APPRECIATION

I would like to take this opportunity to thank you for your consideration and support, and to commend Mr. Charles Booth, of your staff, for his cooperation and fairness and the expeditious manner in which he negotiated the Medicare Appeals Settlement Agreement with our Department. According to my staff, Mr. Booth was very considerate throughout the negotiations and acutely aware of our need to reach settlement quickly. This settlement greatly facilitates our ability to reduce our projected deficit and related service curtailments for next year.

Additionally, I would like to thank Jackie Anderson and Dino Gosai, of Blue Cross, for their roles in expediting payment to our Department.

Thank you once again for giving us the opportunity to resolve prior appeals to fund current and future years' services.

Very truly yours,

Mark Finucane
Director of Health Services

MF:jr

c: Jackie Anderson
Charles Booth
Dino Gosai
Reginald S. Nakaoka
Donald C. Petite
Gary W. Wells

Senate Permanent Subcommittee
On Investigations

EXHIBIT # 10

December 1, 1994

NOTE TO BRUCE VLADECK, ADMINISTRATOR, HCFA

Re: Settlement of Howard University Hospital
Overpayment Dispute

Attached is the final settlement agreement with Howard University Hospital to resolve our Medicare overpayment dispute for the years 1983 -1991. Howard has accepted the terms of this agreement. This agreement is in accord with the terms previously discussed with you, including a fifteen year repayment period and an agreement by Howard to accept the auditors' determination of the base year per resident amount for all future years. The monetary aspects of the agreement have been approved by the Department of Justice. A copy of the letter notifying me of that approval is attached. You have the authority to approve this settlement and it has been prepared for your signature. I recommend that you approve the agreement.

The final agreement has been reviewed and approved by the Associate Administrator for Operations and his staff as well as by the Region III Regional Administrator. Please let me know if you have any questions.

Darrel J. Grinstead
Chief Counsel

The monetary aspects of the agreement have been approved by the Department of Justice. A copy of the letter notifying me of that approval is attached. You have the authority to approve this settlement and it has been prepared for your signature.

Senate Permanent Subcommittee
On Investigations

EXHIBIT # 11

SUBCHAPTER II—CLAIMS OF THE UNITED STATES GOVERNMENT

Cross References

Third party tort liability to United States for hospital and medical care, see section 2651 et seq. of Title 42, The Public Health and Welfare.

§ 3711. Collection and compromise

(a) The head of an executive or legislative agency—

(1) shall try to collect a claim of the United States Government for money or property arising out of the activities of, or referred to, the agency;

(2) may compromise a claim of the Government of not more than $20,000 (excluding interest) that has not been referred to another executive or legislative agency for further collection action; and

(3) may suspend or end collection action on a claim referred to in clause (2) of this subsection when it appears that no person liable on the claim has the present or prospective ability to pay a significant amount of the claim or the cost of collecting the claim is likely to be more than the amount recovered.

(b) The Comptroller General has the same authority that the head of the agency has under subsection (a) of this section when the claim is referred to the Comptroller General for further collection action. Only the Comptroller General may compromise a claim arising out of an exception the Comptroller General makes in the account of an accountable official.

(c)(1) The head of an executive or legislative agency may not act under subsection (a)(2) or (3) of this section on a claim that appears to be fraudulent, false, or misrepresented by a party with an interest in the claim, or that is based on conduct in violation of the antitrust laws.

(2) The Secretary of Transportation may not compromise for less than $250 a penalty under section 6 of the Act of March 2, 1893 (45 U.S.C. 6), section 4 of the Act of April 14, 1910 (45 U.S.C. 13), section 9 of the Act of February 17, 1911 (45 U.S.C. 34), and section 25(h) of the Interstate Commerce Act (49 U.S.C. 26(h)).

(d) A compromise under this section is final and conclusive unless gotten by fraud, misrepresentation, presenting a false claim, or mutual mistake of fact. An accountable official is not liable for an amount paid or for the value of property lost or damaged if the amount or value is not recovered because of a compromise under this section.

(e) The head of an executive or legislative agency acts under—

(1) regulations prescribed by the head of the agency; and

(2) standards that the Attorney General and the Comptroller General may prescribe jointly.

(f)(1) When trying to collect a claim of the Government under a law except the Internal Revenue Code of 1954 (26 U.S.C. 1 et seq.), the head of an executive or legislative agency may disclose to a consumer reporting agency information from a system of records that an individual is responsible for a claim if—

(A) notice required by section 552a(e)(4) of title 5 indicates that information in the system may be disclosed to a consumer reporting agency;

(B) the head of the agency has reviewed the claim and decided that the claim is valid and overdue;

(C) the head of the agency has notified the individual in writing—

(i) that payment of the claim is overdue;

(ii) that, within not less than 60 days after sending the notice, the head of the agency intends to disclose to a consumer reporting agency that the individual is responsible for the claim;

(iii) of the specific information to be disclosed to the consumer reporting agency; and

(iv) of the rights the individual has to a complete explanation of the claim, to dispute information in the records of the agency about the claim, and to administrative repeal or review of the claim;

(D) the individual has not—

(i) repaid or agreed to repay the claim under a written repayment plan that the individual has signed and the head of the agency has agreed to; or

(ii) filed for review of the claim under paragraph (2) of this subsection;

(E) the head of the agency has established procedures to—

(i) disclose promptly, to each consumer reporting agency to which the original disclosure was made, a substantial change in the condition or amount of the claim;

(ii) verify or correct promptly information about the claim on request of a consumer reporting agency for verification of information disclosed; and

(iii) get satisfactory assurances from each consumer reporting agency that the agency is complying with all laws of the United States related to providing consumer credit information; and

(F) the information disclosed to the consumer reporting agency is limited to—

(i) information necessary to establish the identity of the individual, including name, address, and taxpayer identification number;

(ii) the amount, status, and history of the claim; and

(iii) the agency or program under which the claim arose.

(2) Before disclosing information to a consumer reporting agency under paragraph (1) of this subsection and at other times allowed by law, the head of an executive or legislative agency shall provide, on request of an individual alleged by the agency to be responsible for the claim, for a review of the obligation of the individual, including an opportunity for reconsideration of the initial decision on the claim.

(3) Before disclosing information to a consumer reporting agency under paragraph (1) of this subsection, the head of an executive or legislative agency shall take reasonable action to locate an individual for whom the head of the agency does not have a current address to send the notice under paragraph (1)(C).

(Pub.L. 97-258, Sept. 13, 1982, 96 Stat. 971; Pub.L. 97-452, § 1(15), Jan. 12, 1983, 96 Stat. 2470.)

Senate Permanent Subcommittee
On Investigations
EXHIBIT # 12

:om: XR28 --HCFACOM Date and time 02/08/94 13:28:20
): XC15 --HCFADOM Ault, Thomas XS38 --HCFADOM Kuhl, Robert

:om: CHARLES BOOTH
ıbject: Exit Conference Between Visiting Nurses, N.Y. and FI
ıry Flachner from the FI called; the exit conference just ended; and I'm
ıre you will be surprised to know the provider is not happy. Liz Dunst
ɜpresented that they thought the FI would have some alternative method of
ılculating time for visits and suggested adding 5.5 hours to the average
ɜdicare visit as an alternative. The FI responded that was arbitrary and
f the provider wanted to suggest something and had some supporting data,
ıe FI would review. The FI also told VNS they planned to issue the NPRs
/ the end of the month. Tom, I expect you will be hearing from Liz fairly
ɔon. In my view, we need to keep the ball in their court. Chuck

Senate Permanent Subcommittee
On Investigations

EXHIBIT # 13

MAR-03-2000 12:42

P.02

Health Care Financing Administrator

The Administrator
Washington, D.C. 20201

APR 7 1997

TO: Kevin Thurm
Deputy Secretary

FROM: Bruce C. Vladeck
Administrator

SUBJECT: Settlement of Cost Report Issues with Los Angeles County

You will recall we settled several outstanding issues with New York Health and Hospitals Corporation last Summer. We discovered a few months ago there were several similar issues with the hospitals owned and operated by Los Angeles County. Just as with the New York hospitals, we found it beneficial to settle many of these issues. My staff informs me that in exchange for their agreement to not pursue these issues through the appeals process, we have instructed our intermediary to pay Los Angeles County $51,000,000. Both we and the County officials are pleased with this result.

97-027:

Senate Permanent Subcommittee
On Investigations
EXHIBIT # 14

U.S. Department of Justice
Civil Division
Commercial Litigation Branch
Corporate/Finance Group

J. Christopher Kohn
Director

P.O. Box 875
Ben Franklin Station
Washington, D.C. 20044-0875

Tel: 202-514-7450
Fax: 202-514-9163
E-mail: chris.kohn@usdoj.gov

March 27, 2000

By Facsimile: 202-224-7042

K. Lee Blalack, II
Chief Counsel & Staff Director
Permanent Subcommittee on Investigations
United States Senate
100 Russell Building
Washington, D.C. 20510

Dear Mr. Blalack:

By memorandum dated March 24, 2000, Karina Lynch of your staff requested that Stuart Schiffer address three issues regarding your investigation of settlements by the Health Care Financing Administration. As Karen Wilson advised you, Mr. Schiffer is out of the country and, therefore, I am responding in his stead. I shared a copy of this letter with Mr. Schiffer and with the Office of Legal Counsel ("OLC"). They concur in its contents.

I will address each of your concerns (indicated by italicized print) separately below.

1. *Neither the Civil Division nor the Office of Legal Counsel for the Department of Justice ("DOJ"), has ever been shown actual agreements, or any documents pertaining thereto, related to the settlements between HCFA and (a) Visiting Nurse Service of New York, (b) New York City Health and Hospitals Corporations, and (c) Department of Health Services County of Los Angeles County.*

To the best of our knowledge, we have not been shown any agreements or other documents related to the identified settlements. We have checked our computer listing of matters for which files have been opened in the Civil Division; it reveals no listing for these settlements. Furthermore, the individuals in the

Civil Division most likely to have handled such settlements have no recollection of seeing any papers concerning them. We are advised by OLC that they too have no record or recollection of agreements or other documents related to the identified settlements.

2. *Neither the Civil Division nor the Office of Legal Counsel for DOJ has been asked by the Department of Health and Human Services ("HHS") to render a legal opinion on whether the aforementioned HCFA settlements violated the Federal Claims Collection Act ("FCCA"), or whether they violated HCFA's own regulations implementing FCCA.*

To the best of our knowledge, this statement is correct.

3. *Neither the Civil Division nor the Office of Legal Counsel for DOJ has been asked by HHS to render a legal opinion as to the applications of FCCA to Medicare reimbursement disputes.*

As we discussed during our meeting on March 15, 2000, representatives of the Civil Division and OLC met in September, 1999, with HHS representatives to discuss generally the interplay between the FCCA and Medicare reimbursement disputes. HHS did not ask that we render a legal opinion. HHS subsequently contacted the Civil Division to request a letter essentially memorializing the subjects we discussed during our meeting. A copy of our October 8, 1999 letter which responds to that request is enclosed. HHS also sent an October 1, 1999 letter to OLC; a copy is enclosed. That letter does not seek a legal opinion but closes with the statement that HHS "would appreciate any insights that [OLC] may have to offer" on the HCFA settlement issue. OLC has not responded to that letter.

Very truly yours,

J. Christopher Kohn

Enclosures

cc: Linda Gustitus
Minority Chief Counsel
(By Facsimile: 202-224-1972)

Senate Permanent Subcommittee
On Investigations

EXHIBIT # 15

From Provider Reimbursement MANUAL - Part I § 2409

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...provisions of the regulations, that the NPRs could only reflect adjustments to the current year for which a cost report

HCFA Admr. Dec., Sept. 6, 1979, aff'g *PRRB Dec.* Nos. 79-D41, 79-D42, and 79-D43. [The HCFA decision was reported at NEW DEVELOPMENTS ¶ 30,057.]

[¶ 7350] OVERPAYMENTS TO PROVIDERS—GENERAL (Prov. Reimb. Man., Part I, § 2409)

Once a determination of overpayment has been made, the amount so determined is a debt owed to the United States Government. Under the Federal Claims Collection Act of 1966, enacted by Congress on July 19, 1966, each agency of the Federal Government, pursuant to regulations jointly promulgated by the Attorney General and the Comptroller General of the United States, must attempt collection of claims of the Federal Government for money arising out of the activities of the agency. These regulations require the head of each agency to take action on a timely basis to collect claims of the United States.

There are generally two ways in which repayment can be made: (1) refund and (2) set-off, or a combination of these two. In some cases, the provider may be able to refund the entire amount in a lump-sum payment; in others, a schedule of repayments may be the most feasible way to repay. There will be cases where some form of set-off is the only way to repay the money owed; e.g., withholding given amounts of money from interim payments. Other cases may lend themselves to partial repayment through refund and the remainder through set-off.

.01 Source:

As adopted, Trans. No. 5 (May 1968), and amended by Trans. No. 35 (Apr. 1971).

Trans. No. 35 renumbered "Overpayments to Providers" from Sec. 2408.5 to 2409.

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.05 Accelerated payments.—See ¶ 7390 *et seq.*

.07 Accounting and legal expenses in overpayments litigation.—Where a civil suit charged a

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provider and some of its managing physicians with participating in a fraudulent scheme to obtain Medicare reimbursement for nonallowable costs, and a settlement was entered into with respect to that suit, the court held that, as a matter of law, legal and accounting expenses incurred in an unsuccessful defense of an action for Medicare fraud are not reasonable costs related to patient care.

Good Luck Nursing Home, Inc., d/b/a Magnolia Gardens Nursing Home v. Harris, CA-DC, 636 F2d 572 (1980), vac'g and rem'g USDC (DC), Civ. No. 78-863, June 22, 1979. [These decisions were originally reported at NEW DEVELOPMENTS ¶ 30,635 and 29,746, respectively.]

.10 Bankrupt providers, recovery from.—See ¶ 7250D and 7850B.

.15 Classification of overpayments.—*Individual Overpayments.*—Overpayments in individual cases may arise in a variety of ways, but generally stem from an incorrect payment made to a provider on behalf of a beneficiary for a particular stay. Some examples of individual overpayments are: (1) payment for provider services after benefits have been exhausted or where the individual is not otherwise entitled to benefits; (2) inaccurate application of the deductible or coinsurance; (3) payment for noncovered items and services, including medically unnecessary services and custodial care where payment cannot be made under the waiver of liability provisions in section 1879.

Instructions for handling individual overpayments may be found in Part 3 of the *Medicare Intermediary Manual*, §§ 3707ff [see ¶ 11,245 in "MEDICARE: REQUIREMENTS FOR PAYMENT WAIVER OF LIABILITY" Division in Volume 2].

Medicare Intermediary Manual, HIM-13 (Part 2), § 2220.1.

Aggregate Overpayments.—Aggregate overpayments to providers (overpayments arising in other than individual cases) may occur by:

A. a pattern of furnishing and billing for excessive or noncovered services [see ¶ 7352];

B. other causes (§ 2230):

—inclusion of nonallowable or excessive costs in the provider's cost report;

—excessive interim payments made to the provider; or

—failure to repay accelerated payments.

- Failure to file cost reports. (§ 7351.)
- Determination of amounts due during desk review, final settlement and reopening of the cost report.

Medicare Intermediary Manual, HIM-13 (Part 2), § 2220.2.

.17 Current financing payments.—See ¶ 7354.

.19 Determination of amount of overpayment.—You are responsible for determining the amount of provider overpayments. The methods for computing these amounts are:

A. *Cost Report Filed and Settled.*—The overpayment is the difference between the provider's claimed reimbursable costs on the filed cost report and the cost report settled by you. The differences may be due to (this list is *not* all-inclusive):

- The claimed program costs are higher than the program costs you determined;
- The difference between claimed program utilization and actual covered utilization;
- Inclusion of nonallowable or excessive costs in the cost report;
- Adjustments to claimed pass-through amounts, DRG payments, outlier amounts, interim payments; or
- Correction of errors in the cost report.

B. *Cost Report Filed But Not Settled.*—The amount of the overpayment is the sum of:

- The amount you determined to be due from the provider for the period for which the cost report was filed (less any amounts recovered);
- Errors in the cost report;
- Amounts you determined to have been overpaid as a result of a review of claims because that provider had a pattern of furnishing excessive or noncovered services; and/or
- Adjustments to the provider's claimed pass-through amounts, DRG payments, outlier amounts and interim payments.

C. *Cost Report Overdue.*—Where a cost report has not been filed timely, the overpayment is the sum of:

- All interim payments made for beneficiary services rendered during the accounting period for which the cost report has not been filed;
- All interim payments made for beneficiary services rendered subsequent to such accounting period; and
- Any outstanding accelerated payments on account, lump-sum interim payments, and any other interim payments.

D. *Interim Rate Adjustments.*—The overpayment is the difference between the amounts that were previously paid and the amounts that should have been paid under the most recent interim rate determination. Overpayments to providers (overpayments arising in other than individual cases) may occur because of (this list is *not* all-inclusive):

- Decrease in the case mix index use in computing the interim rate;
- Fluctuations in utilization, pass-through costs, number of available beds, number of interns and residents;
- Change in services provided which was not timely reported to you;
- Lack of timely billing by a PIP provider; or
- Excessive denial rates experienced by the provider.

Senate Permanent Subcommittee
On Investigations

EXHIBIT # 16

medicare
Intermediary Manual
Part 2 – Audits, Reimbursement Program Administration

Department of Health and Human Services

Health Care Financing Administration

Transmittal No. 378 Date JULY 1990

REVISED MATERIAL	REVISED PAGES	REPLACED PAGES
Table of Contents		
Chapter III	2-201 - 2-202 (2pp.)	2-201 - 2-202 (2pp.)
Sec. 2220 - 2235.6	2-217 - 2-229 (65pp.)	2-217 - 2-229 (60pp.)

NEW PROCEDURE—EFFECTIVE DATE: 07/20/90

Sections 2220.1, Individual Overpayments, Section 2220.2, Aggregate Overpayments and Section 2221, Determination of Amount of Overpayment.—Revised to identify overpayment situations associated with PPS providers.

Section 2222 and Exhibits 1, 2, 3 and 4, Overpayment Demand Letters.—Revised to strengthen the overpayment recovery procedures. The major revisions are:

- Give providers 15 days (instead of 30 days) notification that a suspension of payments under 42 CFR §405.370ff. will be put into effect.
- Where the cost report is overdue, suspend interim payments on the first day after the due date of the cost report.
- Send only the first overpayment demand letter by certified mail.

Sections 2224.1 and 2224.2, Repayment Extended Longer Than 12 Months and Monitoring an Approved Extended Repayment Schedule.—Requests for extended repayment of 12 months or more must be accompanied by at least two letters from separate financial institutions denying the provider's loan request for the amount of the overpayment. Also, an extended repayment schedule protocol must be completed for all extended repayment requests.

Sections 2225 and 2225.2, Procedure for Suspension of Interim Payments.—Redesignates regulation citations.

Section 2227, Referral of Potentially Uncollectible Provider Overpayments.—Shows that overpayment cases are referred to the Department of Justice instead of GAO.

Section 2228 through 2228.2, Referral to the Department of Justice .—Uncollected overpayment cases are prepared in quadruplicate for referral to the DJ. Also, each case must contain a Claims Collection Litigation Report.

2220. OVERPAYMENT FOR PROVIDER SERVICES--GENERAL

Overpayments are Medicare funds a provider has received in excess of amounts due and payable under the statute and regulations. Once a determination of overpayment has been made, the amount is a debt owed by the provider to the United States Government.

Under the Federal Claims Collection Act of 1966, as amended, each agency of the Federal Government (pursuant to regulations jointly promulgated by the Attorney General and the Comptroller General of the U.S.) must attempt collection of claims of the Federal Government for money arising out of the activities of the agency. While you will not be liable for overpayments you make to providers in the absence of fraud or gross negligence on your part, as agents of HCFA, you must attempt recovery of provider overpayments in accordance with HCFA regulations.

The Federal Claims Collection Act clearly requires timely and aggressive efforts to recover overpayments, including efforts to locate the debtor where necessary, demands for repayment, and establishment of repayment schedules, suspension of interim payment, and recoupment or setoff, where appropriate.

2220.1 Individual Overpayments.--Overpayments may arise in a variety of ways, but generally stem from an incorrect payment to a provider on behalf of a beneficiary for a particular stay. Some examples are:

- Payment for provider services after benefits have been exhausted or where the individual is not otherwise entitled to benefits;
- Inaccurate application of the deductible or coinsurance;
- Payment for noncovered items and services, including medically unnecessary services and custodial care where payment cannot be made under the waiver of liability provisions in §1879; and/or
- Erroneous information on bills causing incorrect DRG codes.

For handling individual overpayments see Part 3, §§3707ff.

2220.2 Aggregate Overpayments.--Aggregate overpayments to providers (overpayments arising in other than individual cases) may occur by:

- A pattern of furnishing and billing for excessive or noncovered services (See §2229.);
- Other causes (See §2230.):

  --inclusion of nonallowable or excessive costs in the provider's cost report;

—excessive interim payments made to the provider; or

—failure to repay accelerated payments.

o Failure to file cost reports. (§ 2231.)

o Determination of amounts due during desk review, final settlement and reopening of the cost report.

2220.3 Unsolicited Overpayment Refunds.—Actual costs of services cannot be determined until the end of the accounting period because providers are paid on an estimated cost basis during the year. However, when a provider believes that an overpayment has been received and makes an unsolicited overpayment refund, accept it regardless of the amount. A retroactive adjustment based on actual costs will be made at the end of the reporting period.

2221. DETERMINATION OF AMOUNT OF OVERPAYMENT

You are responsible for determining the amount of provider overpayments. The methods for computing these amounts are:

A. Cost Report Filed and Settled.--The overpayment is the difference between the provider's claimed reimbursable costs on the filed cost report and the cost report settled by you. The differences may be due to (this list is not all-inclusive):

o The claimed program costs are higher than the program costs you determined:

o The difference between claimed program utilization and actual covered utilization;

o Inclusion of nonallowable or excessive costs in the cost report;

o Adjustments to claimed pass-through amounts, DRG payments, outlier amounts, interim payments; or

o Correction of errors in the cost report.

B. Cost Report Filed But Not Settled.--The amount of the overpayment is the sum of:

o The amount you determined to be due from the provider for the period for which the cost report was filed (less any amounts recovered);

o Errors in the cost report;

o Amounts you determined to have been overpaid as a result of a review of claims because that provider had a pattern of furnishing excessive or noncovered services; and/or

Senate Permanent Subcommittee
On Investigations

EXHIBIT # 17

EXCERPT
FROM
DEPOSITION OF CHARLES R. BOOTH
MARCH 6, 2000
BEFORE THE
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

PAGE 116:

15 **MR. SMOLONSKY*:** A point of clarification, Mr.

16 Booth. Have you testified or are you in agreement with the

17 statement that every other provider goes through the

18 administrative process?

19 **THE WITNESS:** Most every other provider goes

20 through the administrative process.

* Mr. Smolonsky was present at the deposition representing the Department of Health and Human Service, Office of Legislation and the Office of General Counsel.

Senate Permanent Subcommittee
On Investigations
EXHIBIT # 18

5 C.F.R. 2635.502 - Standards of Ethical Conduct for Employees of the Executive Branch

§ 2635.502 Personal and business relationships

(a) Consideration of appearances by the employee. Where an employee knows that a particular matter involving specific parties is likely to have a direct and predictable effect on the financial interest of a member of his household, or knows that a person with whom he has a covered relationship is or represents a party to such matter, and where the employee determines that the circumstances would cause a reasonable person with knowledge of the relevant facts to question his impartiality in the matter, the employee should not participate in the matter unless he has informed the agency designee of the appearance problem and received authorization from the agency designee in accordance . . .

Senate Permanent Subcommittee
On Investigations

EXHIBIT # 19

MORVILLO, ABRAMOWITZ, GRAND, IASON & SILBERBERG, P.C.

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**ADMITTED ONLY IN COLORADO, MARYLAND AND D.C.
***ADMITTED ONLY IN MICHIGAN AND FLORIDA

March 27, 2000

BY HAND

The Honorable Susan M. Collins
Chairman
The Honorable Carl Levin
Ranking Minority Member
Permanent Subcommittee on Investigations
Committee on Governmental Affairs
United States Senate
Washington, D.C. 20510-6250

Re: Bruce Vladeck

Dear Ms. Collins and Mr. Levin:

I represent Bruce Vladeck and am writing to address a concern that has been raised regarding Mr. Vladeck's failure to be interviewed by GAO investigators. Mr. Vladeck wished to speak with the investigators, and I told counsel for the majority of this Subcommittee almost six months ago that Mr. Vladeck was willing to meet with the GAO. Before that time, I was concerned about what I believed to be an ongoing grand jury investigation in the Southern District of New York into some of the same issues that were being looked into by Mr. William Hamel and the GAO. As an attorney, I was concerned about the overlapping nature of the investigations, and advised Mr. Vladeck to defer speaking with GAO investigators until I could determine the status of the dual investigations. In October, 1999, after I had satisfied myself with regard to the status of the grand jury matter, I notified majority counsel that Mr. Vladeck was available for an interview. I was told, however, that "the train had left the station," and the GAO already was preparing a Report. No one from GAO ever contacted us thereafter.

Background

In January of 1998, the Southern District of New York began an investigation of one of the settlements that is now being reviewed by this subcommittee, HCFA's 1995 settlement with Visiting Nurse Service of New York ("VNS"). Mr. Hamel, an agent for the Inspector General, was the primary investigator for the Southern District of New York. In that regard, he worked closely with Assistant United States Attorney Andrea Labov, served grand jury subpoenas, reviewed subpoenaed documents, and prepared several witnesses for their grand jury appearances. He and the government lawyer were my primary contacts in that investigation.

As part of this grand jury investigation, in May 1998, I met with both AUSA Andrea Labov and Mr. Hamel for the purpose of giving them extensive information about VNS's settlement with HCFA. Prior to this meeting, AUSA Labov had given me a list of specific questions to address, and in response, I gave Ms. Labov and Mr. Hamel detailed information about the VNS settlement, Mr. Vladeck's role in that settlement, and Mr. Vladeck's familiarity with VNS. The facts I conveyed to Ms. Labov and Mr. Hamel at this meeting were the same facts that Mr. Vladeck testified to at his March 9, 2000 voluntary deposition before the Subcommittee staff. GAO's apparent failure to inform this Subcommittee about my voluntary provision of this detailed information to Mr. Hamel or to refer to it in their report is, at best, disingenuous.

At that meeting with Ms. Labov and Mr. Hamel, I also raised with Ms. Labov my concern that Mr. Hamel was mischaracterizing witnesses' testimony to AUSA Labov, misrepresenting facts to witnesses he was interviewing, and improperly suggesting to witnesses that it was inappropriate for them to speak to me and other private attorneys.

At the end of this meeting, AUSA Labov told me that she would get back to me if she needed additional information. I heard nothing from either AUSA Labov or Mr. Hamel, however, until the summer of 1999. At that time, Mr. Hamel called me, informed me that he was no longer working with the Southern District of New York, and requested to interview Mr. Vladeck on behalf of the GAO.

Immediately concerned about the possibility of parallel investigations, I asked Mr. Hamel about the status of the grand jury investigation that he had been conducting. Despite the fact that the GAO was investigating the VNS settlement, along with other HCFA settlements, Mr. Hamel tried to assure me that the GAO investigation was different than the grand jury investigation. He also refused to comment on whether the grand jury investigation had concluded. During this conversation, I raised with Mr. Hamel that I believed his participation in the GAO's investigation was a violation of Rule

6(e) of the Federal Rules of Criminal Procedure, which prohibits the disclosure of matters occurring before the grand jury. That rule generally has been interpreted as prohibiting individuals who have worked on grand jury matters from disclosing information obtained to any individual or entity not involved in the criminal investigation, including members of Congress. See United States v. Sells Engineering, Inc., 463 U.S. 418, 103 S.Ct. 3133 (1983) ("disclosure is limited to use by those attorneys who conduct the criminal matters to which the materials pertain"); In re Grand Jury Investigation of Uranium Industry, 1979 WL 1661, at *3 (D.D.C. Aug. 21, 1979) (Rule 6(e) applies to disclosures to Congress).

After my conversation with Mr. Hamel, I made several inquiries to attorneys in the Southern District of New York to see whether the grand jury investigation was continuing. Because AUSA Labov was on maternity leave at this time, it was not until September or October, 1999 that I finally was informed, in substance, that the grand jury investigation, as it related to matters relevant to Mr. Vladeck and to this subcommittee's inquiry, was concluded.

It was at this point that I became increasingly concerned about Mr. Hamel's participation in the GAO investigation. First, it appeared to me that Mr. Hamel was personally vested in this matter and was not being completely candid with me or others.

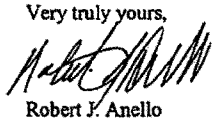
Second, Mr. Hamel, who was intimately familiar with the grand jury investigation, was now leading the GAO investigation on behalf of the Subcommittee. Rule 6(e) and cases interpreting it make clear that investigators, like Mr. Hamel, who are aware of the identities of grand jury witnesses, the substance of their testimony, as well as the strategy and direction of the grand jury investigation, cannot disclose such information, even to Congress, without violating longstanding principles of grand jury secrecy. See In re sealed Case No. 99-3091, 192 F.3d 995, 1001 (D.C. Cir. 1999) (quoting In re Motion of Dow Jones and Co., 142 F.3d 496. 500 (D.C. Cir.), cert. denied, 119 S.Ct. 60 (1998)) (the phrase "matters occurring before the grand jury" "encompasses not only what has occurred and what is occurring, but also what is likely to occur, including the identities of witnesses or jurors, the substance of testimony as well as actual transcripts, the strategy or direction of the investigation, the deliberation, or questions of jurors and the like."); In re Grand Jury Matter, 697 F.2d 511, 512-13 (3d. Cir. 1982) (grand jury materials include not just the transcript, of the grand jury proceeding, but also interviews with witnesses conducted outside the presence of the grand jury and, analyses of evidence prepare to assist the grand jury).

Despite my concerns, last October I called counsel for the majority of this Subcommittee, Mr. Blalack, shortly after I learned that the Southern District of New

York's investigation had concluded, and told him that Mr. Vladeck was willing to be interviewed informally by the GAO investigators. Mr. Blalack informed me, however, that the proverbial "train had left the station," and the GAO was already preparing a Report. As you know, prior to the Report's release, however, Mr. Vladeck did voluntarily appear for a deposition on March 9, 2000 by counsel for the Subcommittee. In light of this history, it is disturbing and wholly unfair to now hear that Mr. Vladeck has been labeled by some as a reluctant witness; and that the GAO report, which had "left the station" six months ago, was made available to Mr. Vladeck and me only one day before the Subcommittee's hearing– despite repeated requests – and despite the fact that the information in the report was leaked to a New York Times reporter last week.

Thus, the Subcommittee should resist Mr. Hamel's efforts to portray Mr. Vladeck as an uncooperative witness, and can draw no negative inference from Mr. Vladeck accepting his lawyer's advice and deferring the interview with GAO. Mr. Vladeck always has wanted to be helpful, and to relate fully his understanding of the settlements which the Subcommittee is now reviewing. For that reason he voluntarily testified at a deposition before the Subcommittee and will be testifying voluntarily tomorrow.

Very truly yours,



Robert J. Anello

cc: Carl Levin (By Fax 202-224-1972
Ranking Minority Member
Permanent Subcommittee on Investigations

K. Lee Blalack, II (By Fax – 202-224-7042)
Chief Counsel and Staff Director
Permanent Subcommittee on Investigations

Linda Gustitus (By Fax – 202-224-1972)
Minority Staff Director and Chief Counsel
Permanent Subcommittee on Investigations

PROG-MEM, MED-GUIDE 1997 ? MED-GUIDE-TB ¶45,506,
Services., Program Memorand Intermediaries/Carriers), HCFA Pub. 60 /
01, 1997)

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Senate Permanent Subcommittee
On Investigations

EXHIBIT # 20

Calculation of Average Cost Per Visit for Home Health Services.

Program Memorandum (Intermediaries/Carriers), HCFA Pub. 60 A/B, Transmittal No. AB-97-11 August 1, 1997

Medicare: Cost Reports

Part A coverage--Home health services--Visits.--The *Program Memorandum* clarifies that all Medicare eligibility and coverage criteria must be met in determining whether to include non-Medicare home health visits, referred to as "like-kind" visits, and associated costs in the calculation of the average cost per visit for home health services. The *PM*, which provides general eligibility and coverage requirements, specifically states that in counting "like-kind" visits must be of the same type as those that would be covered by Medicare. "Like-kind" visits are recorded in a reimbursable cost center on the Medicare cost report. Costs for not "like-kind" visits, when eligibility and criteria are applied, should be properly classified in a nonreimbursable cost center. These policies are effective for all costs reports that have not been issued a final notice of program reimbursement as of August 1, 1997. all pending

See ¶1498, ¶5908.
[Text of Memorandum]

SUBJECT: Counting of Non-Medicare Home Health Visits and the Reporting of the Associated Costs in Determining the Average Cost Per Visit for Home Health Services

This program memorandum (PM) provides clarification regarding the inclusion of non-Medicare home health visits and associated costs in the calculation of the average cost per visit. This is commonly referred to by the home health industry as the inclusion of "like-kind" visits and associated costs in the calculation of the average cost per visit.

In preparing the Medicare cost report, providers must recognize only the costs associated with the "like-kind" visits as set forth in this PM in a reimbursable cost center. In determining whether non-Medicare home health visits and associated costs are included in the calculation of the average cost per visit, all Medicare eligibility criteria and coverage criteria must be met. The following are general eligibility and coverage requirements and are not intended to be an all-inclusive description of the Medicare requirements.

ELIGIBILITY

For coverage of home health services, a beneficiary must meet each of the following requirements: (1) confined to the home, (2) under the care of a physician, (3) in need of intermittent skilled nursing services, physical therapy or speech therapy, or have a continuing need for occupational therapy, (4) under a plan of care, and (5) the home health services must be furnished by, or under arrangements made by, a participating home health agency (HHA). To qualifying individuals, HHAs may provide needed skilled nursing services on a part-time or intermittent basis as well as part time or intermittent home aide services, physical or occupational therapy or speech-language pathology, medical social services, durable medical equipment, medical supplies, and intern and resident services as described in 42 CFR 409.45(b) through (g).

COVERAGE

In counting "like-kind" visits, it is critical that the non-Medicare visits are of the same type as those that would be covered by Medicare. This ensures that the costs of services are comparable across insurers and Medicare is paying for its fair share for comparable home health services. Furthermore, the regulation in 42 CFR 413.53(a)(3) requires HHAs to use the cost per visit by type of service method of apportioning cost between Medicare and non-Medicare patients. This regulation states, in part,

> "Under this method the total allowable cost of all visits for each type of service is divided by the total number of visits for that type of service. Next, for each type of service, the number of Medicare-covered visits is multiplied by the average cost per visit just computed."

The types of services referenced in this regulation are the home health disciplines recognized under the Medicare statute and regulations. They are skilled nursing care, physical therapy, speech language pathology, occupational therapy, medical social services, and home health aides. The requirements that must be met for Medicare payment to be made for these services furnished to eligible beneficiaries are set forth in 42 CFR 409.41 through 409.50.

Further, to be covered by Medicare, home health aide services must meet the standards set forth in the Home Health Agency Manual, §206.2, subsections a and e. Home health aide services are hands-on personal care or services which are needed to maintain a beneficiary health or to facilitate treatment in conjunction with skilled services. The types of services may include changing dressings for simple wounds, assistance with medications, assistance with some therapy activities, and routine care of prosthetic and orthotic devises. Incidental to a visit that is for the provision of care covered by Medicare, home health aide services may include tasks not covered, such as, preparing a light meal, changing bed linens, or personal laundry.

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Relative to a non-Medicare visit being considered "like-kind", the part-time or intermittent service coverage criteria must be applied to skilled nursing and home health aide services combined as identified on the patient plan of care. Part-time is up to 8 hours per day, up to 28 hours per week (or up to 35 hours per week based on documented need) and may be daily. Intermittent is less than daily, 6 or fewer days per week, up to 28 hours per week (or up to 35 hours per week based on documented need), or up to 8 hours per day for 7 days per week for a temporary period of up to 21 days (with extensions in exceptional circumstances for a definite period of time). A "visit" is an episode of personal contact with the beneficiary by staff of the HHA or others under arrangements with the HHA for the purpose of providing a covered service. Medicare does not cover full-time home health aide services, custodial care, personal care aide, homemaker, or home attendant services.

HCFA recognizes that it is common for HHAs to provide visits that are not "like-kind" visits, sometimes on a broad scale. Under some State Medicaid programs, there is often coverage available for patients who require mainly supervisory or homemaker services which are characteristically longer stays than would be covered by Medicare. The intent and purpose for such visits go beyond the hands-on, personal care duties previously described. Reasons for this include "family working," "unsafe to be home alone," and "respite for care givers." Some patients require nonintermittent care or supervision where the disease process leads to immobility or bed bound status needing continuous attendance or monitoring. These visits would probably not be considered "like-kind" visits and, as such, they would not be recorded in a reimbursable cost center on the Medicare cost report.

The responsibility to identify the "like-kind" visits and properly record the costs on the Medicare cost report rests with the provider. For the single eligible Medicare beneficiary, the guidelines are relatively straightforward. For the dually eligible Medicare beneficiary receiving home health services, the Medicare visit is concluded after the provision of the last Medicare covered home health task identified on the plan of care for the patient. Other services not covered by Medicare which are provided after that point are to be recorded in a nonreimbursable cost center on the cost report. Any visit and associated costs which would not be covered under Medicare, regardless of the insurer, cannot be included in the calculation of the average cost per visit.

A visit is either covered by Medicare or not, based on the existing rules and regulations governing such visits. Costs for those visits billed to other insurers that are not "like-kind" visits, when eligibility and coverage criteria are applied, should be properly classified in a non-reimbursable cost center for purposes of reporting costs on the cost report. This would also apply to the split bill for services received by a beneficiary which are not billed to or covered. Where the beneficiary may have dual insurance eligibility and Medicare is the primary insurer, the services that are not covered by and not billed to Medicare must be shown in a nonreimbursable cost center for purposes of reporting visits and associated costs on the cost report.

EFFECTIVE DATE

This PM does not include any new policies regarding home health services payable under Medicare. However, to the extent that a less stringent policy in the counting of non-Medicare home health visits and the reporting of the associated costs has been conveyed to the HHA, the enforcement of the policies set forth in this PM will be effective with cost reporting periods beginning on or after August 1, 1997. For all other HHAs, this PM will be effective for all cost reports that have not been issued a final notice of program reimbursement as of August 1, 1997. For administrative simplicity, no cost reports will be reopened for the specific purpose of applying this PM.

Contact person for this Program Memorandum is Ed Rees on (410) 786-8974.

This Program Memorandum may be discarded August 31, 1998.

Senate Permanent Subcommittee
On Investigations
EXHIBIT # 21a.

VisitingNurseService OF NEW YORK

1893-1993 A LEADER IN QUALITY HOME HEALTH CARE FOR 100 YEARS

Samuel Heller
VICE PRESIDENT FOR FINANCE

MAY - 1

April 28, 1995

Charles R. Booth
Director Office of Hospital Policy
Healthcare Finance Administration
6325 Security Blvd.
Baltimore, Maryland 21207

Dear Mr. Booth:

I am quite pleased to attach a fully executed copy of the settlement agreement between the Visiting Nurse Service of New York and the Department of Health and Human Services, Health Care Financing & Administration. We have retained one original signed copy for our files.

I look forward to working with you in the future.

Sincerely,

Samuel Heller

cc: Carol Raphael (w/o copy)
Charles Blum (w/o copy)
Marva King, Blue Cross Wisconsin

3 PENN PLAZA ~ NEW YORK, NY 10001-1816 ~ (212) 330-7000

SETTLEMENT AGREEMENT

This settlement Agreement ("Agreement) is entered into on April 19 1995 between the Department of Health and Human Services Health Care Financing Administration ("HCFA") and the Visiting Nurse Service of New York Home Care ("VNS") and its affiliates and subsidiaries.

WHEREAS, Blue Cross & Blue Shield United of Wisconsin ("Blue Cross") acts as an agent for HCFA in administering Part A of the Medicare Program;

WHEREAS, Blue Cross, in their role as an agent for HCFA, has undertaken a review of VNS Medicare cost reports filed for fiscal years ended 12/31/88, 12/31/89, 12/31/90, 12/31/91 and 12/31/92 and Medicare data submitted for fiscal year ended 12/31/93 and has determined that VNS has been overpaid by the Medicare Program for these years due to inclusion in its calculation of Medicare cost the cost of certain home health aide visits reimbursed by other programs that are unlike those reimbursed by Medicare;

WHEREAS, VNS upon its review of the cost reports filed for fiscal years ended 12/31/88, 12/31/89, 12/31/90, 12/31/91, 12/31/92 and 12/31/93 has determined that the inclusion in its cost report of the home health aide visits questioned by Blue Cross were completely appropriate and consistent with existing HCFA rules, policies and cost reporting instructions; and

WHEREAS, the parties desire to resolve the matter concerning the inclusion of home health aide non-Medicare visits,

NOW THEREFORE, the parties agree as follows:

1. Blue Cross will utilize a 5.5 hour average non-Medicare visit length for home health aides for adjusting VNS cost reports for fiscal years ended 12/31/88, 12/31/89, 12/31/90, 12/31/91, 12/31/92 and 12/31/93. The amounts due for these six years regarding this issue are stated on the attached schedule. These amounts represent full and final settlement of this issue for these six years.

2. VNS will repay the Medicare Program the amounts set forth in Schedule A to this Agreement, in accordance with the schedule for repayment set forth therein.

3. VNS agrees not to appeal or in any way contest the use of the 5.5 average non-Medicare hours for home health aides as described in paragraph 1 above.

4. In any future cost report years, and, until such time as HCFA promulgates a rule, through notice and comment rulemaking, setting forth a policy regarding inclusion of home health aide hours, Blue Cross will utilize the lesser of VNS's actual average non-Medicare home health aide visit length or VNS's actual Medicare home health aide visit length plus 1.63 hour per visit as the average non-Medicare home health aide visit length in settlement of VNS's Medicare cost reports; provided, however, that the methodology described in this paragraph shall not apply to any future cost report years remaining unsettled at such time where another provider (or providers) appeals the claim made against it by Blue Cross and/or HCFA that it has been overpaid in the same manner as it was alleged that VNS was, and the claim is rejected in favor of the provider(s), or a ruling is made in favor of the provider(s) by the Health Care Finance Administration (HCFA) or a court of final jurisdiction.

5. The parties agree that this Agreement involves a resolution of a disputed issue. The parties agree that nothing in this Agreement shall be construed as an admission of liability or wrongdoing on the part of VNS, but has instead been entered into solely to avoid the expense and uncertainty of further controversy.

6. The parties agree that they have not, and shall not, to the extent permissible under statute and regulation, disclose the terms and conditions of this Agreement to any third party, and to the extent possible shall not disclose any fact concerning its negotiation, nor any of the facts or conditions surrounding or leading to its execution.

IN WITNESS WHEREOF, each party through a duly authorized representative has executed this Settlement Agreement as of the date first set forth above.

By VNS New York:

Carol Raphael
Signature

Carol Raphael
Name

4/19/95
Date

President + Chief Executive Officer
Title

By Department of Health and Human Services
Health Care Financing Administration

Charles R. Beatty
Signature

Charles R. Beatty
Name

4/7/95
Date

Director, Hospital Policy
Title

SCHEDULE II

VNS HOMECARE PAYMENT PLAN

See attached schedule and notes for detail of amounts.

PAYMENT DATE	AMOUNT DUE	EXPLANATION
04/24/94	$22,585,981 (371,800) (260,937) (286,508) $21,666,736	Final settlements for FY 1988 thru 1991 offset by FY 1993 lump sum adjustment dated 02/28/94 and reopenings for FY 1990 and FY 1991.
07/30/94	$19,711,062 (4,015,365) (227,952) $15,467,745	Tentative settlement for FY 1992 offset by amounts already collected and interest charged based on amended report which was not used.
09/30/94	$24,196,918 (1,906,000) $22,290,918 /3= $ 7,430,306	Lump sum adjustment for FY 1993 issued prior to 04/30/94 with net amount payable in 3 equal installments and non interest bearing. Represents HH aide issue amount offset by PIP adjustment.
10/30/94	$ 7,430,306	Second of 3 installments.
11/30/94	$ 7,430,306	Third of 3 installments.
TOTAL	$59,425,399	

Notes:

1) We plan to finalize cost reports for both FY 1992 and 1993 in FY 1995.

2) Current settlement data for FY 1992 would indicate an amount due the program of $859,535, however, historically 1% of the providers' claims are submitted later than one year after the fiscal year end. Thus, we anticipate this amount will disappear by the time we reach final settlement of FY 1992's cost report.

3) Per HCFA Central Office, overpayments determined in relation to the HH aide issue will not bear penalty interest for late filing of cost reports for the years involved. Interest will accrue, however, at the appropriate rate, if amounts are not paid within agreed upon time frames.

4) A lump sum adjustment of FY 1994 interim rates will not be made until the provider's first quarter data is reviewed. Our review will include an adjustment for the HH aide issue. If the review results in an overpayment, it will be handled in the standard manner. If an underpayment, it will be offset against amounts due on 07/30/94. Interim rates will remain at the lower rate which began on 3/25/94 until first quarter data is reviewed.

5) The provider's FY 1993 cost report will be reviewed for adjustments other than the HH aide issue. Any resulting underpayments will be offset against the amounts due on 07/30/94. If the review results in an overpayment, it will be handled in the standard manner as a tentative settlement.

NOTES TO VNS HOMECARE:

(1) Gross amount of the home health aide adjustment for FY 1988 through 1993 is as follows:

(23,056,065)	FY 1988-1991
(19,711,062)	FY 1992
(24,196,918)	FY 1993
(66,964,045)	

Our calculations yield a figure slightly below the figure settled upon in our negotiations.

(2) Amounts due for FY 1988-1991 have been corrected for an error in the initial split of adjustments for the home health aide issue and all other adjustments. We will issue a revised demand letter with the same due date.

(3) PIP Underpayments for 1993 and 1994

-1992 PS&R data as of 12/31/93 results in an overpayment of $859,535.

-1993 figures reflect an interim rate adjustment of $371,800 made on 2/28/94 which we used as an offset against amounts due for FY 1988-1991 in our demand letter dated 3/25/94. We typically reduce payments by an estimated audit effect. We've shown an additional amount due the provider of $1,906,000 from changing that reduction for audit findings from 3% to approximately 1.5% based on the latest finalized cost report excluding the home health aide issue.

-1994's interim payment is based on 1993 data, which is the most current data we have at this time. Applying the impact of the home health aide adjustment at this point results in the overpayment shown of $2,444,000. When we receive data for the first quarter, we will adjust the interim rate again.

(4) $228,000 in Interest Payments

-Per instructions from HCFA Central Office, we are refunding the interest charged.

(5) 1990/1991 Audit Adjustments

-reopenings on the issues outstanding result in the positive adjustments shown. Supporting workpapers have been given to VNS.

(6) The collection made on the revised cost report for FY 1992 which was not ultimately recognized has been offset against the amount currently due.

4/5/94

VNS HOMECARE

FINAL SETTLEMENTS/REOPENINGS:	FY 1988	FY 1989	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994	TOTAL
TOTAL OVERPAYMENT								
(A) PER 2/28/94 MPR (B+C+D)	(2,181,993)	(4,430,010)	(10,288,805)	(16,978,654)				(33,879,462)
(B) HH AIDE ISSUE	(2,354,644)	(4,838,882)	(10,963,571)	(16,992,449)				(34,349,546)
(C) SETTLEMENT DATA	172,651	408,872	839,923	892,372				2,313,818
(D) OTHER ISSUES			(565,157)	(1,278,577)				(1,843,734)
(E) HH AIDE SETTLEMENT	(1,333,501)	(3,008,606)	(7,435,742)	(11,278,216)				(1) (23,056,065)
REVISED AMOUNT DUE (A-B+E)	(1,160,850)	(2,599,734)	(7,160,976)	(11,664,421)	0	0		(2) (22,585,981) ✓
REOPENINGS			(5) 260,937	(5) 286,508				547,445 ✓

TENTATIVE SETTLEMENTS:	FY 1988	FY 1989	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994	TOTAL
AS FILED					(1,126,569) ✓			(1,126,569)
HH AIDE ISSUE					(1) (19,711,062)			(19,711,062)
SETTLEMENT DATA					(3) (859,535)			(859,535)
TOTAL	0	0	0	0	(21,697,166)	0	0	(21,697,166)
ALREADY COLLECTED					(1,126,569) ✓			(1,126,569)
					(6) (4,015,365)			(4,015,365)
NET	0	0	0	0	(16,555,232)	0	0	(16,555,232) ✓

INTERIM RATE ADJUSTMENTS:	FY 1988	FY 1989	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994	TOTAL
HH AIDE ISSUE					(1) (24,196,918)			(24,196,918)
PIP QUARTERLY					(3) 371,800	(5) (2,444,000)		(2,072,200)
					(3) 1,906,000			1,906,000
NET	0	0	0	0	0	(21,919,118)	(2,444,000)	(24,363,118) ✓
INTEREST REFUND					(4) 227,952			227,952 ✓
TOTAL AMOUNT DUE	(1,160,850)	(2,599,734)	(6,900,039)	(11,377,913)	(16,327,280)	(21,919,118)	(2,444,000)	(62,728,934)

00401

Senate Permanent Subcommittee
On Investigations
EXHIBIT # 21b.

SETTLEMENT AGREEMENT BETWEEN NYCHHC AND HCFA

This Agreement is made as of September 20, 1996 at New York, New York, and Baltimore, MD. respectively, by and between the New York City Health and Hospitals Corporation (NYCHHC), which provides services to Medicare beneficiaries pursuant to the provisions of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq., and the Health Care Financing Administration (HCFA), the agency within the Department of Health and Human Services which administers the Medicare program.

WHEREAS, NYCHHC has appealed to the Provider Reimbursement Review Board (PRRB) for review of the amount of Medicare reimbursement determined by the HCFA to be payable to NYCHHC for services furnished by NYCHHC providers to Medicare beneficiaries for fiscal years ending June 30, 1983, through June 30, 1992; and

WHEREAS, NYCHHC and HCFA presently desire to resolve this controversy (and reimbursement issues for subsequent fiscal years to the extent herein provided) in a fair and equitable manner that is acceptable to both parties;

NOW THEREFORE, in consideration of the mutual promises and covenants contained herein, NYCHHC and HCFA hereby agree as follows:

1. HCFA will pay to NYCHHC the amount of $82,422,777 for outpatient and $1,513,454 for inpatient in full satisfaction of all claims to Medicare reimbursement for fiscal years ending June 30, 1983, through June 30, 1993, for inpatient and outpatient bad debts which were incurred by NYCHHC during such periods and which were attributable to Part A and Part B Medicare deductible and coinsurance amounts uncollected from Medicare patients.

OPHELIA McCLARY
OCT - 2 1996
MEDICARE "A" REIMBURSEMENT

(a) Payment for outpatient bad debts, for each fiscal year, is the lesser of (i) the aggregate outpatient bad debts claimed by NYCHHC, and (ii) the sum of the amounts calculated by multiplying each provider's disproportionate share hospital (DSH) percentage as filed on NYCHHC's June 30, 1994 cost reports by the provider-specific coinsurance and deductible amount set forth in the latest available PS&R Reports for that fiscal year. The DSH percentages will be recalculated on final settlement and the outpatient bad debt settlement will be adjusted accordingly.

(b) For cost report periods beginning after June 30, 1993 for which a DSH percent is calculated and applied, the same methodology described in paragraph 1(a) shall be used to calculate NYCHHC's reimbursable outpatient bad debt, except that the DSH percent shall be the percent applicable to each such period and the amounts set forth in the PS&R Reports and amounts claimed shall be the amounts applicable to each period. For each such period, NYCHHC hereby waives its right to seek reimbursement for reimbursable outpatient bad debt under a different methodology than that specified herein.

2. (a) HCFA will pay to NYCHHC the amount of $6,772,138 in full satisfaction of all claims to Medicare reimbursement of fiscal years June 30, 1986 through June 30, 1993 for cost associated with provider-based physicians in NYCHHC hospitals electing the "Teaching Amendment" under 42 U.S.C. 1395x(b)(7).

(b) For each cost-reporting period beginning after June 30, 1993:

(i) A visit to day ratio of one to three will be utilized in calculating NYCHHC's provider-based physician reimbursement for hospitals electing the reimbursement provided for under the "Teaching Amendment."

aggregate - total amount

(ii) Where NYCHHC receives such reimbursement calculated pursuant to paragraph (i), NYCHHC hereby waives its right to file an administrative appeal seeking utilization of any other visit to day ratio unless applicable provisions of law and regulation are revised.

3. HCFA will pay to NYCHHC the amount of $7,959,317 in full satisfaction of all claims to Medicare direct medical education reimbursement for fiscal years June 30, 1990 through June 30, 1992. Should [illegible] 6/24/99 see p

Gnte - up to 6/24/99

As long as Medicare reimbursement for direct medical education is based upon base year per resident amounts, the base year per resident amounts utilized in this agreement shall be utilized and NYCHHC hereby waives its right to file appeals challenging such base year per resident amounts.

4. HCFA will pay to NYCHHC the amount of $18,332,314 in full satisfaction of all claims to Medicare reimbursement for fiscal years June 30, 1983 through June 30, 1992 for previously disallowed outpatient cost.

5. HCFA will pay to NYCHHC the amount of $13,000,000.00 in full satisfaction of all claims to Medicare reimbursement for relating to fiscal years June 30, 1983 through June 30, 1992 for all remaining issues before the PRRB with the following exceptions relating to fiscal year ending June 30, 1992 (as filed March 18, 1996):

- Working capital interest (Issue 27)
- Capital interest (Issue 24)
- Pension cost (Issue 18)

6. HCFA will not issue revised Notices of Program Reimbursement for fiscal years ending June 30, 1983, through June 30, 1992, and shall not recoup payments made, or to be made pursuant to this Agreement, for such period. NYCHHC will have no right of appeal, administrative or judicial, with respect to the amount of payment made by HCFA pursuant hereto, or any other matter covered by this Agreement, except as provided in Paragraph 8.

7. NYCHHC will withdraw all individual and group PRRB appeals with respect to all issues of Medicare reimbursement for fiscal years ending June 30, 1983, through June 30, 1992 with the exceptions specified in paragraph 5. NYCHHC will execute and transmit to the PRRB a letter withdrawing these issues for such fiscal years upon the execution of this Agreement. NYCHHC will not file a civil action to recover amounts in excess of the payment made pursuant to this agreement.

8. With respect to the $130,000,000 payment provided for in this Agreement, which shall be made within 45 days of its execution, and any other matters covered by this Agreement, NYCHHC may make a claim or bring an action only for the purpose of enforcing this Agreement.

9. Except as provided in Paragraph 8 of this Agreement, NYCHHC may cite and rely on this Agreement only in a court or administrative action initiated against NYCHHC or any of its providers in whole or in part to recoup any portion of the $130,000,000 payment made to NYCHHC pursuant to this Agreement, and NYCHHC will not otherwise refer to or rely upon this Agreement or the terms of this Agreement in any court or administrative action.

10. NYCHHC will not disclose the execution or terms of this Agreement, except to its third-party payors and their duly authorized agents and accounting firm(s) in connection with audit and/or certification of NYCHHC's financial records and reports, and to its counsel or as required by law.

11. This Agreement shall have no effect on the amount of Medicare reimbursement payable to NYCHHC for cost reporting periods ending prior to June 30, 1983, or subsequent to June 30, 1992, except as stated in Paragraphs 1(b) and 2(b). The matters covered by this Agreement may not be considered precedent by any person for any purpose whatsoever. Specific agreements documented in Paragraphs 1, 2 and 3 will be void in the event of a change in ownership or management change to any facility covered by this agreement.

12. The administrative resolution reflected herein is agreed to solely for the purpose of settling the matters at issue between the parties. The parties agree that no costs claimed by NYCHHC are deemed to be unallowable as a result of this Agreement. This Agreement does not constitute and shall not be construed as an admission by either NYCHHC or HCFA of any lack of merit in the respective positions taken by the parties before the PRRB or otherwise on the claims of NYCHHC for reimbursement.

13. The administrative resolution reflected herein does not prevent NYCHHC from receiving future benefit of national policy decisions such as those regarding Medicaid eligible days, Medicare "disproportionate share" payment, or PPS outlier payments.

Agreed and Accepted For:

NEW YORK HEALTH AND
HOSPITALS CORPORATION

Date: 9/24/96

By: Rick Langenfelder
Senior Vice-President

HEALTH CARE FINANCING
ADMINISTRATION

Date: 9/19/96

By: Charles R. Booth
Director, Hospital Policy

Senate Permanent Subcommittee
On Investigations
EXHIBIT # 21c.

SETTLEMENT AGREEMENT BETWEEN

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

AND

HEALTH CARE FINANCING ADMINISTRATION

This agreement is made as of March 21, 1997, at Los Angeles, California and Baltimore, Maryland respectively, by and between the Department of Health Services, County of Los Angeles (LA County), which, through hospitals it operates, provides services to Medicare beneficiaries pursuant to the provisions of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq., and the Health Care Financing Administration (HCFA), the agency within the Department of Health and Human Services which administers the Medicare program.

WHEREAS, LA County has appealed to the Provider Reimbursement Review Board (PRRB) for review of the amount of Medicare reimbursement determined by HCFA to be payable to LA County for services furnished by LA County hospitals to Medicare beneficiaries for fiscal years ending June 30, 1981, through June 30, 1993; and

WHEREAS, LA County has pending before its fiscal intermediary, Blue Cross of California (Blue Cross) requests for review of the amount of Medicare reimbursement determined by HCFA to be payable to LA County for services furnished by LA County hospitals to Medicare beneficiaries for fiscal years ending June 30, 1981, through June 30, 1993; and

WHEREAS, the issues referenced below may be found in Attachment D of the January 9, 1997, letter from Reginald S. Nakaoka to Chuck Booth; and

WHEREAS, LA County and HCFA presently desire to resolve these controversies (and reimbursement issues for subsequent fiscal years to the extent herein provided) in a fair and equitable manner that is acceptable to both parties;

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, LA County and HCFA agree as follows:

1. LA County will cease to appeal, either to Blue Cross or the PRRB, for fiscal years ending June 30, 1990 through June 30, 1993, for reimbursement for the issue labeled "ASC/OUTPATIENT RADIOLOGY/OTHER DIAGNOSTIC".

2. LA County will cease to appeal, either to Blue Cross or the PRRB, for fiscal years ending June 30, 1987 and June 30 1988, for reimbursement for the issues labeled "INTERNS AND RESIDENTS IME COUNT".

3. LA County will cease to appeal, either to Blue Cross or the PRRB, for fiscal years ending June 30, 1987 through June 30, 1993 for reimbursement for the issue labeled "BAD DEBTS". Further, LA County will make no claim for Medicare bad debts either to Blue Cross or the PRRB for any fiscal year from June 30, 1994 through June 30, 1997. Except for payment under this agreement, Blue Cross will make no payment for bad debts for periods prior to July 1, 1997.

4. LA County will cease to appeal, either to Blue Cross or the PRRB, for the fiscal year ending June 30, 1991, for reimbursement for the issue labeled "OUTPATIENT CLINIC VISITS".

5. LA County will cease to appeal, either to Blue Cross or the PRRB, for fiscal years ending June 30, 1991 through June 30, 1993, for reimbursement for the issue labeled "PROVIDER STATISTICAL AND REIMBURSEMENT (PS&R) REPORT".

6. LA County will cease to appeal, either to Blue Cross or the PRRB, for fiscal years ending June 30, 1981 through June 30, 1993, for reimbursement for the issue labeled "RELATIVE VALUE UNITS".

7. LA County agrees to withdraw any and all individual and/or group appeals pending either with Blue Cross or the PRRB regarding the issues and fiscal years described in paragraphs 1 through 6 above within sbty (60) days from the date of this agreement. LA County will not file a civil action to recover amounts in addition to the payment made pursuant to this agreement for any of the issues and fiscal years described in paragraphs 1 through 6 above.

8. HCFA will pay LA County fifty one million ($51,000,000.00) dollars within 30 days of the date of this agreement. Neither HCFA nor Blue Cross will issue revised Notices of Program Reimbursement for payments made pursuant to this agreement. This agreement constitutes a comprehensive resolution of the parties' disputes with respect to the amount of payment made by HCFA for any of the issues and fiscal years described in paragraphs 1 through 6 above. Regarding those issues, LA County may make a claim or bring an action only for the purpose of enforcing this agreement.

9. LA County and HCFA agree not to disclose the terms of this Agreement unless compelled to do so by a court of law or administrative tribunal with appropriate jurisdiction. The parties further agree not to refer to or rely upon this agreement or the terms of this Agreement in any court or administrative action except as necessary to enforce this agreement.

10. This Agreement shall have no effect on the amount of Medicare reimbursement payable to LA County for issues not covered by this agreement or for issues covered by this agreements for years not covered by this Agreement. The administrative resolution reflected herein is agreed to solely for the purpose of settling the above matters between the parties. This Agreement does not constitute and shall not be construed as an admission by either LA County or HCFA of any lack of merit in the respective positions taken by the parties before the PRRB or otherwise on the claims of LA County for reimbursement. The administrative resolution reflected herein is agreed to solely for the purpose of settling the matters at issue between the parties.

11. The parties agree that in the event that the amount on a cost report for a period subject to this agreement is necessary to set limits or rates applicable to any later fiscal year(s) (i.e., years beginning on or after July 1, 1996), the parties will negotiate in good faith an appropriate adjustment to reflect the additional costs recognized through this settlement.

FOR LOS ANGELES COUNTY

Mark Finucane
Director of Health Services

3/11/97
Date

Steven J. Carnevale
Principal Deputy County Counsel
Office of the County Counsel

3/17/97
Date

FOR HEALTH CARE FINANCING ADM.

Charles R. Booth
Acting Deputy Director
Bureau of Policy Development

3/13/97
Date

Senate Permanent Subcommittee
On Investigations

EXHIBIT # 21d.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the General Counsel
Health Care Financing Division

Room 500 East High Rise
6325 Security Boulevard
Baltimore, MD 21207

DEC 19 1994

NOTE TO MAURICE HARTMAN

Re: Howard University Settlement Agreement--ACTION

I have attached a signed copy of the Settlement Agreement entered into between HCFA and Howard University (HU) under the auspices of the Department of Justice.

In section 4, the Agreement states that HU's "first payment is due within 60 days of written notice to HU of DoJ approval of this Agreement." In addition, in section 5, it states that "HCFA, or its fiscal intermediary, will provide HU with a consolidated final Notice of Program Reimbursement (NPR) for all cost years covered by this Agreement within 60 days of written notice to HU of DoJ approval of this Agreement."

The Department of Justice has informed us that HCFA should implement the settlement. HCFA should provide the written notice to HU to trigger the above events.

I would like to review the consolidated NPR described in section 5 of the Agreement before it is issued. I suggest that your staff consult with Linda Ruiz' staff regarding the content of the consolidated NPR. I am also available for assistance.

Tom Stuber

Attachment

cc: Darrel Grinstead
Dave Butler
Linda Ruiz

SETTLEMENT AGREEMENT

(1) This Settlement Agreement is entered into by Howard University (HU) and the Health Care Financing Administration (HCFA) in order to settle all Medicare reimbursement issues between HU and HCFA respecting cost years 1983 through (and including) 1991; and for determining the computation of HU's graduate medical education (GME) per resident amount (PRA) for HU's GME base year of 1985, as defined under 42 U.S.C. § 1395ww(h) and 42 CFR § 413.86.

Background

(2) The Medicare fiscal intermediary for HU made its tentative determination of HU's base year PRA, as well as tentative cost report audit determinations showing a net overpayment for the nine cost periods being reviewed. The existence and amount of any such overpayment is disputed between the parties. Discussions between HU and HCFA made clear that it is to the benefit of both HU and HCFA for all reimbursement issues in dispute between HU and HCFA to be resolved as quickly as possible, fully and finally, for the 1983 through 1991 cost years. The following states the parties' agreed resolution of these matters.

The Alleged Overpayments

(3) HU and HCFA agree that, for purposes of this settlement, neither concedes that the other's audit position is correct,

EXCEPT that HU and HCFA agree that the GME base year PRA determination described in the next section (GME Base Year PRA Determination) shall apply, as appropriate, for all affected cost periods, past and future, including those covered by this Settlement Agreement.

(4) NOTWITHSTANDING disputing each other's audit position, HU and HCFA agree to compromise and settle these tentatively determined, alleged overpayments, subject to the approval of this settlement by the U.S. Department of Justice (DoJ), in consideration of the payment of $10,000,000.00 by HU, to be paid pursuant to the attached Schedule of Payments in fifteen (15) annual installments. Such payments shall be made without interest. The first payment is due within 60 days of written notice to HU of DoJ approval of this Agreement; installment payments, following the initial payment, are due on or before the end of HU's fiscal year, i.e. June 30th.

(5) In consideration of this compromise and settlement, HU and HCFA also agree, upon DoJ approval of the settlement, that ALL Medicare reimbursement issues and determinations for HU's 1983 through 1991 Medicare cost years are fully and finally resolved. Accordingly, HCFA, or its fiscal intermediary, will provide HU with a consolidated final Notice of Program Reimbursement (NPR) for all the cost years covered by this Agreement within 60 days of written notice to HU of DoJ approval of this Agreement. Such consolidated NPR will reflect, in the aggregate, the liability of

HU to HCFA for the amount specified in this Agreement (i.e., $10,000,000 without interest). In consideration of HCFA's issuing this consolidated NPR, HU agrees that HCFA may, in accord with medicare law and regulation, reopen any of the cost years covered by this agreement, if there is a change in law that requires HCFA to restate the applicable numbers for purposes of application to, or determination of payments for, a future cost period. However, the reimbursement for the cost years covered by this agreement shall not be affected by any such reopening.

(5-A) Given the uncertainty about the proper GME reimbursement for HU, on May 20, 1987, HU's intermediary reopened the 1982 cost report for GME. In light of the earlier compromise and settlement of this cost year and this Settlement Agreement, HU and HCFA agree that the NPR issued March 15, 1989 respecting the 1982 cost period shall also constitute the final NPR with respect to GME for the 1982 cost period. It is further understood that this agreement not to make adjustments for GME for the 1982 cost period following the 1987 notice of reopening, as well as the March 15, 1989 revised NPR, are not subject to appeal or further reopening.

<u>The GME Base Year PRA Determination</u>

(6) The intermediary has tentatively determined the GME base year PRA for HU. HU objected to the computation and met with HCFA and the intermediary to address HU's objections. The intermediary agreed to include in the calculation of the PRA:

(1) certain physician costs that were omitted due to certain clerical errors; (2) 50% of medical school library costs; (3) costs for five HU legal staff for which there was documentation; and (4) physician support costs for university-based departments by applying the hospital-based department ratio (25%) for such costs.

(7) The methodologies in the immediately preceding paragraph and the reimbursement results created by applying them are agreed to. The resolution of these four issues fully and finally resolves all disputes relating to determination of the GME base year PRA for HU. The resulting PRA for the 1985 base year is $79,051.89. HU agrees not to appeal or further dispute any GME base year issues, including the calculation of the PRA, either for the GME base year or for any future year that may be affected by this determination. This Settlement Agreement, however, does not affect any rights HU may have in disputing other Medicare reimbursement issues in future cost periods (i.e., from and including the 1992 cost year) that may arise.

(8) In sum, in consideration of these changes in computation, HU agrees: (1) that it will not appeal the PRA set forth above; (2) that this revised rate shall be applied, as appropriate, including all inflation and other adjustments thereto contemplated by HCFA's GME regulations or the Medicare statute, for ALL cost periods, whether past, present, or future; and (3) that this PRA determination is final and binding between the

parties respecting all such years, including the 1983 through 1991 cost years specifically covered by this Agreement.

Finality And Effect Of Settlement

(9) Upon DoJ approval of this compromise and settlement: (1) ALL Medicare reimbursement issues and determinations respecting HU for the 1983 through 1991 cost years are fully and finally resolved and not subject to any form of reopening, irrespective of any events (including litigation, but excluding statutory changes) that may apply to other Medicare providers not party to this agreement; (2) ALL GME base year reimbursement and GME base year PRA issues respecting HU are fully and finally resolved for ALL cost years and not subject to any form of reopening, irrespective of any events (including litigation, but excluding statutory changes and all inflation and other adjustments to the PRA contemplated by HCFA's GME regulations or the Medicare statute) that may apply to other Medicare providers not a party to this agreement; and (3) the audited allowable capital related costs respecting HU are final and binding for the cost years that are subject to this Agreement.

(10) This Agreement shall be binding upon HCFA's agents and contractors, including, without limitation, its Medicare fiscal intermediaries and carriers. This Agreement may be amended only by a writing executed by both parties

(11) EXCEPT AS DESCRIBED HEREIN, HU and HCFA retain all rights to dispute any Medicare reimbursement issues for future cost periods (*i.e.*, from and including the 1992 cost year), including for example, the application and amount of the base year hospital specific capital rate to such future periods and Allied Health Sciences Programs.

Bernard K. Jarvis — 12-1-94 DATE
Interim Vice President for
Business and Fiscal Affairs
Howard University

Bruce C. Vladeck, Administrator — 12/2/94 DATE
Health Care Financing Administration

SCHEDULE OF PAYMENTS

The following Schedule of Payments applies to the Settlement Agreement between Howard University and the Health Care Financing Administration regarding Medicare cost years 1983 through 1991. Such payments shall be made without interest.

YEAR	ANNUAL PAYMENT
1	$500,000
2	$1,000,000
3	$500,000
4	$1,000,000
5	$500,000
6	$1,000,000
7	$500,000
8	$1,000,000
9	$500,000
10	$500,000
11	$500,000
12	$500,000
13	$500,000
14	$500,000
15	$1,000,000
TOTAL	$10,000,000

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Senate Permanent Subcommittee
On Investigations
EXHIBIT # 25

United States General Accounting Office

GAO

Report to the Chairman, Permanent Subcommittee on Investigations, Committee on Governmental Affairs, United States Senate

February 2000

HCFA

Three Largest Medicare Overpayment Settlements Were Improper

GAO/OSI-00-4

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Abbreviations

CFO	Chief Financial Officer
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
NPR	Notice of Program Reimbursement
OGC	Office of General Counsel
OSI	Office of Special Investigations
PRRB	Provider Reimbursement Review Board

United States General Accounting Office
Washington, D.C. 20548

Office of Special Investigations

B-284138

February 25, 2000

The Honorable Susan M. Collins
Chairman
Permanent Subcommittee on Investigations
Committee on Governmental Affairs
United States Senate

Dear Madam Chairman:

The depletion of the Medicare Trust Fund has been the subject of significant scrutiny in recent years. As we have reported previously, fraudulent and abusive practices have raised concerns about program vulnerabilities.[1] The Department of Health and Human Services' (HHS) Health Care Financing Administration (HCFA), which administers the Medicare program, is required to ensure that debts owed the program—generally caused by overpayments to providers—are paid. Historically, rather than collect the entire debt, however, HCFA often enters into settlement agreements with providers and accepts less than the full amount owed.

This report responds to your May 7, 1999, request and discussions with your office that we examine the application of the Federal Claims Collection Act[2] to HCFA's settlement of overpayment matters with providers and develop case studies of settlements that may have been improper. We also attempted to obtain HCFA's response to key questions about the act and specific settlements

[1] See *Medicare: HCFA Faces Multiple Challenges to Prepare for the 21st Century* (GAO/T-HEHS-98-85, Jan. 29, 1998).

[2] 31 U.S.C. §3711 (1994 & Supp. III 1997).

Results in Brief

HCFA provided us with copies of 96 agreements reflecting Medicare overpayment settlements that it negotiated from 1991 through July 1, 1999, in which the overpayment exceeded $100,000. We found nothing improper in the settlement of 93 of the 96 matters. We did determine, however, that HCFA acted inappropriately in several respects as to settlement of the three largest matters, which constituted 66 percent of all Medicare overpayment settlements since 1991 for which HCFA provided us records.[5] In these settlements, HCFA agreed to accept $120 million for debts exceeding $332 million (about 36 percent of the total principal). Appendixes I, II, and III discuss these three settlements and the circumstances surrounding them in more detail.

As to these three matters, HCFA should have obtained clarification from those charged with implementing the Federal Claims Collection Act, including the Department of Justice and/or GAO, before unilaterally choosing not to obtain approval from Justice of the settlements. Such clarification should have been sought because HCFA's own regulations required any compromise of a claim over $100,000 to be approved by Justice, and those who settled the matter thought approval was necessary. The official who negotiated these three settlements chose not to seek approval because he was concerned that if he did, the "deals would go up in smoke" and he knew that the settlements were not in the best interest of the government. Moreover, only a few months before beginning discussions with the provider on the first of these three settlements, Justice rejected a HCFA proposal to settle a similar overpayment matter. (See app. IV.)

Although HCFA chose not to seek a clarification or actual approval from Justice, it is not entirely clear that the Federal Claims Collection Act actually required Justice approval. The Federal Claims Collection Standards, promulgated pursuant to the act, govern the issue. Those standards require Justice approval only when an "appropriate agency official" has determined that the compromised claim is owed. There is some doubt whether HCFA's fiscal intermediaries, who determine the overpayment amounts, are "appropriate agency officials" within the meaning of the standards, however. In such circumstances, we believe the prudent course for HCFA to have followed would have been to seek

[5] HCFA was unable to provide us with documentation showing the overpayment amounts in some instances.

specific clarification from Justice and/or GAO as to their views on the matter.

Concerning the specifics surrounding the three settlements, HCFA appears to have disregarded the permissible settlement criteria established by regulation, since evidence suggests that the providers were all able to pay the entire overpayment amount, that HCFA would have prevailed if the matters were litigated, and that the amount of recovery would have exceeded the cost of collecting each of these multimillion-dollar debts. In addition, the agreements contained several questionable provisions. The terms of two of the settlement agreements permit future provider reimbursement for costs for which they would not otherwise be entitled. HCFA also waived interest and permitted repayment in installments for one of the agreements, despite contrary directions in its internal guidance. Further, HCFA officials acted imprudently by executing these settlement agreements without the benefit of legal counsel. Finally, our investigation revealed that former HCFA Administrator Bruce Vladeck had directed subordinates to settle these matters. More importantly, his participation in the largest of these settlements raised conflict-of-interest concerns, which we could not resolve given his refusal to meet with us.

Background

Overview of Medicare Payment System and Recovery of Overpayments From Providers

The Secretary of HHS administers the Medicare program. Pursuant to the Social Security Act, the Secretary is required to periodically determine the amount that should be paid to each provider for its services under the program and to pay each provider the reasonable or customary cost for these services at such time or times as the Secretary believes appropriate (but not less often than monthly).[4] The Secretary has delegated her authority to administer the Medicare program to HCFA.

[4] 42 U.S.C. § 1395f(b) (1994 & Supp. III 1997). See 42 U.S.C. § 1395x(v) for the definition of "reasonable costs."

To carry out the mandates of the Social Security Act, Medicare providers that meet Medicare certification standards are required to enter a provider agreement with HCFA and provide HCFA with annual cost reports that detail the services provided Medicare patients for the previous year.[5] Fiscal intermediaries, who are HCFA contractors, pay providers periodically for covered services on an interim basis. These payments are based on an estimated cost basis using the provider's previous year's cost report for covered services with any appropriate adjustments.[6] Retroactive adjustments are then made, based on the provider's actual cost report for the year.[7] Providers must maintain adequate documentation to establish proper payment under the program.[8] Based upon a review of the annual cost report, the fiscal intermediaries issue a Notice of Program Reimbursement (NPR) to each provider that sets forth the Medicare reimbursement and the expenses allowed and disallowed for the year.[9] The amounts of provider overpayments become debts owed by the provider to the United States.[10]

[5] 42 C.F.R. § 413.64(b) and (e).

[6] 42 C.F.R. § 413.64(e) (1998). When a provider first begins participation in the program, an interim rate is established and applied until the provider has filed a cost report. 42 C.F.R. § 413.64(c).

[7] Id. §§ 405.1801(b); 413.20; 413.24.

[8] Id. § 413.20(a), (d).

[9] Id. § 405.1803.

[10] Provider Reimbursement Manual, Part I § 2409 (Oct. 1995), Medicare Intermediary Manual, Part 2, Chapter III, Payments to Providers § 2220-2221 (May 1991).

The determination of the amount owed as reflected in the NPR is final and binding unless the fiscal intermediary itself reverses its determination or the provider appeals the fiscal intermediary's determination to the Provider Reimbursement Review Board (PRRB), which is an administrative tribunal within HHS.[11] After holding a hearing, the PRRB makes a decision that is final unless the HCFA Administrator reverses, affirms, or modifies it within 60 days after the provider is notified of the decision. Providers can seek judicial review of the amount due after receipt of a decision from the PRRB.[12]

There are generally two ways in which repayments due HCFA can be made. The provider may refund the amount of the overpayment to HCFA, or HCFA may offset the money owed from payments to be made to the provider. Those methods are applicable regardless of whether the provider appeals.[13]

[11] 42 C.F.R. § 1807. Providers have 180 days to file an appeal with the PRRB. 42 U.S.C. § 1395oo(a).

[12] 42 U.S.C. § 1395oo(f)(1).

[13] Providers who receive NPRs must pay the amount due while administrative appeals are pending. 42 U.S.C. § 1395gg(b)(1); 42 C.F.R. § 405.371(a)(2). Moreover, a fiscal intermediary's determination forms the basis for making retroactive adjustment to any program payments and recoupment of overpayments, regardless of appeal. 42 C.F.R. § 1803(c).

The Federal Claims Collection Act and HCFA's Regulations

The Federal Claims Collection Act of 1966, as amended,[14] provides the basic legal framework for agency collection of debts owed to the United States. It was enacted to remedy the inadequacies of most federal agencies in recovering claims owed the United States arising out of their respective activities.[15] The act gives the heads of agencies authority to settle or "compromise" claims of $100,000 or less.[16] If the principal amount of the debt exceeds $100,000 or involves fraud, however, the settlement must be referred to Justice for approval, unless the agency has its own agency-specific or program-specific compromise authority.[17]

Pursuant to the act, the Comptroller General of the United States and the Attorney General[18] jointly promulgated the Federal Claims Collection Standards. These standards provide guidance to federal agencies on the administrative collection and compromise of claims, the termination of agency collection action, and the referral to GAO and to Justice of certain claims the United States has against third parties.[19]

[14] 31 U.S.C. § 3711.

[15] 31 U.S.C. § 3711(a); S. Rep. No. 89-1331, at 2 (1966).

[16] "[T]he terms 'claim' and 'debt' are synonymous and interchangeable, [and] refer to an amount of money or property which has been determined by an appropriate agency official to be owed to the United States. . . ." 4 C.F.R. § 101.2 (1996).

[17] 31 U.S.C. §§ 3711(a)(2), (c)(1); 4 C.F.R. § 103.1(b).

[18] Effective Oct. 19, 1996, the Comptroller General's statutory authority under the Federal Claims Collection Act was removed pursuant to the General Accounting Act of 1996, Pub. L. No. 104-316, 110 Stat. 3826, 3834-35. The Secretary of the Treasury now shares this authority with the Attorney General. 31 U.S.C. § 3711(d)(2).

[19] 4 C.F.R. ch. II (1996).

HCFA's regulations on the compromise of Medicare overpayment claims state, "HCFA refers all claims that exceed $100,000 or such higher amount as the Attorney General may from time to time prescribe, exclusive of interest, to the Department of Justice or the General Accounting Office...."[20] HCFA's regulations define "claim" as any debt owed to HCFA.[21] At HCFA, the authority to compromise a debt rests with HCFA's Claims Collection Officer, unless a delegation of authority has been granted to the agency component involved.[22] HCFA's Associate Regional Administrator -- Medicare, its Regional Administrators, and the "Responsible Collecting Component" are empowered to compromise debts of $100,000 or less.[23] HCFA's guidance requires that the compromise of a debt over $100,000 be referred to Justice through HCFA's central office and its Office of General Counsel (OGC).[24]

[20] 42 C.F.R. § 401.601(c); *see* HCFA-Administrative Issuances System Guide, Financial Management, HCFA g: 0306-1, Federal Claims Collection Act Policies & Procedures, § 0306-1-45 (Oct. 1, 1995) (hereafter HCFA's Guide).

[21] 42 C.F.R. § 401.603. *Compare* 42 C.F.R. §§ 401.601, 405.376 *with* 4 C.F.R. pt. 101. HCFA's claims collection and compromise regulations define "claim" as any debt owed HCFA and "debtor" as any entity against which HCFA has a claim. 42 C.F.R. § 401.603. HCFA's complementary regulations addressing overpayment claims simply define "debtor" as a provider that has been overpaid. 45 C.F.R. § 405.376(b). However, HCFA's Guide defines "debt" as an amount owed that is no longer eligible for adjustment and "claim" as any amount HCFA has tentatively identified as owed but still eligible for adjustment. HCFA's Guide, § 0306-1-25.

[22] 42 C.F.R. § 401.613; HCFA's Guide, § 0306-1-45(A).

[23] HCFA's Guide, §§ 0306-1-20(C), 0306-1-30(I), 0306-1-45(B).

[24] 42 C.F.R. § 401.601(c); HCFA's Guide requires that debts of over $100,000 be referred to Justice through HCFA's central office and OGC to Justice. HCFA's Guide, § 0306-1-20(C).

The Federal Claims Collection Act does not authorize accepting a lesser amount in compromise of a claim merely for the sake of closing out a claim. Rather the joint regulations promulgated by the Comptroller General and the Attorney General set forth criteria that agencies must consider in determining whether to compromise a debt or claim. These regulations permit compromise of claims only if one or more of the following reasons exist: (1) the debtor cannot pay the full amount within a reasonable time, (2) the debtor refuses to pay and the United States is unable to collect the full amount in legal proceedings, (3) there is real doubt that the United States can prove its case in court, or (4) the cost of collecting the claim does not justify seeking full recovery.[25] HCFA's regulations generally mirror the joint regulations.

Overview of Improper Agreements We Examined

Based on the evidence we obtained, we found the 3 largest of 96 settlement agreements to be improper. HCFA's settlement of the three matters—in 1995, 1996, and 1997, respectively—was questionable in several respects. Further, we note that the Federal Claims Collection Act was not applicable to at least 57 of these matters that were settled because they were referred to Justice for enforced collection or for representation of HCFA in bankruptcy proceedings.

1995 Settlement With a Home Health Agency

In September 1991, a fiscal intermediary reviewing a home health agency's 1989 cost report determined that its average cost per home health aide visit was more than 3 times HCFA's published 1989 limit. (See app. I.) Therefore, the fiscal intermediary notified the home health agency of a proposed audit adjustment. The intermediary also determined that this home health agency's average patient visit was 12 hours long, compared to the 3.3-hour average for a Medicare home health aide visit. A subsequent investigation by the intermediary revealed that many of the services provided during the agency's longer patient visits were actually homemaker services not covered by Medicare. The fiscal intermediary also determined that the longer visits were being provided under the federally funded Medicaid program, not Medicare. Ultimately, the fiscal intermediary concluded that the home health agency would owe HCFA approximately $98 million, for which HCFA agreed to accept $67 million in settlement.

[25] 4 C.F.R. pt. 103.

In February 1993, HCFA's OGC advised HCFA's then Director of Payment Policy, Charles Booth,[26] that the fiscal intermediary's audit adjustment "would be legally supportable." In May 1993, the home health agency's president, senior officials, and legal counsel met with Mr. Booth and other HCFA staff to discuss the disputed matter. No resolution was reached, however; and the matter remained unresolved.[27]

However, according to Thomas Ault, the former Director of HCFA's Bureau of Policy Development, on November 9, 1993, HCFA Administrator Vladeck told him that the home health agency's president had approached him on the previous day to seek a settlement of this matter. Mr. Ault said that Mr. Vladeck wanted the matter "moved along and settled" but did not want to be kept informed because of Mr. Vladeck's previous relationships in the same geographic area as this home health agency. We learned that Mr. Vladeck had sat on an Advisory Committee for a research division of this provider immediately before he became HCFA Administrator. Mr. Ault assigned the matter to his subordinate, Mr. Booth, and told him that Mr. Vladeck requested the settlement as a result of the conversation that Mr. Vladeck had had with the home health agency's president.

Mr. Booth told us that Mr. Ault had made it clear that the settlement was necessary as an "accommodation" to the home health agency and Mr. Vladeck's "friend." Mr. Booth reported that Mr. Ault and he were accordingly "circumspect" and "uncomfortable" with proceeding with the settlement. He also stated that Mr. Ault was particularly uncomfortable because of the large size of the overpayment.

[26] During the time period discussed in this report, Mr. Booth subsequently became HCFA's Director of Hospital Policy and then Acting Deputy Director, Bureau of Policy Development. Mr. Booth is currently a Deputy Director in HCFA's Office of Financial Management.

[27] On July 28, 1993, a newspaper reporter requested that HCFA produce a list of the top 50 home health agencies by amount billed to Medicare. The list produced to the newspaper indicated that this provider was the largest Medicare-billing home health agency in the United States; the next largest had about one-third this agency's total billings. In a HCFA memorandum drafted in mid-August 1993, HCFA Administrator Vladeck was advised about the provider's "considerably higher" billings.

On February 28, 1994, the fiscal intermediary issued NPRs for cost report years 1988, 1989, 1990, and 1991, demanding repayment of over $33.5 million.[28] Efforts to settle the matter before then were unsuccessful.

On March 2, 1994, however, the home health agency's attorney argued to Mr. Booth that the fiscal intermediary's adjustments were incorrect and urged him to accept a proposal that would have resulted in repayment of approximately $56 million of the estimated $98 million in overpayments. The same day, the fiscal intermediary sent Mr. Booth a letter by facsimile, urging that the proposal be rejected since it would establish an improper precedent that could increase the overall cost to the Medicare program. The home health agency's president also called Mr. Vladeck the same day to move the matter toward some type of resolution. We learned that by this time, the home health agency had established a reserve of approximately $56 million for this matter and intended to pay no more than this amount to settle its debt. By the following day, Mr. Vladeck had asked Messrs. Booth and Ault about the status of the negotiations.

Eight days later, on March 10, 1994, Mr. Booth negotiated a settlement, agreeing to accept approximately $67 million in repayment of the approximately $98-million debt and permitting the provider to add a specified number of hours to its Medicare average for all future years, regardless of the number of hours that services were actually rendered. HCFA also permitted the home health agency to repay most of the amount that exceeded its reserve fund by offsets, permitted repayment of some of the debt in installments, and waived the requirement to pay interest and penalties.[29]

At the provider's request, the settlement was to be kept as secret as possible. As a result, since NPRs are publicly available documents, the fiscal intermediary withdrew its February 28, 1994, NPRs for the 1988-1991 cost report years and issued new NPRs to reflect the newly negotiated settlement amount. No government attorney reviewed the settlement agreement before it was executed on April 19, 1995.

[28] The fiscal intermediary had projected the provider's overpayments for 1992 and 1993 but had not prepared NPRs. The fiscal intermediary also reopened the home health agency's 1988 cost report to seek recovery of funds from that year's billings. The total estimated 5-year overpayment amounted to approximately $98 million.

[29] The fiscal intermediary also returned over $225,000 in interest already paid by the home health agency.

1996 Settlement With a Hospital

Between 1983 and 1993, a fiscal intermediary issued NPRs to a provider hospital, disallowing reimbursement for, among other costs, bad debts because the hospital lacked the appropriate documentation to support them. (See app. II.) Over the 11-year period, the fiscal intermediary withheld approximately $155 million from the hospital's future claims to recover the overpayments.[26] The hospital appealed these disallowances to the PRRB. Prior to any PRRB hearing, HCFA settled the matter by agreeing to accept $25 million for the amount of overpayments.

From 1993 to 1995, the hospital sought resolution of some of the overpayment issues with HCFA officials; but no resolution was reached. Then sometime between January 19, 1996, and February 16, 1996, Mr. Vladeck met with the chairman of the hospital's Board of Directors and apparently discussed the pending appeals. Until shortly before his 1993 appointment, Mr. Vladeck was a member of the hospital's Board of Directors. Around this time, according to Mr. Booth, Mr. Vladeck instructed him to settle the hospital's claims. Mr. Booth characterized his role as "an expediter" in this and the other two settlements that he negotiated for Mr. Vladeck.

On April 18, 1996, Mr. Booth and other HCFA officials met with senior hospital officials to discuss a potential resolution to the appeals. During this period, Mr. Booth provided Mr. Vladeck, at his request, with status reports every 3 to 4 weeks.

According to Mr. Booth, Mr. Vladeck advised him in late spring 1996 that he (Mr. Vladeck) "had to tell the sixth floor something," referring to the location of the office of the Secretary of HHS. Kevin Thurm, then Chief of Staff to HHS Secretary Donna Shalala and now the HHS Deputy Secretary, told us that he had instructed Mr. Vladeck to ask about the hospital's outstanding disputed claims. That spring, a Member of Congress expressed concern to Mr. Thurm that impending budget cuts would force the hospital to curtail its services. Mr. Thurm told us he therefore spoke to Mr. Vladeck on several occasions to determine the status of the situation.

In June Mr. Booth met with senior hospital and fiscal intermediary officials to initiate formal negotiations. In July 1996, Mr. Vladeck e-mailed Mr. Booth, complaining that the settlement was taking too long to

[26] The fiscal intermediary also withheld funds to recover disallowed graduate medical education and other costs.

accomplish. Mr. Booth advised Mr. Vladeck that speeding up the settlement process could cost HCFA an extra $8 million to $10 million. According to Mr. Booth, Mr. Vladeck suggested that "time was more important than money" and instructed him to mover faster. Thus, in July and August 1996, representatives of the hospital and the fiscal intermediary met with Mr. Booth and other HCFA officials and worked out the final details of a settlement.

On September 24, 1996, Mr. Booth executed an agreement with the hospital, the terms of which were to be kept confidential. In the settlement, the hospital agreed to withdraw all but three of its outstanding PRRB appeals; and HCFA agreed to accept $25 million to settle HCFA's overpayment claims of approximately $155 million. The agreement also permitted the hospital to continue to bill indefinitely for bad debts without any documentation to support these costs. A senior fiscal intermediary official told us that this made it unnecessary to audit the hospital for bad debts since HCFA had promised to pay the hospital regardless of documentation or support.[31]

No government attorney reviewed the settlement agreement before it was executed. Of the 96 settlements we reviewed, this was the only matter in which HCFA had failed to maintain any documentation, including a copy of the settlement agreement.

1997 Settlement With a Hospital

Between 1987 and 1993, a fiscal intermediary issued NPRs to a provider hospital disallowing its claimed reimbursement for bad debts and other costs for lack of documentation. (See app. III.) The hospital appealed the fiscal intermediary's decisions to the PRRB. Before the PRRB hearings, HCFA agreed to accept $28 million in payment of the debt of $79.4 million in overpayments.[32]

[31] A HCFA official who was present when this was proposed was "so disgusted" by the formula adopted to derive future bad debt payments that he walked out of the meeting and refused to attend the additional negotiation sessions.

[32] This includes some cost disallowances that predate 1987.

During the pendency of the appeals, the hospital experienced substantial budget shortfalls and, in September 1996, asked HCFA if it would settle expeditiously the outstanding PRRB appeals to avert curtailment of its health care services. Mr. Vladeck—who learned as early as June 1996 that the hospital's Medicare problems were caused by its "long history of being late, incomplete, and/or inaccurate" in its billings—participated with hospital officials in some meetings at which this matter was discussed and, in approximately November 1996, instructed Mr. Booth to negotiate a settlement.[33]

In February 1997, Mr. Booth discussed a settlement with the hospital's Director of Program Reimbursement, explaining that HCFA would agree to pay the hospital $51 million in withheld funds, thus agreeing to accept $28 million to settle the overpayment amounts owed.[34] On or about March 3, 1997, Mr. Booth faxed a copy of a draft settlement agreement to the fiscal intermediary and to HCFA's regional office for comments. The draft contained the terms that he had proposed. The fiscal intermediary did not comment; however, on March 6, the Manager for Program Safeguards for the regional office wrote a detailed e-mail to Mr. Booth, opining that the agreement was not in Medicare's best interest. Among other things, the manager noted that the hospital had been "a 'problem child' for years and years" and asserted that there was a good likelihood that the fiscal intermediary would prevail on most of the issues before the PRRB since the hospital lacked documentation to support its claims.

The settlement agreement was executed on March 21, 1997, by Mr. Booth who, on HCFA's behalf, agreed to accept $28 million in compromise of

[33] HCFA requested the fiscal intermediary to attempt administrative resolution of the matters on PRRB appeal, which the fiscal intermediary can do if a provider can convince it that its claimed costs are legitimate. In this case, however, a regional HCFA official advised Mr. Booth

"that the appeal issues are the result of [the hospital] not providing the FI [fiscal intermediary] with proper supporting documentation.... They [the hospital] have also postponed a PRRB hearing on some of those appealed issues .... At this point, I don't know what more the [fiscal intermediary] can do to accelerate the resolution of these issues. [The hospital's] inability to provide proper supporting documentation appears to be the bottleneck."

[34] According to Mr. Booth, the hospital had already learned of the offer from Mr. Vladeck, who apparently spoke with higher-level hospital officials about the proposal. Mr. Booth told us that he had briefed Mr. Vladeck on the negotiations and told him and no one else about his proposed $51-million settlement offer.

$79.4 million in overpayments. The agreement also contained a confidentiality clause. No government attorney reviewed the settlement agreement before it was executed.

Improper HCFA Settlement of These Matters

Our investigation determined that HCFA should have sought clarification from Justice and GAO before ignoring its own regulations and procedures requiring Justice approval of the settlements. In addition, it appears that HCFA failed to consider necessary factors for settlement when it agreed to accept less than the full amount owed in these matters. The settlement agreements themselves also contained questionable provisions and were not reviewed by any government attorney. Lastly, the settlement of the largest of these three matters raised conflict-of-interest concerns.

HCFA Improperly Determined Not to Seek Clarification of Federal Claims Collection Act Requirements

The applicability of the Federal Claims Collection Act to the three settlements upon which we focused depends upon whether the amount of overpayments determined by the fiscal intermediaries and set forth in the NPRs constitutes a "claim" or "debt" within the meaning of the act. The Federal Claims Collection Standards,[35] which implement the act, make clear that Justice approval is required only when a debt or claim is compromised.[36] In the claims context, we have previously said that "compromise" means accepting less than the full amount owed in full satisfaction of the claim.[37] Based upon the facts set forth above, we believe it is clear that HCFA accepted less than the full amount of the overpayments. It is not, however, as clear whether such overpayments constituted a claim or debt within the meaning of the act. The standards use the terms "claim" and "debt" interchangeably and define them as "an amount of money or property which has been determined by an appropriate agency official to be owed to the United States...."[38] The term "appropriate agency official" is not defined in the standards. However, the meaning of this phrase is critical to whether the act applied to the settlement agreements under discussion here.

[35] 4 C.F.R. ch.2.

[36] *Id.* § 103.1(b).

[37] E.g., *In re Economic Development Admin.*, 62 Comp. Gen. 489, 492-93 (1983).

[38] 4 C.F.R. § 101.2(a).

Under what is often referred to as the Chevron doctrine, the Supreme Court has long recognized that considerable deference should be given to the agency's construction of a statutory scheme it is charged with administering.[39] At the time the 1995 and 1996 settlements were negotiated and signed, the Attorney General and the Comptroller General had joint responsibility for the interpretation and administration of the Federal Claims Collection Act.[40] However, effective approximately 1 month after the second settlement was signed, the Comptroller General's authority to prescribe regulations under the act was removed. Under the revised provisions, both the Attorney General and Secretary of the Treasury have authority to implement the act.[41] Therefore significant deference is owed to the Attorney General's and the Comptroller General's interpretation of the Federal Claims Collection Standards as to the first and second settlements.[42] However, deference must be accorded to the Attorney General's and Treasury's interpretation of the standards with respect to the third agreement. The persons having authority to implement the Federal Claims Collection Act are especially important here because, as the following discussion demonstrates, they did not always agree on the meaning of the standards.

In 1975, Justice's Office of Legal Counsel considered an issue similar to those involved with the HCFA settlements. At that time, it was asked whether the compromise of certain administrative penalties assessed by the Department of the Interior against coal mine operators under the Federal Coal Mine Health and Safety Act was subject to the Federal Claims Collection Act. The Office of Legal Counsel concluded that the Federal Claims Collection Act did not apply because at the time of the settlement, the penalties were subject to review in an administrative hearing and were not yet final. Stressing the nonfinal nature of the Interior Department's administrative determination, the Office of Legal Counsel stated that a

[39] *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-45 (1984).

[40] 31 U.S.C. § 3711(e)(2).

[41] The Secretary of the Treasury and the Attorney General proposed to revise the Federal Claims Collection Standards in 1997. Federal Claims Collection Standards, 62 Fed. Reg. 68,476 (1997). The proposed revisions would not affect the issues discussed in this report.

[42] See *Commonwealth Edison Co. v. United States Nuclear Regulatory Comm'n*, 830 F.2d 610, 620 (7th Cir. 1987) (Attorney General's interpretation of the Federal Claims Collection Standards entitled to significant deference).

"claim" under the Federal Claims Collection Act connotes a degree of finality that did not exist with respect to the penalty under review.

After the HCFA settlements at issue here were signed, both GAO and the Office of Legal Counsel rendered opinions on the meaning of the term "appropriate agency official" in the Federal Claims Collection Standards. Although GAO no longer had statutory authority to prescribe standards under the Federal Claims Collection Act, in March 1997 it was asked whether the settlement of royalty claims by the Department of the Interior's Mineral Management Service should have been submitted to Justice under the act.[43] In this case, the Mineral Management Service agreed to accept $44 million from Exxon to settle claims exceeding this amount. GAO stated that "the appropriate agency official" establishing the debt should be identified based on the agency's delegation of authority and governing regulations. After reviewing these, GAO concluded that the Associate Director, Mineral Management Service, or delegatee had authority to determine royalty claims owed the Interior Department and was an "appropriate agency official within the meaning of the standards." Thus, even though Exxon had appealed the claims' determination to an appropriate administrative tribunal, GAO concluded that the Mineral Management Service should not have settled these claims without Justice approval.

The following year, Department of the Interior officials asked Justice's Office of Legal Counsel its opinion as to whether the Mineral Management Service could settle claims over $100,000 without Justice approval while the matter remained subject to administrative appeal. After analyzing the statutory scheme and noting the Secretary of the Interior's broad discretion to audit the relevant payments and determine the amount owing, the Office of Legal Counsel concluded that the Mineral Management Service could settle and compromise a matter without Justice approval if the agency had yet to issue a final decision concerning the debt.[44] According to the Office of Legal Counsel, because no "final decision" could be rendered before a potential debtor exhausted its administrative appeals, the "appropriate agency officials" contemplated by the standards were only those who could issue decisions on appeal. In contrast to GAO's opinion, under this analysis

[43] B-276561 (1997) (letter to Representative Carolyn B. Maloney).

[44] Office of Legal Counsel, Memorandum for Lois J. Schiffer, Assistant Attorney General, Environment and Natural Resources Division and for John D. Leshy, Solicitor, Department of the Interior at 11 (July 28, 1998) (unpublished).

the contested "order to pay" issued by the Associate Director, Mineral Management Service, did not give rise to a claim within the meaning of the standards; and therefore no Justice approval was required for settlement of such an order.

We note that there are many similarities between the systems used by the Mineral Management Service and HCFA to determine amounts each is owed. For example, in each system, the initial amount due is determined by a periodic audit. In both situations, the initial decisionmaker issues a document that compels payment; and the affected entity can appeal the matter to an administrative review panel before seeking judicial review. There are also similarities in the statutory authority and responsibility of the Secretaries of the Interior and Health and Human Services to make adjustments to the amounts owed.[45] Further, two of the three HCFA matters we examined closely were under appeal administratively—and the third could have been appealed administratively—when they were settled.[46]

Based upon the opinions of Justice and GAO concerning application of the Federal Claims Collection Act to the Mineral Management Service, it is clear that they have placed fundamentally different constructions on the Federal Claims Collection Standards. It would appear that these different interpretations would lead to differing views by Justice and GAO as to whether HCFA complied with the act when it did not submit the settlements to Justice.

[45] *Compare* 30 U.S.C. § 1711(a), (c) (1) (1994) (Secretary of the Interior must establish a comprehensive inspection, collection, and fiscal and production accounting and auditing system ... and audit and reconcile, to the extent practicable, all current and past accounts ... and take appropriate actions to make additional collections or refunds as warranted) *with* 42 U.S.C. § 1395g(a) (Secretary of HHS shall periodically determine the amount to be paid to each provider ... with necessary adjustments on account of previously made overpayments or underpayments).

[46] There are some differences; however, the most significant one was concerning whether debt must be paid to the agency regardless of an appeal. Unlike the initial determinations under the Mineral Management Service scheme, providers who receive NPRs must pay the amount due while an administrative appeal is pending; and HCFA can institute offset regardless of appeal.

Nevertheless, the issue of whether HCFA complied with the Federal Claims Collection Act is not free from doubt and is complicated by the fact that at the time the first two settlements were signed, the Attorney General and the Comptroller General were charged with administering the standards, with their interpretations entitled to deference. When the third settlement was signed, the Attorney General and the Secretary of the Treasury had such responsibility. We do not know how the Attorney General and the Comptroller General would have resolved the question had the matter been presented to them. Indeed, in a recent letter to the HHS General Counsel, Justice declined to express a view on whether the compromise of Medicare overpayments was subject to the act, commenting instead that further study was required.[47] In such circumstances, we do not believe HCFA should have unilaterally decided to settle the matters without Justice approval. The more prudent course would have been for HCFA to ask those in charge of administering the act for their views on the issue.

This course would have been especially appropriate since HCFA's regulations and guidelines required the three matters to be approved by Justice. Significantly, Mr. Booth, who negotiated the settlements, and others at HCFA believed they were required to submit the settlements to Justice for approval. Mr. Booth told us that he knew about the requirement to go to Justice for approval of the three settlements but chose not to do this because the "deals would go up in smoke" if Justice or HCFA's OGC got involved. He continued that therefore he would have been "unable to satisfy Mr. Vladeck."[48] Mr. Booth told us that he knew that these three settlements were all made to accommodate the providers and were not in the best interest of the government. He told us that he nevertheless settled the three matters out of "loyalty" to Mr. Vladeck.

[47] During our investigation, and after we interviewed Sheree Kanner, HCFA's Chief Counsel, and Michelle Snyder, HCFA's Chief Financial Officer, HHS's General Counsel met with officials in Justice's Civil Division and inquired whether reimbursement determinations made in the Medicare claim review process were subject to the Federal Claims Collection Standards and therefore required Justice approval before settlement. Justice's Oct. 8, 1999, response to the HHS General Counsel declined to determine whether HCFA was required to obtain its approval before settling Medicare overpayment cases without more study. Justice did, however, posit several theories to explain why the Federal Claims Collection Act might be inapplicable, including the reasoning of the opinion by the Office of Legal Counsel.

[48] Similarly, Mr. Ault told us that "everyone at HCFA knew about the OGC requirement on overpayment settlements as it was agency policy." Indeed, although our inability to interview Mr. Vladeck precludes us from determining whether he knew about these regulatory requirements, he was aware that Justice was involved in approving another settlement early in his tenure as Administrator. (See app. IV.)

Further, Justice itself acted under the Federal Claims Collection Act when in early 1993, HCFA's former chief counsel sought Justice's approval to settle a $58-million overpayment claim with a hospital for $3 million. The matter was brought to Justice's attention before an NPR had been issued and a final decision rendered. Justice rejected the proposal in September 1993 because it was "not sufficient" and "out of line with settlement amounts from comparable institutions." It then took over the negotiations with the hospital, which continued until March 1994, when the hospital rejected Justice's offer to settle the matter for $12 million. After the hospital's rejection, Justice returned the matter to HCFA for collection. (See app. IV.)

In view of these circumstances, HCFA officials should not have unilaterally decided that they would not submit the settlement agreements to Justice for approval. Instead they should have sought advice from those charged with administering the Federal Claims Collection Act as to whether Justice approval was required. In failing to do so, HCFA acted inappropriately.

HCFA Settled These Matters Without Considering Required Factors

HCFA's regulations and manuals recognize that circumstances may exist in which compromise of a debt is appropriate. HCFA's Guide states,

"[C]ompromise of debts should not be considered until all administrative collection action to collect a debt in full has been exhausted, unless it becomes clear at some point during the collection activity that further action to collect the debt in full is not in the best interest of the Government."[49]

Circumstances that could lead to such a determination include HCFA's inability to collect the debt in full, a legal issue that raises doubts as to HCFA's ability to prove its case in court for the full amount, or the further cost of collecting the debt would exceed the amount of the debt.[50]

Although these provisions were promulgated pursuant to the Federal Claims Collection Act, we believe that government agencies should normally consider elements like these before agreeing to settle significant claims. It does not appear that these settlements, however, were negotiated

[49] HCFA's Guide, § 0306-1-45(I).

[50] *Id.* § 0306-1-45(E); 42 C.F.R. § 405.376(d).

after careful consideration of these factors. Indeed, as we reported previously, Mr. Booth told us that the settlements were not in the government's best interest. In apparently failing to consider these or similar elements before entering into these multimillion-dollar settlements, HCFA acted improperly, regardless of the applicability of the act and its associated regulations. Moreover, had HCFA considered these factors, it is unlikely that settlement would have been appropriate.

For example, HCFA appeared not to consider that all of the providers were able to pay the amounts owed. One of the providers, the home health agency, had established a reserve fund to pay most of the amount owed; and the fiscal intermediaries had already withheld the amounts owed by the other two providers by offset, so that no additional payment was necessary from them.

Further, it does not appear that there was a substantial risk of loss should HCFA or its intermediaries litigate these claims. In all three cases, the provider either claimed that it provided covered services or incurred bad debts; however all three providers lacked documentation to support any of these claims. Therefore it is unlikely that any of the providers could have mounted strong defenses. Moreover, the fiscal intermediaries, who would represent HCFA in any legal action to collect these debts, were confident in their ability to prevail. Although a risk in litigation always exists, consideration of "litigation risk" does not appear to justify settlement. Even if settlement had been appropriate, HCFA regulations require that the amount accepted in compromise be reasonable in relation to the amount that can be recovered by enforced collection proceedings.[51] Since it appears there was little litigation risk to HCFA to collect the full debt, the significant compromise of the amounts owed in these three matters is apparently unjustified.

Consideration of the cost of collection also would not justify these settlements. Under both HCFA and the Federal Claims Collection Standards, costs of collecting should not normally carry great weight in the settlement of large claims.[52] It is unlikely that the cost of collecting these debts, which collectively approximated $332 million, could outweigh their recovery.

[51] 4 C.F.R. § 103.4, 42 C.F.R. § 405.376(h).

[52] HCFA's Guide, § 0306-1-45(B) (4).

Settlement Agreements Contained Questionable Provisions and Were Not Reviewed by HCFA's Office of General Counsel

The agreements contained several provisions that were not in accord with HCFA's guidance for settling claims. For example, HCFA agreed to waive interest in the settlement with the home health agency, despite contrary direction contained in its financial management guide.[53] It also permitted the home health agency to pay part of its debt in installments, which should be considered "only in rare instances."[54]

Moreover, two of the agreements explicitly permitted the providers to continue to be reimbursed for costs regardless of whether they were actually incurred. The settlement with the home health agency permits it to be reimbursed in the future for costs that might not be covered by Medicare, although capped at a specific level. Similarly, the 1996 agreement with the hospital permits it to be reimbursed for bad debts without documentation as otherwise required by regulation.[55]

In addition, none of the three agreements were reviewed by HCFA's OGC or any other government attorney before they were executed, even though HCFA's internal guidance requires that debts of over $100,000 be referred to Justice through HCFA's central office and OGC.[56] The failure to subject these agreements to review by HCFA's attorneys was intentional, since Mr. Booth told us that he knew the settlements would not get done as they were written if OGC were involved. The lack of legal review is further evidence of HCFA's failure to assess the litigation risks and other factors involved before settling these matters. We also believe that legal review is appropriate before government officials sign agreements relinquishing the government's right to recover tens of millions of dollars.

[53] HCFA's Guide directs HCFA to charge interest on all debts owed the government unless a different rule is prescribed but requires that interest be charged on all debts paid in installments. Id. § 0306-1-40(P)(1). Note, however, that HCFA's regulations provide for the adjustments to interest charges for overpayment determinations reversed administratively. 42 C.F.R. § 405.378(h)(2).

[54] HCFA's Guide, § 0306-1-45(E).

[55] 42 C.F.R. § 413.20(d).

[56] HCFA's Guide, § 0306-1-20(C).

Conflict-of-Interest Concerns

The Standards of Ethical Conduct instruct government officials not to participate in a matter if a reasonable person with knowledge of the relevant facts would question their impartiality, unless authorization to participate has been received from an appropriate agency ethics official.[57] Although Mr. Vladeck's participation in the settlement of the hospital's debt occurred more than a year after he had left the hospital's Board of Directors, in our view Mr. Vladeck should have been concerned about the appearance of his involvement and sought authorization to participate in the negotiations from appropriate agency officials.[58]

We also learned that Mr. Vladeck had failed to disclose his previous affiliation with the home health agency's Advisory Committee on the public financial disclosure forms he filed upon his appointment. Our inability to interview Mr. Vladeck prevents us from assessing whether this omission was intentional and a violation of law.[59]

HCFA's Unsatisfactory Response to Our Questions

We interviewed Sheree Kanner, HCFA's current Chief Counsel, and Michelle Snyder, HCFA's current Chief Financial Officer, who were unable to advise us about HCFA's claims collection processes or provide an opinion on whether the three settlements discussed above complied with the Federal Claims Collection Act. Subsequently we were advised that HCFA would provide us written correspondence addressing these specific issues and its opinion about the legal sufficiency of the three settlements. Michael Hash, HCFA's Deputy Administrator, sent us a letter that neither addressed these issues nor expressed HCFA's view of the three settlements. Mr. Hash and Ms. Snyder both informed us, however, that a working group is examining "debt collection" issues and they expect it to make recommendations in the future.

[57] 5 C.F.R. § 2635.502(a)(2) (1998).

[58] Government employees are prohibited from participating in a particular matter that is likely to have a direct and predictable effect on the financial interest of entities in which they served as an officer or employee within the previous year . *Id.* § 2635.502.

[59] 18 U.S.C. § 1001 (Supp. IV 1998).

Scope and Methodology

We conducted our investigation from May through December 1999. We interviewed current and former HCFA, HHS, fiscal intermediary, Justice, and provider officials and others. We also reviewed documentation from these and other sources.

We sought Mr. Vladeck's interview to discuss (1) his views about HCFA's settlement practices during his tenure as administrator, (2) his involvement in the three settlements discussed above and others, (3) whether he had considered how his involvement might appear to third parties, and (4) his failure to disclose his affiliation with one of these providers on his financial disclosure forms. Although Mr. Vladeck initially agreed to meet with us, his attorney later told us that his client would be unavailable for interview.

As discussed with your office, unless you announce its contents earlier, we plan no further distribution of this report until 30 days after the date of this letter. At that time, we will send copies of this report to interested congressional committees and members and make copies available to others upon request. If you have questions about our investigation, please contact Deputy Director for Investigations Donald Fulwider or me at (202) 512-6722. Special Agent William Hamel was a key contributor to this investigation.

Sincerely yours,

Robert H. Hast
Acting Assistant Comptroller General
for Special Investigations

Investigation of HCFA's 1995 Settlement With a Home Health Agency

Chronology of Overpayment Determination

In September 1991, the fiscal intermediary completed its audit adjustment for a provider, a home health agency, for 1989. As a result, the fiscal intermediary notified the home health agency that a Notice of Program Reimbursement (NPR) would be issued. The fiscal intermediary determined that the home health agency had billed Medicare an average cost per home health aide visit that was more than 3 times HCFA's published limit. HCFA's cost limit for that year was about $50 per visit, but the home health agency had claimed about $160 per visit. Further, the fiscal intermediary determined that while the average length for a Medicare home health aide visit was 3.3 hours, the average home health agency's non-Medicare patient visit was 12 hours in length.[1] The fiscal intermediary had deemed the home health agency's costs and hours to be unreasonable and further determined the longer length of visits indicated that a different service type had been inappropriately added to the calculation. To add support for its proposed adjustment, the fiscal intermediary conducted a survey that compared the average cost and average length of service by home health agencies in several large urban areas and found that the subject home health agency's billings were disproportionately high and unreasonable. The fiscal intermediary concluded that the home health agency had violated a basic Medicare principle of reasonable costs as codified at 42 C.F.R. section 413.9(b)(1), which states,

"...[T]he costs with respect to individuals covered by the [Medicare] program will not be borne by individuals not so covered and, the costs with respect to individuals not so covered will not be borne by the program."

The home health agency disagreed, and the fiscal intermediary gave it an opportunity to furnish documentation to support its contention that it was providing services similar in type to its non-Medicare patients who were, in fact, Medicaid patients. According to the fiscal intermediary, the additional documentation that the home health agency furnished to the fiscal intermediary failed to demonstrate that the Medicaid patients had received services similar to those provided the Medicare patients.

[1] Calculation of a home health agency's average per-visit length and cost can include non-Medicare visits, provided the visits are for services that are allowable under Medicare.

According to a fiscal intermediary official, based upon the home health agency's angry and hostile posture in 1991, the fiscal intermediary had sought guidance and support from HCFA's Central Office. As a result, HCFA instructed the fiscal intermediary to perform a medical review of a sample of non-Medicare patient files to determine if the services provided would be covered for Medicare patients and to project the disallowed costs from the sample.[2]

The fiscal intermediary performed an on-site medical review of about 60 of the home health agency's non-Medicare patients. It found that only 27 percent of the non-Medicare patient visits were found to be Medicare-like. The medical review determined that many of the services provided during the longer Medicaid patient visits were homemaker services, which are not covered by Medicare. In addition, the fiscal intermediary found multiple other deficiencies in the non-Medicare patient files that the fiscal intermediary believed would have been grounds for denial had they been Medicare patients. These included such deficiencies as no physician services being rendered, services provided beyond what a physician ordered, no documentation, or incomplete documentation of services.

As a result of a request by Charles Booth, HCFA's then Director, Office of Payment Policy, on February 2, 1993, HCFA's Office of General Counsel (OGC) issued a memorandum that concluded that the fiscal intermediary was correct to exclude all non-Medicare visits of patients that did not meet basic Medicare eligibility, including the homebound requirement. OGC added that the fiscal intermediary should also exclude from the reimbursement calculation any non-Medicare visit that is not of the same type as a Medicare visit, namely those longer visits that provided primarily homemaker-type services. OGC determined that the fiscal intermediary's proposed audit adjustment "would be legally supportable." Lastly, OGC recommended that the Medicare manuals and possibly the regulations on which they are based be amended to clarify HCFA's policies regarding this billing situation.

[2] On Nov. 25, 1991, Barbara J. Gagel, HCFA's then Director, Bureau of Program Operations, wrote a memorandum to the Regional Administrator with instructions for conducting the medical review of the home health agency. This internal HCFA memorandum contains information that appears to be for government use only; however, the home health agency obtained a copy. The copy that the home health agency produced to us appears to have been faxed from HCFA's Bureau of Policy Development, but the home health agency was unable to tell us how or when it obtained it.

Sometime in May 1993, the home health agency's president, Chief Financial Officer (CFO), General Counsel, outside counsel, and others met with Mr. Booth and other HCFA staff in HCFA's Central Office in Baltimore, Maryland, to discuss the disputed matter. According to the home health agency's CFO, the purpose of the meeting was to get the issue before HCFA officials because they thought the fiscal intermediary was being unreasonable in its approach.

On July 28, 1993, a newspaper reporter requested that HCFA produce a list of the top 50 home health agencies by amount billed to Medicare. The list produced to the newspaper indicated that the subject home health agency was the largest Medicare-billing home health agency in the United States; the next largest had about one-third of the subject home health agency's total billings. A memorandum drafted on or about August 16, 1993, to HCFA Administrator Bruce Vladeck advised of the home health agency's status in this regard and that the home health agency's billings were "considerably higher than all other home health agencies." In an August 25, 1993, note to a HCFA analyst, a HCFA official expressed concern "about how HCFA could be critized [sic] on [the home health agency's] higher cost." On August 30, 1993, a faxed note between two high-level HCFA officials addressed the issue of the home health agency's higher billings stating, "We need to look into this this week because the response to the [newspaper reporter's] request will be released this week and the Administrator's Office wants to be prepared."

On September 20, 1993, at the request of senior fiscal intermediary representatives, HCFA senior staff, including Mr. Booth, met with the fiscal intermediary to discuss the case. According to the fiscal intermediary officials, the fiscal intermediary was trying to get HCFA to decide whether or not to support the proposed 1991 audit adjustment. During this meeting, the fiscal intermediary's then Director of Finance made a formal presentation to HCFA that demonstrated the findings of the medical review and the basis for the fiscal intermediary's opinion that the home health agency had billed improperly. According to the fiscal intermediary, HCFA made no decisions after this meeting. However, HCFA had been representing to the fiscal intermediary as early as April 1992[3] that it would

[3] In a letter dated Oct. 14, 1992, sent by the fiscal intermediary to HCFA, the fiscal intermediary expressed its concern that HCFA had as of that date failed to provide a decision. In the letter, it references a HCFA representation from April 1992 that HCFA would be providing a decision in the near future.

be issuing guidance "in the near future." During this entire period, the home health agency continued to bill Medicare using the same methodology that had caused the 1991 proposed audit adjustment. However, the home health agency had set up a reserve fund to cover any potential Medicare overpayment.

Chronology of Settlement Negotiations

On November 3, 1993, as a result of HCFA Administrator Vladeck's agreeing to speak at an event co-sponsored by the home health agency on November 8, 1993, Mr. Booth, Director of HCFA's Office of Payment Policy, sent a memorandum to HCFA's Public Affairs office. The memorandum stated, in part, that HCFA was in the process of resolving a payment issue with the home health agency and anticipated collecting an estimated Medicare overpayment of $57 million. At that time, the estimated calculated overpayment included additional years beyond 1988.

Thomas Ault, HCFA's former Director, Bureau of Policy Development, told us that Mr. Vladeck had approached him on November 9, 1993, while attending a HCFA senior staff meeting. Mr. Vladeck advised Mr. Ault that during the prior day, while giving a dinner speech at the home health agency's co-sponsored conference, the home health agency's president approached Mr. Vladeck and requested a settlement to get closure on the overpayment issue. Mr. Vladeck told Mr. Ault that he (Mr. Vladeck) wanted the matter "moved along and settled" and not to keep Mr. Vladeck informed of the details because of Mr. Vladeck's prior relationships in the geographic location of the home health agency. According to Mr. Ault, he assigned the matter to Mr. Booth; and the two met shortly afterward on November 12, 1993, to discuss Mr. Vladeck's instructions. According to Mr. Ault, he told Mr. Booth that Mr. Vladeck wanted this done. Mr. Booth acknowledged this conversation and added that Mr. Ault had advised him that the settlement was to be "an accommodation" to the home health agency at Mr. Vladeck's request and for a "friend" of Mr. Vladeck. Mr. Booth told us that he and Mr. Ault were both "circumspect" and "uncomfortable" with making the settlement because of this situation. He continued that Mr. Ault was uncomfortable specifically because of the large size of the overpayment.

On November 24, 1993, Mr. Ault convened a meeting of HCFA and fiscal intermediary personnel to discuss the issue. As a result, he became convinced that the fiscal intermediary was correct in its interpretation of the Medicare reimbursement regulations that the fiscal intermediary should recover the overpayments.

On December 22, 1993, Mr. Booth sent the fiscal intermediary a signed letter discussing the regulations and policy regarding home health aide visits.[4] This letter was the guidance for which the fiscal intermediary had been waiting over 2 years. In the letter, Mr. Booth stated that the fiscal intermediary should apply Medicare coverage criteria in determining if non-Medicare patients are to be included in the cost-per-visit calculation for reimbursement. The home health agency obtained an unsigned copy of this letter.[5] According to calendar entries maintained by Mr. Ault, he and the home health agency's outside counsel had discussed the home health agency's issues on December 15, 1993. Another entry on December 22 mentions the "home-bound" issue. According to a handwritten note dated "12/30" provided to us by HCFA, Mr. Ault spoke with someone who appears to be the home health agency's outside counsel; and as a result, the letter "was revised to delete the suggestion that the intermediary could review [a] patient's qualification of being homebound." A fiscal intermediary official told us that removing this homebound requirement weakened the guidance from HCFA. According to the home health agency's CFO, the home health agency was unhappy with the December 22 version of the guidance letter, which stated that non-Medicare patients that are included in the per-visit calculation must meet the Medicare "homebound" requirements. On December 28, 1993, Mr. Booth sent the fiscal intermediary a revised version of this letter that removed the reference to applying Medicare qualifying criteria to the non-Medicare patients even though the February 2, 1993, HCFA OGC legal opinion had concluded that application of all Medicare requirements to the non-Medicare patients, including the homebound requirement, was correct.

On February 8, 1994, the fiscal intermediary met with the home health agency; a HCFA regional office representative was also present. During this meeting, the fiscal intermediary again presented its conclusions and its intentions to make the audit adjustment per HCFA instructions. The home health agency made an offer to settle and presented an offer of being allowed the Medicare average visit length plus 5.5 hours. The fiscal intermediary gave the home health agency the opportunity to provide additional support for its position. On February 8, 1994, Mr. Booth advised

[4] Documents provided to us by the home health agency indicate that on or about May 4, 1993, the home health agency obtained an unsigned version draft of this letter. Home health agency officials were unable to state how they obtained this.

[5] This draft is copied to the home health agency's outside counsel. The home health agency's outside counsel was a former attorney in HCFA's OGC.

Mr. Ault by e-mail that the meeting had taken place. He advised Mr. Ault of the home health agency's offer, the fiscal intermediary's response, and the planned issuance of the NPRs, stating that "the provider is not happy." Mr. Booth also advised that he expected the home health agency's outside counsel to be contacting Mr. Ault "fairly soon."

On February 18, 1994, the home health agency submitted the fiscal intermediary its written proposal that offered to remove the 24-hour visits, which lowered its average visit length to 9 hours. However, this lowered average still had many 12-hour visits included in it. According to the fiscal intermediary, the home health agency's proposal failed to respond to the specific concerns raised by the fiscal intermediary because (1) it was unable to document that the non-Medicare visits were of a Medicare type and (2) it did not respond to the other concerns noted during the medical review. On February 18, 1994, Mr. Booth e-mailed Mr. Ault with an update on the matter and advised that the NPRs would "be issued 2/28 as planned."

On February 22, 1994, the home health agency and the fiscal intermediary discussed the February 18, 1994, proposal paper. In a February 23 memorandum from the fiscal intermediary to HCFA, the fiscal intermediary advised that during a conference call, the home health agency had been unable to respond to the specific concerns raised by the fiscal intermediary, and it had been unable to document that the non-Medicare patient visits were of a Medicare type. The home health agency was also unable to respond to the fiscal intermediary's earlier findings concerning lack of documentation and physician orders. The fiscal intermediary advised the home health agency that the content of the February 18, 1994, "proposal did not warrant an extension of the February 28, 1994[,] deadline" for issuance of the NPRs and that in keeping with "direction from HCFA," the NPRs would be issued on that date.[8] According to the memorandum, the home health agency asked with whom the fiscal intermediary was speaking at HCFA and indicated the home health agency's intention to speak further about this matter with the president of the fiscal intermediary. The fiscal intermediary's Director of Finance said that the home health agency made

[8] According to a fiscal intermediary memorandum, on Feb. 16, 1994, the home health agency's CFO called the fiscal intermediary. On Feb. 17, the fiscal intermediary returned the call. The home health agency's CFO requested an additional 2 weeks beyond the February 28 deadline for NPR issuance that the fiscal intermediary had given the home health agency. The fiscal intermediary told the home health agency that, in consultation with HCFA, the deadline date was firm. However, the home health agency's CFO "was not satisfied" and asked that the fiscal intermediary's president review the request for more time.

"threats to use its influence with their political clout" to get the matter resolved. According to a former official of the fiscal intermediary, the fiscal intermediary believed that the home health agency was "politically powerful" and that the home health agency had more influence with HCFA than the fiscal intermediary did. On February 22, 1994, Mr. Booth e-mailed Mr. Ault. He wrote in part,

"[The home health agency and the fiscal intermediary] reached an impasse; [the home health agency] wants the FI [fiscal intermediary] to just add 5.5 hours to each visit because patients are sicker in [that state]. The FI says there is no justification; give us something to show any adjustment makes sense, but [the home health agency] apparently has nothing. I continue to tell [the fiscal intermediary's Director of Finance] that we agree with their position and to proceed with the NPRs. [The fiscal intermediary's president] is afraid we [HCFA] will point fingers and wants to figuratively hold your hand so you can't."

On February 25, 1994, the home health agency submitted another proposal to the fiscal intermediary offering to remove all visits of 12 hours or more from the hours-per-visit calculation, which would result in repaying approximately $56 million of the overpayment for years 1988 through 1993. The home health agency's CFO told us that the home health agency had set up a reserve fund that had about this amount in it and that it was the home health agency's intention not to pay more than what it had in the reserve fund.

The fiscal intermediary ceased to negotiate with the home health agency and on February 28, 1994, sent NPRs for cost report years 1988, 1989, 1990, and 1991 to the home health agency, demanding repayment of over $33.5 million.[7] The fiscal intermediary had projected overpayments for 1992 and 1993, but NPRs were not prepared as of this date. However, a projection was made that the total overpayment would approximate $98 million.

On March 2, 1994, the home health agency's attorney faxed a letter to Mr. Booth, arguing why the fiscal intermediary's audit adjustments were incorrect and stating that the home health agency's February 25, 1994, proposal was "a most reasonable proposal to settle this long standing issue." The home health agency's attorney also requested that the home health agency be able to negotiate a settlement directly with HCFA and asked to meet with Mr. Booth personally to discuss this further.

[7] The fiscal intermediary reopened the home health agency's 1988 cost report audit to seek recovery of funds from that year's billing.

On March 2, 1994, the fiscal intermediary's Director of Finance faxed and sent a letter to Mr. Booth, updating him on the most current overpayment calculation of about $98 million as compared with the home health agency's offer to repay about $56 million. The offer to pay $56 million equated to allowing the home health agency 7 hours per visit for the years in question as opposed to the Medicare average of 3.6 hours. The fiscal intermediary's Director of Finance further recommended that HCFA not accept the home health agency's proposal and wrote,

"In our opinion, any calculation resulting in average hours in excess of the Medicare average, (which is 3.6 hours for the six years involved), results in a duplicate payment. This conclusion is based on the fact that the majority of other than Medicare visits are provided to Medicaid patients and are paid for on a per hours basis .... Thus, in 1989 [the home health agency's] Medicare beneficiaries received, on average, 18 home health visits of a 3.5 hours duration, while their non-Medicare counterparts (principally Medicaid) were provided 71 visits averaging 12 hours in length. We feel that accepting a methodology excluding all costs associated with visits exceeding a specified length would be establishing a precedent. Our concern is not limited to the future impact on [the home health agency], but the impact on a national level. Aggressive consultants and provider associations could view this established hour limit as a guideline and, in fact, include visits previously considered to be non-home health aide in the calculation of average cost per visit. This could increase the overall cost to the Medicare program."

According to notes written by the fiscal intermediary's Director of Finance, the home health agency's president called Mr. Vladeck on March 2, 1994. Two March 3, 1994, handwritten notes by the fiscal intermediary's Director of Finance indicate that on March 2 the Director of Finance had spoken with Mr. Booth, who advised that the home health agency's president had called Mr. Vladeck. One note dated March 3, 1994, written to the file reads "—President of [the home health agency] called Vladeck yesterday (3/2)."

The fiscal intermediary's Director of Finance wrote a second note that day to the fiscal intermediary's president. It states,

"HCFA CO [Central Office] is reviewing [the home health agency's] most recent proposal which would have them repay $56M for the six year period FY88-93 instead of the $97M we've calculated. I should hear more from them today.

"[The home health agency's] president called Bruce Vladeck yesterday. As a result, Bruce asked Tom Ault and Chuck Booth for an update and was *apparently* OK with how its [sic] going." (Emphasis is in the original.)

According to the fiscal intermediary's Director of Finance, the Director of Finance remembered the call with Mr. Booth and that the director's second note provided a status report to the director's superiors. The home health

agency's president confirmed with us that the call to Mr. Vladeck had taken place to request a meeting to "air out" the home health agency's views on the matter and "move towards some type of resolution" of the dispute.

Eight days later on March 10, 1994, Mr. Booth traveled to the home health agency's offices and negotiated a settlement. The fiscal intermediary had two representatives present. They met with the home health agency's president, senior staff, and outside counsel. Notes taken by one of the fiscal intermediary officials during the meeting states, "Per Bruce Vladeck + Tom Ault." Mr. Booth then negotiated a settlement for the home health agency to repay approximately $67 million and allowed the home health agency to add 1.63 hours to its Medicare average up to a 5.5-hour per-visit limit for all future years. No interest or penalties were assessed.[8] According to the fiscal intermediary, at the home health agency's request with HCFA's consent, the settlement was to be kept "secret." The home health agency's president and Mr. Booth both confirmed to us that an agreement was made not to disclose the settlement. The home health agency's president was concerned about negative publicity, and Mr. Booth was concerned that the terms of this agreement could negatively impact any future agreements with other providers since the fiscal intermediary was planning on taking similar action against other home health agencies. According to the fiscal intermediary, since NPRs are publicly available documents, the fiscal intermediary had to withdraw the February 28, 1994, NPRs for the 1988-1991 cost report years, which totaled over $33.5 million, in order to keep the settlement secret. The intermediary then issued new NPRs to reflect the newly negotiated settlement amount of about $21.75 million for those years. Thus, the existence of the original overpayment amount would not be disclosed. A payment schedule to repay a remaining $33 million in three more installments was also prepared. The balance of the settled $67 million was paid in offsets.

On March 16, 1994, Mr. Booth sent an e-mail to the regional staff stating, "I tried to send you a cc of a [e-mail] note I sent Bruce Vladeck, but I must have done something wrong. In that note, I commented that the FI did a great job and Bruce expressed his thanks to them." On March 17, 1994, this e-mail was forwarded to the fiscal intermediary's president who distributed it to fiscal intermediary staff with a memorandum stating that he wanted them "to know that Bruce Vladeck knows about the good work you did and he appreciates it."

[8] The fiscal intermediary had to return over $225,000 in paid interest.

On April 19, 1995, the written settlement agreement was executed. No attorney for the government ever reviewed any of the drafts or the final agreement. Mr. Booth advised us that he knew that the settlement as it was written would not have been accomplished had HCFA's OGC or the Department of Justice reviewed it, as he knew was required. According to the fiscal intermediary's former Director of Finance, the former Director actually drafted the settlement agreement and advised HCFA officials that not only should HCFA get the entire overpayment back but that the matter should be pursued for fraud. The former Director of Finance told HCFA that the home health agency knew what it was doing when it billed Medicare and that it was fraudulent, but HCFA's response was that it "was not going to pursue" the fraud issue.

According to documents provided us by the home health agency and what the home health agency's president told us, immediately prior to becoming HCFA Administrator, Mr. Vladeck sat on an Advisory Committee for a research division of the home health agency. The home health agency's president told us that Mr. Vladeck accepted the invitation for membership of the Advisory Committee, attended one meeting, and resigned the position when he was appointed HCFA Administrator. Mr. Vladeck did not report this professional association on any of the required federal financial disclosure reports. The home health agency's president also told us that the home health agency invited Mr. Vladeck to become a member of the home health agency's Board of Directors shortly after Mr. Vladeck left HCFA. The home health agency later rescinded the offer.

Mr. Booth told us that this was a bad settlement that was not in the best interest of the government but that it was done on behalf of a "friend" of Mr. Vladeck.

Investigation of HCFA's 1996 Settlement With a Hospital

Chronology of Overpayment Determination

Between 1983 and 1993, a provider hospital submitted cost reports claiming reimbursement for, among other costs, bad debts without maintaining the proper bad debt documentation. In each year that the hospital's fiscal intermediary disallowed these costs, the hospital appealed the disallowance to the Provider Reimbursement Review Board (PRRB). Over the 11-year period, the fiscal intermediary had disallowed approximately $155 million in costs and withheld that money from the hospital's future claims administratively to recover the disallowances that included costs for bad debts and graduate medical education costs. As of 1996, the PRRB had not heard the appeals on bad debt matters; but hearings had been scheduled and both the hospital and the fiscal intermediary were preparing for litigation.

According to interviews and documents, in early 1993 the then Chairman of the Board of Directors of the hospital contacted William Toby, HCFA's then Acting Administrator, to discuss the outstanding PRRB appeals for graduate medical education costs. The issue of disallowed bad debt claims was addressed later and became the substantive aspect of the final settlement. Bruce Vladeck was nominated to be HCFA Administrator on April 28, 1993. His financial disclosure forms show that Mr. Vladeck was a member of the hospital's Board of Directors until April 1993 and was appointed HCFA Administrator on May 26, 1993.

On May 25, 1993, the then Chairman of the Board of Directors of the hospital, accompanied by his Vice President for Finance and Capital/Chief Financial Officer and an Assistant Vice President for Corporate Reimbursement Services, met in Washington, D.C., with Mr. Toby; Thomas Ault, HCFA's then Deputy Director of Policy Development; and Darrell Grinstead, HCFA's then Chief Counsel. The hospital presented its issues and concerns about the outstanding appeals on graduate medical education costs as a result of its claimed higher graduate medical education costs. Between July 1993 and April 1995, the hospital, HCFA, and the fiscal intermediary had numerous meetings and discussions and exchanged correspondence on how to resolve the outstanding graduate medical education issues. According to the hospital's Assistant Vice President for Corporate Reimbursement Services, it is common practice for the hospital to use political influence or interference with HCFA to achieve resolution to disputes if the hospital is not satisfied with the fiscal intermediary. Mr. Ault recalled meeting with the hospital and stated that graduate medical education was an issue for which HCFA had disputes with many providers because HCFA had failed to issue graduate medical education

regulations in a timely manner pursuant to legislation that had been implemented several years earlier.

Initiation and Negotiation of Settlement

On January 19, 1996, the hospital's Vice President for Finance and Capital/Chief Financial Officer wrote a memorandum to the hospital's then Chairman of the Board of Directors. The memorandum listed the subject as "Further Details for HCFA Meeting," addressed the issues under appeal, and discussed the matters in what appears to be a briefing document prior to a meeting with HCFA. Charles Booth, HCFA's then Director of Hospital Policy, told us that a hospital official had advised him that the memorandum was written in preparation for a meeting on the appeals issues between the hospital's then Chairman of the Board of Directors and Mr. Vladeck. According to a note from Mr. Booth to a HCFA regional staff person, the hospital's then Chairman of the Board of Directors gave the January 19, 1996, memorandum to then HCFA Administrator Bruce Vladeck during a meeting. Based upon interviews and documents, this meeting occurred sometime between January 19, 1996, and February 16, 1996. According to the hospital's then Chairman of the Board of Directors, the chairman had met with Mr. Vladeck. However, the chairman remembered neither discussing the appeals issues nor giving the January 19, 1996, memorandum to Mr. Vladeck. Further, the hospital's Vice President for Finance and Capital/Chief Financial Officer did not recall this memorandum. Notes taken by a fiscal intermediary official present during the first settlement negotiation meeting, which took place later, stated that Mr. Vladeck had met with the hospital's then Chairman of the Board of Directors on the appeals issues. According to Mr. Booth, sometime between January 19, 1996, and February 16, 1996, Mr. Vladeck instructed him to make a settlement with the hospital.

On April 18, 1996, Mr. Booth and other HCFA officials met in HCFA's Central Office with the hospital's Vice President for Finance and Capital/Chief Financial Officer, the Assistant Vice President for Corporate Reimbursement Services, and another senior staff member to discuss the issues and a potential resolution to the appeals. The hospital prepared an agenda of the outstanding discussion issues that included the PRRB appeals and bad debts.

The hospital produced to us another agenda entitled "HCFA MEETING" dated June 10, 1996, which lists item II as "STOP PRRB HEARINGS AND NEGOTIATE ITEMS."

On June 13, 1996, the hospital's Vice President for Finance and Capital/Chief Financial Officer, Assistant Vice President for Corporate Reimbursement Services, and another senior staff member met again with Mr. Booth—this time at HCFA's regional office—to negotiate a settlement with fiscal intermediary representatives present.

On June 21, 1996, the fiscal intermediary prepared a financial spreadsheet calculating the bad debt settlement amount by using a percentage used in a prior bad debt settlement with the hospital. The resulting calculation would have had HCFA release $42 million to the hospital for the bad debts disallowed and withheld. Mr. Booth could not explain to us how the amount almost doubled to $82 million in the final settlement.

According to Mr. Booth, Mr. Vladeck informed Mr. Booth that he (Mr. Vladeck) "had to tell the sixth floor something," referring to the location of the offices of the Secretary of Health and Human Services (HHS), of which HCFA is a component. Mr. Booth told us that it was his understanding that the settlement was to be made based upon orders from persons in supervisory positions to Mr. Vladeck. Mr. Booth told us that Mr. Vladeck had required him to give briefings every 3 to 4 weeks on the status of the settlement. At one point in July 1996, Mr. Vladeck e-mailed him, complaining that the settlement was taking too long to accomplish. Mr. Booth advised Mr. Vladeck that speeding up the settlement process could cost HCFA an extra $8 million to $10 million. In response, Mr. Vladeck suggested "that time was more important than money" and instructed him to move faster.

Kevin Thurm, the then Chief of Staff to the HHS Secretary and the current Deputy Secretary, HHS, told us that he had instructed Mr. Vladeck to ask about the hospital's outstanding disputed claims because Mr. Thurm had received an inquiry from a Member of Congress. This Member had told Mr. Thurm that he was concerned that, due to impending budget cuts, the hospital would curtail its services. Mr. Thurm told us that he was concerned about this and spoke to Mr. Vladeck on several occasions to determine the status of the situation. He made his concern clear to Mr. Vladeck.

During July and August 1996, representatives of the hospital, the fiscal intermediary, and HCFA, including Mr. Booth, met twice more and held conference calls to work out the final details of the negotiated settlement.

On September 24, 1996, a finalized settlement agreement was executed, whereby the fiscal intermediary agreed to pay $130 million of the withheld overpayments to the hospital. HCFA agreed to accept $25 million of the approximately $155 million in overpayments.[1] The hospital agreed to withdraw all but three of its outstanding PRRB appeals. In the settlement, HCFA agreed to allow the hospital to continue to bill for bad debts indefinitely into the future without any documentation to support its costs. According to HCFA and fiscal intermediary officials, the formula used to arrive at the bad debt payment for past and future years was developed with no verified or empirical data.

One senior fiscal intermediary official told us that, based upon the settlement agreement, there is no point continuing to audit the hospital's bad debts since HCFA had agreed to pay them without documentation or support. This official also told us that this settlement is unfair because all providers except this one are required to adhere to regulations to support their costs. He also "feels uncomfortable" telling all other providers that they have to adhere to regulations while this hospital does not. A regional HCFA official who participated in the settlement process expressed the same concerns to us about what he termed the settlement's "perpetuity" provision. He further stated that the settlement made an effective waiver to HCFA's regulations requiring the documentation of costs. HCFA maintained no documentation of this settlement, not even the agreement itself. Further, no attorney for the government ever reviewed this settlement because, as Mr. Booth told us, the deal "would go up in smoke" had HCFA's OGC or the Department of Justice known about it. Mr. Booth also advised that of the three settlements he did for Mr. Vladeck, this was the worst because he said the direction to settle came from the HHS Secretary's office.

[1] The hospital received about $84 million for bad debts, $8 million for graduate medical education, and $38 million broken down into several other amounts for other issues.

Investigation of HCFA's 1997 Settlement With a Hospital

Chronology of Overpayment Determination

Between 1987 and 1993, a provider hospital submitted cost reports claiming reimbursement for, among other costs, bad debts without the proper supporting documentation. During the 1987-93 time period, the hospital's fiscal intermediary disallowed these costs. The hospital calculated the reimbursement impact of the total appealed costs at $79.4 million,[1] of which $50.5 million was for bad debts. In each year that the fiscal intermediary made a disallowance for lack of documentation for bad debts, the hospital appealed the disallowance to the Provider Reimbursement Review Board (PRRB). As of late 1996, the PRRB had not yet heard the appeals. According to fiscal intermediary and regional HCFA officials, the hospital's chances of prevailing in the PRRB hearings were not good because the hospital could not document its bad-debt costs. Additionally, according to these same officials, every time a PRRB hearing was scheduled, the hospital requested a postponement because, the officials believed, of the likely resulting loss. The hospital official responsible for preparing and submitting claims to Medicare told us that the hospital did not have the documentation because of resource limitations.

According to the hospital and HCFA officials, in fiscal years 1995-96 and 1996-97, the hospital had substantial budget shortfalls.

Initiation and Negotiation of Settlement

On September 10, 1996, the hospital representatives, while meeting with HCFA officials on an unrelated matter, asked HCFA if it could expeditiously settle the outstanding Medicare appeals pending before the PRRB as a way to infuse cash into the hospital to avert a curtailment of its health-care services. According to a former regional HCFA official, then HCFA Administrator Bruce Vladeck asked him to attend a meeting with the hospital representatives on Mr. Vladeck's behalf and report back the results.[2] This former HCFA official advised us that he had e-mailed Mr. Vladeck the details of the meeting and the hospital's request regarding the Medicare appeals. Although we were unable to obtain a copy of the actual e-mail sent, this former official was able to identify to us his draft

[1] This amount includes some cost report disallowance issues that predate 1987.

[2] We identified contacts between Mr. Vladeck and the hospital concerning Medicare billing issues dating as early as June 1996 in which Mr. Vladeck was advised by regional HCFA officials that the hospital's Medicare problems were attributable to the hospital's "long history of being late, incomplete, and/or inaccurate" in its billings.

e-mail to Mr. Vladeck that was retained in the HCFA regional office files. It stated that the hospital had "a number of 'frozen' Medicare appeals pending. If given a priority through the appeal system, the ones that [the hospital] 'wins' would provide the necessary funding." As a result, HCFA requested information from the hospital regarding the appeals.

On September 12, 1996, HCFA and the hospital officials held a conference call; and on September 26, 1996, the hospital responded in writing to issues raised during the conference call. The hospital wrote to HCFA's Central Office providing specific information on the outstanding appeals regarding its request "for expediting administrative resolutions through [the hospital's] fiscal intermediary." Regional HCFA staff advised that they had instructed the fiscal intermediary to attempt to administratively resolve the appeals with the hospital. However, regional HCFA and fiscal intermediary officials determined that an "administrative resolution" was inconceivable since the hospital was unable to document its costs.

On October 17, 1996, a HCFA regional staff person faxed the fiscal intermediary a request to evaluate information that the hospital had furnished to HCFA regarding the outstanding appeals issues. The fax coversheet stated "Need information for Bruce Vladeck." On October 21, 1996, the fiscal intermediary faxed and sent a response to the October 17 HCFA request with information that demonstrated that the hospital had numerous bad-debt appeals outstanding and had sought postponements to its scheduled PRRB hearings on these matters. On October 21, 1996, there was also a conference call between HCFA and the hospital officials. On October 24, 1996, a HCFA regional staff person faxed the hospital's Director of Finance a handwritten memorandum stating that the hospital and the fiscal intermediary needed to reconcile the documentation differences between the hospital and the fiscal intermediary and that HCFA needed to be satisfied that the hospital and the fiscal intermediary were working toward an administrative resolution. On November 6, 1996, the hospital's Assistant Director of Administrative and Financial Services wrote to HCFA providing additional documentation on the appeals issues. According to HCFA and the hospital officials as well as agendas given to us by the hospital, there were a number of meetings and conference calls between HCFA and the hospital on an unrelated matter but in which the appeals issue was discussed. HCFA and the hospital officials also told us that Mr. Vladeck had participated in many of these meetings, but we were unable to determine the ones in which he had participated.

On November 14, 1996, Charles Booth, HCFA's then Director of Hospital Policy e-mailed HCFA regional management, advising that he had been asked to look at the appeals issues. He further stated that over 3 years prior to this, the hospital had made a similar request to HCFA but HCFA and the hospital "were unable to agree on much of anything."

On November 15, 1996, Mr. Booth sent an e-mail to the HCFA Regional Office inquiring on the progress. In the e-mail, he wrote,

"[T]here may be some middle ground between the various [fiscal intermediary] positions and those of the hospitals which would allow the hospitals to get some money they might no [sic] otherwise receive until 1998. I believe the Administrator wants to at least have the question answered."

A HCFA regional official replied,

"[The fiscal intermediary] stated that the appeal issues are the result of [the hospital] not providing the [fiscal intermediary] with proper supporting documenation. [The hospital] has been very slow in providing the necessary documentation. They have also postponed a PRRB hearing on some of those appealed issues .... At this point, I don't know what more the [fiscal intermediary] can do to accelerate the resolution of these issues. [The hospital's] inability to provide proper supporting documentation appears to be the bottleneck."

During a November 21, 1996, conference call between the hospital and HCFA, the hospital was advised that Mr. Booth would be taking the matter over from the HCFA Regional Office to pursue a settlement on the appealed issues.

On November 27, 1996, Mr. Booth e-mailed the Regional Administrator stating, "I believe Bruce Vladeck hopes we can move this process faster than [the fiscal intermediary] will because of the lack of good documentation." On November 29, 1996, the Associate Regional Administrator sent an e-mail to the Regional Administrator advising, "I don't know what [Mr. Booth] thinks we can 'negotiate' but...without additional documentation from providers [the fiscal intermediary] cannot go further." Minutes later, the Regional Administrator sent an e-mail to Mr. Booth stating, "Can we talk about what you have in mind for moving this along? I've had discussions with [regional staff] and don't know what can be suggested given what they told me about the lack of documentation by the providers." According to HCFA officials we interviewed, the only assistance that HCFA could provide to the hospital would be to reprioritize the scheduled PRRB hearings so that the hospital would go ahead of other scheduled providers for the hearings. According to these officials, it was unheard of to "subvert" the appeals process completely.

On December 2, 1996, the hospital sent an e-mail to the HCFA regional office with additional information regarding the appeals issues. On December 3, 1996, HCFA's Regional Office forwarded this information to Mr. Booth at the HCFA Central Office. On December 19, 1996, a HCFA regional staff person e-mailed Mr. Booth advising whom he should contact at the hospital.

On December 30, 1996, the hospital's Director of Program Reimbursement teleconferenced with Mr. Booth, who requested additional information on the Medicare appeals.

According to a memorandum written on or about January 8, 1997, by the hospital's Director of Program Reimbursement, Mr. Booth notified the hospital officials that Mr. Booth was "delegated the authority to negotiate settlements regarding Medicare appeals with [the hospital]" and "...will identify several issues that he would be willing to negotiate." The hospital's Director of Program Reimbursement told us that this conversation may have occurred in December 1996.

On January 9, 1997, the hospital's Director of Program Reimbursement sent Mr. Booth the additional information requested during the December 30, 1996, telephone call. The hospital's Director of Program Reimbursement also wrote, "...I would like to thank you for yesterday's assistance in drafting a status for our Board regarding HCFA's commitment to the project, and your willingness to negotiate appeal resolutions...."

On January 15, 1997, Mr. Booth faxed a letter to the fiscal intermediary requesting additional information. He wrote, "At this point, I'm trying to identify which issues may be ripe for some sort of settlement before I try to negotiate any specific deal. Anything you want to tell me will be appreciated and will be kept confidential if necessary."

According to memorandums written by the hospital's Director of Program Reimbursement, on January 29, 1997, Mr. Booth teleconferenced with the hospital's Director of Program Reimbursement to discuss the issues for the settlement. On February 12, 1997, Mr. Booth teleconferenced again with the hospital's Director of Program Reimbursement and discussed a financial schedule that identified over $50 million in bad debts between fiscal years 1986-87 and 1996-97. The memorandum states that Mr. Booth asked the hospital for an initial settlement offer and that the hospital advised it was waiting for HCFA's initial offer. The hospital's Director of Program Reimbursement told us that he believed that the calculated $79.4 million of disallowances in dispute "could be considered the initial offer" to HCFA. On February 18, 1997, Mr. Booth, whose title had changed to Acting Deputy Director, Bureau of Policy Development, teleconferenced with the hospital's Director of Program Reimbursement and offered to settle by paying the hospital $51 million in withheld funds, with certain stipulations.[3] However, according to Mr. Booth, the hospital had already learned of the offer from Mr. Vladeck, who apparently contacted higher-level hospital officials. Mr. Booth advised that he had briefed Mr. Vladeck on the status of the negotiations and told Mr. Vladeck that he (Mr. Booth) would be offering to settle for $51 million. Mr. Booth told no one else of this offer before contacting the hospital. However, when he contacted the hospital, he was told that they already knew of the offer.

The fiscal intermediary's Manager for Medicare told us that the HCFA Regional Administrator had contacted her sometime in late February or early March and told her that there "was a very important special arrangement" that HCFA was working out with the hospital.

On or about March 3, 1997, Mr. Booth faxed a copy of a draft settlement agreement to the fiscal intermediary and, on or about the same date, transmitted a copy to HCFA's Regional Office for comments. On March 4, 1997, the fiscal intermediary faxed a note to HCFA's Regional Office advising that it had no comment on the draft settlement agreement. A March 5, 1997, note written by the fiscal intermediary's Manager for Appeals to her supervisor indicates that the fiscal intermediary had no comments on the draft because the fiscal intermediary did not know how the hospital had calculated the appeals reimbursement impact. Mr. Booth

[3] These stipulations were that the hospital withdraw its appeals, not use the settlement as precedent for resolving other appeals, and not use in other negotiations any potential resolutions discussed but not settled.

advised that no written response was necessary. Fiscal intermediary management told us that they did not think the settlement was appropriate because it "subverted the PRRB process." They said it was thus unfair to other providers that have to go through this process. According to the management, they told this to Mr. Booth who replied, "HCFA was looking into it."

On March 6, 1997, the Manager for Program Safeguards for the regional office wrote an e-mail to Mr. Booth on behalf of the Associate Regional Administrator:

"As we discussed earlier in our phone call with you, we have some major concerns with an agreement of this type. It appears this is a political action on the part of [the hospital] to circumvent Medicare requirements and undermine the Medicare's administrative resolution process. It sets a bad precedence [sic] especially since [the hospital] has been a 'problem child' for years and years. Furthermore, based on our discussions with [the fiscal intermediary] about some of these appeal issues, the basic dispute between [the hospital] and the [fiscal intermediary] is one of record keeping and billing requirements (or the lack of supporting documentation), rather than a difference in policy interpretation. There is a good likelihood that [the fiscal intermediary] will prevail on most of these issues, if and when the issues are heard by the PRRB ([the hospital] keeps postponing the hearing, we believe because they know they do NOT have documentation and know they will not prevail).

"Therefore, we believe this agreement is not in Medicare's best interest. If a settlement is in HCFA's best interest, we strongly encourage you to have the PRRB appeals moved forward to resolve these issues. If it is in HCFA's best interest to get Federal funding to [the hospital], we suggest you consider a block grant, ORD project or some other means that does not require [the fiscal intermediary] or Medicare staff to subvert, or circumvent, Medicare regulations.... We believe this is not consistent with our fiduciary responsibility to protect the interests of our customers, the Medicare beneficiaries.

"We also do not believe the settlement will permanently resolve the underlying issue that [the hospital] cannot or will not, maintain the records required of all other Medicare providers. What will happen to costs and claims for subsequent periods of time? This settlement does not require [the hospital] to meet Medicare record keeping requirements in the future, or lose the resulting Medicare reimbursement. Will HCFA be facing another 'settlement' of this type in 8 to 10 years from now? Medicare is offering to pay $51 million in the settlement. What is [the hospital] giving in return - - Ceasing to appeal issues they really don't want the PRRB to hear because they know they don't have documentation and cannot prevail? In our opinion, unless Medicare can get some agreement that [the hospital] in the future will meet Medicare documentation requirements or not claim the costs, this is not a settlement where both parties realize some benefit. It is more of a 'grant' and should be called that, without the compromise being called a 'Medicare reimbursement settlement' under Medicare regulations."

Lastly, after writing some specific questions to terms and clauses in the agreement, the Manager for Program Safeguards asked if the clause "[the hospital] and HCFA agree not to disclose the terms of this Agreement" was needed.

On March 7, 1997, Mr. Booth replied by stating that the hospital had implemented a new system for tracking and claiming bad debts since this was the majority of the settlement. He also wrote that if the hospital does "not develop a good system for bad debts, we may have similar problems in several years. We'll see." HCFA's Manager for Program Safeguards for the region and other HCFA regional staff told us that Mr. Booth never addressed the overall concerns of regional management that the settlement subverted the appeals process. The regional Manager for Program Safeguards also advised that on at least one occasion when this concern was discussed with Mr. Booth, he told them that he was acting under the direction of HCFA Administrator Bruce Vladeck to get the matter resolved and to get money to the hospital.

On March 7, 1997, HCFA's regional Manager for Program Safeguards wrote another e-mail to Mr. Booth, advising that the nondisclosure provision of the draft settlement might violate a newly enacted state law; therefore HCFA's OGC should "ensure this is ok with State laws." According to the regional Manager for Program Safeguards, Mr. Booth never responded to the manager's concerns on this matter. Mr. Booth told us he never brought this matter or the settlement to OGC. He also told us that while it was "clear" to him that the region would not have "gone around the [PRRB] process" it was also "clear" to him "that [Mr.] Vladeck wanted to go around the [PRRB] process." He also said that Mr. Vladeck had advised him that although he (Mr. Vladeck) wanted the settlement done, it was not as time sensitive as the settlement for another provider. This other provider is the hospital discussed in appendix II.

On March 21, 1997, the settlement was finalized; and on March 25, 1997, Mr. Booth directed the fiscal intermediary to pay the hospital $51 million. Therefore HCFA agreed to accept $28 million of the $79.4 million in overpayments. The finalized settlement retained the nondisclosure clause, and no terms were added to require the hospital to meet Medicare requirements in the future.

On April 1, 1997, the hospital sent a letter to the PRRB withdrawing the appeals. On April 28, 1997, the director of the hospital sent a letter to Mr. Vladeck thanking him for his "consideration and support" and

commending Mr. Booth for the "expeditious" manner in which Mr. Booth had negotiated the settlement.

On April 7, 1997, Mr. Vladeck sent a memorandum to Kevin Thurm, Deputy Secretary, HHS, advising him of the settlement. It stated,

"You will recall we settled several outstanding issues with [the hospital discussed in app. II] last Summer [sic]. We discovered a few months ago there were several similar issues with hospitals owned and operated by [the hospital]. Just as with the [1995 settlement in app. II]..., we found it beneficial to settle many of these issues. My staff informs me that in exchange for their agreement to not pursue these issues through the appeals process, we have instructed our intermediary to pay [the hospital] $51,000,000. Both we and the [the hospital] officials are pleased with this result."

Mr. Thurm told us that he had no recollection of this matter before reviewing this memorandum prior to his interview with us. Other than the memorandum, he said he still had no recollection of this matter. The Director of Health Services for the hospital placed Mr. Thurm at one of the meetings with the hospital and HCFA.

The Manager of Medicare for the fiscal intermediary told us that HCFA wanted the settlement kept "hush hush" so that other providers would not know there was a "bypass to the PRRB" process. However, the fiscal intermediary never questioned HCFA on this because it reports to HCFA and "have to do as they are told." Therefore the fiscal intermediary did the work as ordered. Fiscal intermediary management also told us they expressed their concerns to Mr. Booth and HCFA regional staff, stating to them that making a settlement that "subverted the PRRB process" would be "precedent setting." The fiscal intermediary also told them that all providers should be treated equally and that making such a settlement would be unfair to other providers, especially since other providers ask this fiscal intermediary for settlements that compromise the overpayment and the fiscal intermediary always refuses. The fiscal intermediary advised us it is not comfortable with treating providers differently, especially when it tells other providers that all providers are subject to the same rules and process no matter how onerous. HCFA's response was that it (HCFA) was asking for documentation and was "looking into it." Fiscal intermediary management also told us that they had asked Mr. Booth, "Why do we have to do this?" referring to the settlement since all providers make claims for bad debts and the hospital should be treated no differently. The fiscal intermediary told us that Mr. Booth's response was "HCFA is working on this." The fiscal intermediary's Manager of Medicare told us that this is the

only settlement of its kind that she knows of in 30 years of administering the Medicare program as a contractor.

The hospital's officials told us that this was the only settlement that the hospital had done in which they did not have to document their costs to the satisfaction of the fiscal intermediary.

No attorney for the government ever reviewed this settlement because Mr. Booth knew that this deal, among others, "would go up in smoke" if either OGC or Justice became involved. Mr. Booth also acknowledged to us that this was a bad settlement not made in the best interest of the government.

The HCFA regional management whom we interviewed stated that they viewed this settlement as a subversion of Medicare regulations and procedures, that it set bad precedent, and that they "had never before heard of such a settlement." According to one HCFA regional management official, this official had obtained the GAO Fraud Hotline telephone number at the time of the settlement; and every day for the last 2 years the official had thought about calling to report the settlement as a fraud matter to be investigated.

Review of HCFA-proposed Settlement With Hospital Rejected by Department of Justice

Chronology of HCFA Referral to Justice

On December 3, 1992, the fiscal intermediary completed an audit of a provider hospital's cost reports for years 1983 through 1991 and drafted Notices of Program Reimbursements (NPR) for this period reflecting approximately $58 million in overpayments due to HCFA.

On January 5, 1993, Darrell Grinstead, HCFA's then Chief Counsel,[1] spoke with the Department of Justice[2] and advised that the revised overpayment estimate was $50 million. Notes taken by a Justice attorney indicate that Mr. Grinstead advised that the hospital was "willing to pay a token amount" but had no resources to pay and that negotiation discussions could fall apart as a result. The note went on to say that the then Secretary, HHS, Louis Sullivan, had become personally involved in the process, was "pushing for resolution," and "wants immediate action and may call the attorney general."[3] These issues were also written about in an internal Justice newsletter.

In a January 11, 1993, letter, the hospital's president wrote to Secretary Sullivan that the hospital had received the fiscal intermediary's draft NPRs, which amounted to a $57-million overpayment with a required immediate lump sum payment of $45 million. The hospital also stated that it did not have the financial ability to repay the overpayment and requested that HHS accept the hospital's proposed settlement with HCFA on the overpayment. The hospital's president offered to pay $3 million over 3 years. On January 11, 1993, an attorney for HCFA also sent a note to Mr. Grinstead with an "update." The attorney also attached draft copies of a settlement agreement between HCFA and the hospital and a background document for HCFA's then Acting Administrator William Toby and Secretary Sullivan. The drafted settlement agreement accepted the terms offered by the hospital's president.

[1] Mr. Grinstead retired in 1997.

[2] According to internal Justice documents, Mr. Grinstead spoke with an attorney in Justice's Commercial Litigation Branch, Civil Division, sometime in Aug. 1992 to discuss a potential referral of a Medicare-overpayment settlement with a hospital. At that time, the projected overpayment was $15 million to $20 million.

[3] On Dec. 31, 1992, the hospital wrote to Louis Hayes, HCFA's Acting Deputy Administrator, enclosing a copy of a draft letter the hospital was proposing to send to then HHS Secretary Sullivan.

On January 13, 1993, Mr. Grinstead called Justice and advised that he would fax an advance copy of the HCFA referral letter in which HCFA requested Justice approval for the compromise of claims of the hospital. According to a Justice note, Mr. Grinstead asked a Justice attorney how quickly Justice could "turn this around" and if the proposed settlement "would run into any buzzsaws [sic]" at Justice.

Mr. Grinstead told us that this case had to be referred to Justice for approval because there was an ability-to-pay issue and the claim exceeded $100,000. He opined that a claim exceeding $100,000 is still in the jurisdiction of the HHS Secretary while under administrative appeal and not subject to the Federal Claims Collection Act, unless HCFA seeks a compromise settlement for reasons related to a provider's inability to pay or to litigation risk. He believed that in these cases the settlement matters went beyond the Secretary's jurisdiction and required Justice approval.

On January 14, 1993, Mr. Grinstead sent the formal referral letter requesting approval to compromise the $58-million debt for $3 million to Justice. Mr. Grinstead wrote that HCFA believed that the hospital's inability to pay and its potential closing if required to pay, coupled with litigation risk, provided sufficient reason to accept the proposed settlement offer. He also wrote that the settlement would address future billing concerns because the fiscal intermediary had adjusted the current payments to the hospital to eliminate any future overpayment. Lastly, he argued that the Congress would probably appropriate funds to cover the overpayment rather than allow this institution to close. The referral letter attached copies of the draft NPRs, the draft settlement agreement, an overpayment summary, and other related materials.

On April 16, 1993, the hospital's president wrote to Attorney General Janet Reno and advised her that Justice had not yet responded to HCFA's referral for approval of the settlement and had not indicated what Justice's position might be; he also mentioned the hospital's desire to resolve this matter. He requested a meeting with Attorney General Reno or one of her representatives to present the hospital's "position more fully." A copy of the hospital's January 11 letter to Secretary Sullivan was attached.

On April 30, 1993, the Assistant Attorney General for the Civil Division sent a memorandum to the then Associate Attorney General, advising that the hospital's president had written to Attorney General Reno and that the proposed settlement "obviously can not be justified on any traditional analysis of litigative [sic] risk and ability to pay." Justice had heard nothing

from the new administration at HCFA and was trying to arrange a meeting to ascertain HCFA's views. The Assistant Attorney General suggested that Justice take no action until it knew the views of the new administration on this matter.

Further, on April 30, 1993, a Justice attorney faxed Mr. Grinstead a draft of Justice's "evaluation of the proposed settlement" as background for a scheduled meeting with Mr. Grinstead on May 6.[4] In the memorandum, the Justice attorney wrote,

"*First*, rejection of this offer does not result in [the hospital] having to repay the money immediately—it merely forces [the hospital] to exhaust its statutorily provided administrative remedies. They may receive relief there. *Second*, HCFA frequently enters into extended repayment schedules with providers who demonstrate financial need and which owe HCFA for Medicare overpayments. Accepting that [the hospital] can only repay $1 million per year, there is no reason offered that a larger settlement, spread over a longer period of time, would force [the hospital] to close its doors." (Emphasis is in the original.)

The Justice attorney also argued that if the Congress were to appropriate funds to cover the overpayment, then the Medicare trust fund would be reimbursed (a significant fact given the predictions at that time of insolvency for the trust fund) and the hospital would be able to remain open. Additionally the attorney opined that even if full recovery were imposed immediately and the Congress did not take action on the hospital's behalf, the hospital would more likely file for bankruptcy protection than close. Under the hospital's provider agreement with HCFA, HCFA could still recover the overpayment because in bankruptcy matters, the provider agreement is considered an executory contract that the hospital would have to either accept or reject. The Justice attorney reasoned that under either scenario, HCFA could make a recovery greater than the proposed settlement. And, more importantly,

"The 'Medicare community' is close knit, as is the health care bar. A settlement of this nature and size will become quickly known. Such a low settlement also undermines our ability to argue in bankruptcy proceedings that the diminution of the Medicare trust fund is a factor to consider in whether recoupment should be permitted.... Our willingness to compromise a legally defensible overpayment equal to half of all HCFA's bankruptcy related losses in 1991 undermines that argument."

[4] The attorney who wrote the evaluation of the proposed settlement made a disclaimer that this was his opinion and not that of Justice. However, what he wrote was identical to the discussion in Justice's formal rejection memorandum issued later.

The Justice attorney further wrote that in this case HCFA was allowing the provider to "avoid the statutory provisions established for providers to contest Medicare overpayment determinations" and that HCFA itself "frequently uses this legal argument against providers who sue HCFA." The Justice attorney wrote in conclusion,

"We cannot recommend this settlement because it requires HCFA to treat [the hospital] in a manner inconsistent with its regulations and with its treatment of other Medicare providers nationwide. It compromises the claim for a recovery not compelled by the facts or the law. Additionally, HCFA's reasoning asks us to substitute our judgement that the federal government should continue to fund [the hospital's] financial deficiencies for that of Congress, and do it out of the Medicare trust fund rather than general tax revenues. Such a determination is essentially a political decision and should be made by a political body—Congress. Finally, other potential settlements may be available which increase HCFA's recovery on behalf of the Medicare trust fund, present less problems with our representation in other cases, and are more consistent with HCFA's treatment of other providers in similar financial difficulties."

On May 6, 1993, Mr. Toby, Mr. Hayes, Mr. Grinstead, and another HCFA attorney met with Justice attorneys to discuss the proposed settlement and HCFA's request for Justice approval of it. According to a memorandum prepared by one of the Justice attorneys who attended the meeting, Justice expressed to HCFA that it was not opposed to a compromise settlement with the hospital, but it was opposed to the one that had been proposed. According to the memorandum, Mr. Toby stated that the risk of closing the hospital due to the overpayment assessment was "unacceptable" and "that HCFA did not feel this was beyond their ability to decide."

On May 18, 1993, as a result of the May 6 meeting, Mr. Grinstead sent another letter to Justice stressing the litigation risks because HCFA believed that the hospital's inability to pay was sufficient reason to accept the proposed settlement. In the letter, Mr. Grinstead expressed concern that if the matter were appealed to the Provider Reimbursement Review Board (PRRB), the fiscal intermediary would represent the government's position; however, no actual attorney for the government would be present. Given the complexities of the case, he was concerned that the fiscal intermediary would be unable to argue effectively. He also expressed concern about the backlog of PRRB cases and the accrual of interest once the NPRs were issued. The letter cited examples of what the risks were and why they were "convinced that the proposed settlement is in the Government's best interest." Lastly, he argued that the settlement provided ample future savings to the program as a result of adjustments made to the hospital's current and future payments.

On July 30, 1993, Mr. Grinstead wrote to Justice again, responding to the Justice request for additional information. This letter stressed HCFA's prior arguments once again and provided information on two recent lawsuits involving similar matters.

On August 3, 1993, the Deputy Assistant Attorney General sent a memorandum to a subordinate, indicating that the Assistant Attorney General for the Civil Division had "expressed reservations" about the proposed settlement and whether it was an appropriate disposition of the matter.

On August 19, 1993, the Assistant Attorney General met with Mr. Grinstead. According to a memorandum of the meeting prepared by the Assistant Attorney General, Mr. Toby and Mr. Hayes from HCFA and Secretary Sullivan had negotiated the proposed settlement. The $3-million offer had come from the hospital. Mr. Grinstead did not believe that HCFA had made a counteroffer. Mr. Grinstead advised that HCFA did not feel it was "useful to pursue a 'hardnose' negotiation" and was under instructions from Secretary Sullivan to "work it out." When asked by the Assistant Attorney General why the short repayment period and the "rush" to get this settlement done, Mr. Grinstead replied that the hospital did not want to carry the liability on its books. Further, the hospital had convinced its auditors to hold off on reporting the potential liability because of an assurance by Secretary Sullivan that the case would be settled. According to this memorandum, the Assistant Attorney General also offered to provide Justice representation to the fiscal intermediary for a PRRB hearing.

Subsequent Rejection of Proposed Settlement

According to a September 7, 1993, memorandum from a HCFA staff attorney to Mr. Grinstead, Justice contacted a HCFA attorney on September 2, 1993, to advise that Justice would formally reject the proposed settlement offer because the Assistant Attorney General and the Associate Attorney General had concluded that the offer was "not sufficient" and "out of line with settlement amounts from comparable institutions." According to the memorandum, the Associate Attorney General asked the Deputy Assistant Attorney General to contact the hospital and inform it of the Justice position. According to the memorandum, Bruce Vladeck (who had become the HCFA Administrator several months earlier) was also advised of the rejection. After speaking with Mr. Vladeck, a HCFA official asked if Justice could delay informing the hospital until September 10, 1993, so that the Secretary of HHS, Donna Shalala, could be informed, because this was

a proposed settlement from the prior administration and Secretary. Therefore the hospital would likely seek redress from the current Secretary. The memorandum also recalls a discussion between the HCFA attorney and the Deputy Assistant Attorney General when the HCFA attorney asked for the delay. According to the memorandum, when asked for the delay, the Deputy Assistant Attorney General "nearly choked," since the hospital had been pressing Justice for a decision.

On September 7, 1993, Harriet Rabb, General Counsel of HHS, drafted a memorandum to Secretary Shalala, advising her of the Justice rejection. We were unable to determine if this memorandum was ever sent forward.

On September 8, 1993, the Deputy Assistant Attorney General instructed a Justice attorney to inform the hospital of the rejection. The Justice attorney was to tell the hospital that the amount per year was not a problem but that the number of years was. The memorandum of this conversation noted that HCFA agreed to allow Justice to take over the negotiations.

On September 21, 1993, after rejecting HCFA's proposed settlement, Justice began to negotiate for a settlement with the hospital.

On December 1, 1993, Mr. Grinstead sent a memorandum with an attached status report to a senior HCFA official. In the status report, he wrote that the matter was referred "...because...the dollar amount [required] Department of Justice approval of the settlement...."

On January 28, 1994, the hospital wrote to the Assistant Attorney General concerning the overpayment. In the letter, the hospital rejected Justice's offer for the hospital to repay $12 million to settle. As a result, the Assistant Attorney General met with the hospital's general counsel in an effort to reach a settlement. Since the hospital's letter did not increase its original offer, Justice concluded that HCFA was to commence collection efforts.

On March 14, 1994, the Assistant Attorney General wrote to Mr. Grinstead stating that Justice had

"...made every effort to achieve a reasonable settlement. At this time, I have no alternative but to inform you that you should proceed with administrative processing and collection efforts. We shall inform [the hospital] that we have returned this matter to your Department."

On March 24, 1994, the Deputy Assistant Attorney General wrote to the hospital, advising it that the matter had been returned to HCFA for collection.

Sometime between March 24 and September 20, 1994, the hospital made another proposed settlement offer. On or about September 24, a settlement agreement was drafted for the hospital to (1) pay $10 million over 15 years, (2) waive claims of additional payments owed it, and (3) waive its rights to appeal the reduction of future payments.

On October 5, 1994, the Assistant Attorney General sent a memorandum recommending approval of the new settlement agreement to the Associate Attorney General. The Associate Attorney General signed the approval memorandum to accept $10 million over 15 years to settle a $56.5 million overpayment.[5]

On October 11, 1994, the Assistant Attorney General sent a letter to Mr. Grinstead stating that Justice had approved the settlement terms.

On December 1, 1994, Mr. Grinstead sent a memorandum to Mr. Vladeck with an attached copy of the settlement agreement as previously discussed with him. The memorandum recommended that Mr. Vladeck sign the agreement. On December 2, 1994, Mr. Vladeck signed the settlement that had been signed by the hospital on December 1.

On March 15, 1995, the fiscal intermediary sent the hospital the NPRs reflecting the total overpayment amount of $56.5 million but referencing the need to repay $10 million as a result of the settlement.

[5] The fiscal intermediary had adjusted the initial overpayment from $58 million down to $56.5 million.

Senate Permanent Subcommittee
On Investigations

EXHIBIT # 26

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

MEMORANDUM

To: K. Lee Blalack, II
Staff Director and Chief Counsel
Permanent Subcommittee on Investigations
Committee on Governmental Affairs
United States Senate

From: Michael Hash
Deputy Administrator
Health Care Financing Administration

Subject: Guidance on the Resolution of Medicare Payment Disputes

Pursuant to your request, I am providing you with a copy of the guidance resulting from the Health Care Financing Administration's (HCFA's) workgroup on the resolution of Medicare payment disputes.

Today, our Chief Financial Officer (CFO) disseminated widely throughout the agency the attached guidance, which reflects the findings of the workgroup. Similar guidance will soon be issued to all contractors (i.e., Medicare fiscal intermediaries and carriers), and training will thereafter be offered to all affected HCFA and contractor employees to ensure that they understand the guidance's instructions, definitions, illustrations, and points of contact. The guidance makes clear important debt collection practices to be followed, and sets forth new financial controls to be implemented. Among the more notable directives are the following:

- Every proposed resolution in which (1) there is an amount owed to the federal government and (2) there is a proposed compromise of the amount owed is subject to the Federal Claims Collection Act (FCCA) and must be referred to the Deputy CFO. If the amount owed exceeds $100,000 (excluding interest), the Deputy CFO must, in turn, refer the matter to the Department's Office of the General Counsel (OGC) and, ultimately, the Department of Justice (DOJ).

- Every proposed resolution in which (1) there is an amount owed to the federal government but (2) there is no proposed compromise of the amount owed must be referred to the Deputy CFO, even though the FCCA does not compel a referral of any kind. If the proposed resolution would result in the agency paying more or recouping less than it otherwise would have, both the Deputy CFO and the Deputy Director of the Center

for Health Plans and Providers (CHPP), the agency's most senior career Medicare payment policy official, must approve the proposed resolution as an appropriate exercise of programmatic authority.

- Every proposed resolution in which (1) there is no amount owed to the federal government but (2) there is no programmatic authority to resolve the matter must be referred to the Deputy CFO, even though the FCCA does not compel a referral of any kind. The Deputy CFO must, in turn, refer the matter to OGC.

- Every proposed resolution in which (1) there is no amount owed to the federal government and (2) there is programmatic authority to resolve the matter is not subject to the FCCA and need not be referred to the Deputy CFO. Nevertheless, if any agency or contractor employee is concerned that a proposed resolution would not be an appropriate exercise of programmatic authority (e.g., the employee believes that it would be detrimental to the Medicare program or otherwise contrary to public policy), he or she may request, and both the Deputy CFO and the Deputy Director of CHPP must provide, approval of the proposed resolution as an appropriate exercise of programmatic authority.

- HCFA must develop criteria to identify proposed resolutions of particular financial or precedential significance, and must improve its mechanisms for tracking resolutions of payment disputes.

- OGC must be consulted when it is necessary to resolve an issue of law.

- Before a HCFA employee may execute an agreement that memorializes the resolution of a payment dispute, he or she must consult with OGC.

- The inclusion of a confidentiality clause in an agreement that memorializes the resolution of a payment dispute, while not illegal, is contrary to public policy. Therefore, such an agreement may not contain such a clause unless DOJ, in the course of litigation, instructs otherwise.

- The withdrawal of delegations of authority concerning the FCCA now encompasses all HCFA Regional Office officials. At this time, the Deputy CFO is responsible for the coordination of all matters implicating the FCCA.

We are confident that this new guidance significantly enhances our financial controls and complements our numerous other initiatives to improve our financial management practices. We will reevaluate this guidance in six months, and, thereafter, as needed, to determine whether modifications are warranted. Moreover, we will issue additional guidance that will address HCFA operations that fall outside the scope of this guidance (e.g., managed care).

I hope that you agree that our actions represent meaningful progress in our continuing efforts to protect the integrity of the Medicare program

Attachment

cc: Linda Gustitus

MAR-27-2000 17:40 HCFA IOA 202 690 6262 P.05/36

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administratic

The Administrator
Washington, D.C. 20201

TO: SEE BELOW

FROM: THE ADMINISTRATOR Nancy-Ann DeParle

SUBJECT: NEW INSTRUCTIONS DETAILING YOUR RESPONSIBILITIES FOR MONIES OWED TO THE GOVERNMENT

At my direction, HCFA's Chief Financial Officer, working with a cross component workgroup, has started the process of ensuring that HCFA employees have comprehensive and clear guidance regarding collecting monies owed the government. While there has been some guidance in the past, this is a complex and complicated issue, and I wanted to ensure that each of you has a reference document that gives you a clear understanding of what actions to take and with whom you should consult, depending on the situation. The attached memorandum is the first in a series of steps to ensure that you have the tools that you need to do your jobs.

Please read the attached memorandum from the Chief Financial Officer immediately, and retain it for future reference. These instructions are effective immediately and I expect strict compliance with them. You are strongly advised to read and retain these documents even if you have no immediate related responsibilities, since many HCFA employees are likely to have an assignment with similar issues at some time in their careers.

As HCFA administers the Medicare program, through the fiscal intermediaries and carriers, at times we learn that a provider, beneficiary, or another payer owes monies to Medicare. Fiscal intermediaries, carriers, and Federal employees are obliged to seek to recover these monies to the fullest extent feasible. This memorandum and its attachments clarify and limit authorities of all HCFA employees involved in determining and collecting amounts owed to the Medicare program. It provides detailed guidance about whom to consult and in what circumstances. We are also providing guidance on procedures to be used where providers seek additional monies from Medicare.

Soon the Office of Financial Management will be providing training on these materials. We will also be following up with program memoranda to the Fiscal intermediaries and carriers to implement these procedures as they affect contractor operations. In addition, now that this guidance is in effect, we will be monitoring its effectiveness and we may discover gaps that will need to be filled. As further policies and procedures are developed, additional training will be offered to staff.

The issues addressed in this memorandum and its attachments are very important to the proper administration of the billions of taxpayer dollars entrusted to the Health Care Financing Administration. It is critical that we strengthen our financial controls in this area immediately. Your cooperation in this effort, and your full compliance with these instructions, are essential.

Attachments

Addressees:

ALL CENTER AND OFFICE DIRECTORS
ALL REGIONAL ADMINISTRATORS
ALL ASSOCIATE REGIONAL ADMINISTRATORS FOR FINANCIAL MANAGEMENT
ALL OFM STAFF
ALL CHPP STAFF

MARCH 27, 2000

TO: **SEE BELOW**

FROM: **THE CHIEF FINANCIAL OFFICER**

SUBJECT: **YOUR RESPONSIBILITIES CONCERNING MONIES OWED TO THE FEDERAL GOVERNMENT IN THE MEDICARE FEE-FOR-SERVICE PROGRAM**

EFFECTIVE IMMEDIATELY

Each manager receiving this memorandum is directed to ensure that it is distributed to any employee under his or her supervision who has or may have related responsibilities.

Read this memorandum and retain it for future reference. Training will soon be offered to all employees.

This memorandum and its attachments clarify and limit authorities of all HCFA employees involved in collecting amounts owed to the Federal government in the Medicare fee-for-service program. Similar guidance will soon be issued to all affected Medicare contractor employees.

Future guidance will update and revise guidance for all other HCFA operations. As additional policies and procedures are developed, further training will be offered to all employees.

Purposes of This Memorandum

HCFA makes payment from the Medicare Trust Funds for services furnished to Medicare beneficiaries on a fee-for-service basis through Medicare contractors (fiscal intermediaries and carriers) in accordance with HCFA guidelines.

At times, we learn that a provider, beneficiary, or another payer owes monies to Medicare. HCFA and Medicare contractor employees are obligated to seek to recover these monies to the fullest extent feasible. Because the Medicare program is so large and complex, these efforts often involve many employees at contractor sites, in the HCFA Regional Offices, and in several components in the HCFA Central Office. Some matters also involve the Provider Reimbursement Review Board (PRRB), HCFA's Office of the

Attorney Advisor, the Department's Office of the General Counsel (OGC), the Department of Justice, and/or Federal courts.

In mid-summer 1999, the Administrator asked that HCFA's financial controls over the resolution of Medicare **amounts in controversy**, including **debts**, be reevaluated. At that point, it was made clear that the responsibility for decisions involving **compromises of debts and terminations or suspensions of collection actions** lies with the Chief Financial Officer (CFO) or Deputy CFO. Simultaneously, the Administrator charged a cross-agency workgroup, under the leadership of the Office of Financial Management (OFM), to review HCFA's procedures and practices concerning the resolution of Medicare payment disputes, including **compromises of debts** and **programmatic adjustments to amounts in controversy**. The group was also charged with ensuring that clear written instructions were developed for use by all HCFA staff involved in this function. (See the Definitions section of Attachment A for a discussion of terms in **bold**.)

I am writing to you today with three purposes:

> To announce the withdrawal of prior delegations of authority under the Federal Claims Collection Act (FCCA) to compromise or to suspend or terminate collection action on debts from all HCFA Central and Regional Office officials, with the sole exception of the CFO and Deputy CFO (authorities to collect claims in full and to refer claims for collection in full remain in place);
>
> To establish a process through which any HCFA or Medicare contractor employee may contact a designated official if he or she is unable to satisfy himself or herself that a proposed resolution of a Medicare payment dispute would not be improper, and the proposed resolution would result in HCFA paying more or recouping less than it otherwise would have; and
>
> To issue clear instructions concerning monies owed to Medicare that reflect the recommendations of the workgroup, and to announce that the Deputy CFO, currently Deborah Taylor, is now permanently designated by the Administrator as the HCFA official responsible for the coordination of all collection policies.

The development, distribution, and consistent application of this guidance will greatly strengthen financial controls over, and increase accountability within, HCFA's processes for collecting monies owed to Medicare. As such, we can expect:

- Continued compliance with all pertinent statutory, regulatory, and manual provisions;
- More consistent decisions across regions, issues, and provider types;
- Decisions that better support the financial interests of the Medicare program; and
- Decisions that are more certain to be based on input from all appropriate parties with technical, programmatic, legal, and financial management expertise.

Legal Authorities and Delegations

HCFA and its agents have significant authorities to make, adjust, and recover Medicare payments under Title XVIII of the Social Security Act. This memorandum does not revise any of those authorities. It does, however, clarify procedures and practices that must be followed when both Title XVIII and other authorities apply, and it makes clear that the authority to compromise a debt is not one of the Title XVIII authorities.

The collection of monies owed to Medicare may be subject to not only Title XVIII provisions concerning recovery of such monies, but also the FCCA. I want to emphasize that the FCCA does not apply to all collection actions, but when it does apply, it imposes constraints on HCFA's discretion to resolve a Medicare payment dispute. One specific requirement is that every compromise of a debt over $100,000 must be referred to the Department of Justice. Only designated officials have the authority to agree to a debt settlement. Because both Title XVIII and FCCA authorities may govern a case in which the Medicare program is owed money, this is an area in which clear instructions are especially needed. This memorandum sets forth those instructions.

In 1995, HCFA issued an internal Administrative Issuance System Guide entitled "Federal Claims Collection Act Policies and Procedures" (HCFA.g: 0305-1, Attachment G), which updated the procedures to be followed when the FCCA applies to a collection action. HCFA, however, has not similarly issued internal instructions to govern the interaction among HCFA, its agents, providers, and others when the FCCA does NOT so apply. As a result, some of our decisions under Title XVIII authorities have been expressed in terms (e.g., "debt," "compromise," "settlement") that have made them appear to be decisions under FCCA authorities. Also lacking has been a clear description of when the FCCA applies to a matter and when it does not. This memorandum addresses these concerns.

In order to establish clear financial controls over and accountability for collection actions subject to the FCCA, the Administrator has delegated authorities concerning the FCCA to a single point in HCFA: all FCCA matters must be coordinated with Deborah Taylor, the new Deputy CFO, and/or her staff. **No other HCFA or Medicare contractor employee is authorized to approve any compromise of a debt or termination or suspension of a collection action.** OFM will be working with contractors and Regional Offices to establish better mechanisms to identify, track, and refer such FCCA matters.

Referral Of Questions Of Propriety To Designated Officials

In the event that a HCFA or Medicare contractor employee is unable to satisfy himself or herself that a proposed resolution of a Medicare payment dispute would not be improper, and the proposed resolution would result in HCFA paying more or recouping less than is otherwise would have, he or she may contact a designated official.

At this time, those officials are:

Kathleen Buto, Deputy Director, Center for Health Plans and Providers (CHPP)

Deborah Taylor, Deputy CFO
Michelle Snyder, CFO

The question may be referred to any one of these points of contact, at the discretion of the employee.

Non-FCCA Issues of Concern

To strengthen financial controls and increase accountability further, OFM will be working with CHPP and other components in the Central Office, the Regional Offices, OGC, and others to make a number of other improvements in HCFA's financial management practices. This guidance does not attempt to fully revise all such procedures. There are, however, special concerns that warrant certain immediate improvements in HCFA's operations.

In the past, **programmatic adjustments to amounts in controversy** did not necessarily require consultation with OFM and CHPP. Effective immediately, both the Deputy CFO and the Deputy Director of CHPP must approve all **programmatic adjustments** to **amounts in controversy** that meet the following criteria:

- Where the proposed resolution involves a debt and would result in HCFA paying more or recouping less than it otherwise would have; or

- Where a HCFA or Medicare contractor employee requests such approval because he or she is unable to satisfy himself or herself that the proposed resolution would not be improper, and the proposed resolution would result in HCFA paying more or recouping less than it otherwise would have.

Attachment F, Procedures Concerning Certain Non-FCCA Issues Relevant to Medicare Collection Actions, sets forth additional guidance to improve financial management practices in specific areas of concern identified by the workgroup. This additional guidance briefly addresses how to determine if a **programmatic adjustment** to an **amount in controversy** must be coordinated with OFM and/or CHPP, how to consider the financial and/or precedential impact of such a **programmatic adjustment**, **programmatic adjustments** in cases before the PRRB, stipulation agreements, bankruptcy and insolvency, and appeals of adverse court decisions.

Your Responsibilities

Please review and retain this memorandum. A provider or contractor may contact you to consult on an issue that relates to payment policy, cost reimbursement, **cost report settlement**, or recovery of an **overpayment**. At a minimum, you will need this guidance to determine whether to coordinate with CHPP on an issue involving payment policy or cost reimbursement and/or OFM on an issue involving cost report settlement or recovery of an overpayment. CHPP and/or OFM will consult with OGC when it is necessary to resolve an issue of law.

To help you fulfill your responsibilities, this guidance includes the following attachments:

- A discussion of when the FCCA applies to Medicare collection actions, including critical definitions that you all need to understand to make correct distinctions between FCCA and Title XVIII issues (**Attachment A**).

- A worksheet that you can copy and use to help you decide what procedures to follow (**Attachment B**). Correct use of the worksheet depends on an understanding the definitions and principles explained in Attachment A.

- An example that illustrates the use of the worksheet (**Attachment C**). The example demonstrates how the worksheet may yield different conclusions when applied at different points of time to the same monies owed to Medicare in the same cost reporting period by the same provider. This is important to understand because you may have to revise your conclusions in a matter as the facts change.

- A set of Frequently Asked Questions that address some of the factors that can affect your conclusions in a particular matter, such as a PRRB appeal or a provider bankruptcy (**Attachment D**).

- A guide to referring FCCA matters, which specifies the required referrals and identifies points of contact at each step of the process (**Attachment E**).

- Procedures Concerning Certain Non-FCCA Issues Relevant to Medicare Collection Actions (**Attachment F**).

- Related guidance concerning the FCCA (**Attachment G**). This 1995 FCCA guidance is primarily for reference/background; it providers far more detail than most of you will need. OFM is working to update this guidance to reflect the instructions that I am issuing today, to incorporate recent changes in law such as the Debt Collection Improvement Act, to account for HCFA's reorganization, and to make it more user-friendly.

Next Steps

As I noted above, this memorandum and the process improvements that it describes represent a major step toward clearer and stronger financial controls over the resolution of Medicare payment disputes and related functions.

Very shortly, CHPP, in consultation with OFM, will establish guidelines for Medicare contractors so that they may identify **programmatic adjustments** to **amounts in** controversy with respect to which they must obtain HCFA concurrence on both the policy and the financial sides of the agency. CHPP has the lead in developing criteria to be used in identifying proposed resolutions of particular precedential significance, regardless of the amount at issue in an instant claim, and will work with OFM to issue

such guidelines to contractors. CBS will support the implementation of these new guidelines through contractor management and performance evaluation.

In addition, OFM will coordinate meetings with components in the Central Office and the Regional Offices to establish better (i.e., more complete and consistent) tracking mechanisms for both FCCA matters and non-FCCA matters on which HCFA must take action. In the near term, this tracking may be very basic and manual or only partially automated, but we need to begin tracking completely and consistently right away and then upgrade the supporting technology as time and funds permit. OFM has already initiated steps to improve the information that is received from Medicare contractors as a result of audits, cost report settlements, and various collection activities.

Our next task is to establish a more sophisticated means of identifying all collection obligations earlier and more accurately, and especially of tracking and reporting the status of all cases referred to you for consultation and resolution. We also need the capability to search for current and closed cases with particular characteristics, such as similarity to a given case. OFM will develop the capacity to provide HCFA leadership with routine reports on and analyses of our risk exposure in this area. In the meantime, each Regional Administrator and Center and Office Director should make sure that his or her staff are timely logging and tracking all referrals, consultations, and resolutions.

As mentioned above, Deborah Taylor, the Deputy CFO, has the lead on these issues. If you have any questions or concerns, please contact her office at (410) 786-6427.

A. Michelle Snyder

A. Michelle Snyder

Addressees:

All Center And Office Directors
All Regional Administrators
All Associate Regional Administrators for Financial Management
All OFM Staff
All CHPP Staff

Attachments:

Attachment A – When Does the FCCA Apply to Medicare Collection Activities?
Attachment B – Worksheet for Assessing What Procedures to Follow
Attachment C – Example of Application of FCCA Principles
Attachment D – Frequently Asked Questions
Attachment E – Organizational Responsibilities for FCCA Referrals in the Medicare Fee-for-Service Program
Attachment F – Procedures Concerning Certain Non-FCCA Issues Relevant to Medicare Collection Actions
Attachment G – HCFA Administrative Issuance System Guide: Financial Management: Federal Claims Collection Act Policies and Procedures (HCFA.g: 0305-1, October 1, 1995)

Copies to:
Sheree Kanner, Chief Counsel, Health Care Financing Division, OGC
Tim White, Chief Counsel, Business and Administrative Law Division, OGC
All Regional Chief Counsels, OGC

ATTACHMENT A

WHEN DOES THE FCCA APPLY TO MEDICARE COLLECTION ACTIVITIES?

Introduction

Collections of overpayments or other monies paid out under Medicare are authorized under Title XVIII of the Social Security Act, but are also governed by other laws, including the Federal Claims Collection Act (FCCA), the Debt Collection Improvement Act, and bankruptcy laws. Fiscal intermediaries, carriers, and payment safeguard and other contractors that deal with the recovery of Medicare funds and Federal employees must all comply with these many different legal requirements.

This guidance clarifies important points in considering whether a particular Title XVIII collection is also subject to the Federal Claims Collection Act. The clarification has two parts: a section on critical definitions, and a section on principles that apply those definitions.

HCFA calls many activities, and even whole HCFA components and functions, "debt collection." However, most of the time the monies in question do not constitute debts under the FCCA. This guidance establishes rules that every HCFA employee must follow to ensure that Federal Claims Collection Act cases and Medicare-only collections are not confused.

Because the Federal Claims Collection Act and Medicare program guidance have in past used common terms but with different meanings and requirements, it is important that you read and understand the definitions before applying the principles, or using the accompanying worksheet (Attachment B).

Definitions

Some key definitions must be understood and applied consistently for us to establish good controls and make collections in accordance with the Federal Claims Collection Act. You will note that the definitions below are different from what we have become used to saying in our everyday talk. That has contributed to the confusion that has impaired our controls, so a clear understanding of these definitions is critical to your understanding of your responsibilities.

Federal Claims Collection Act (FCCA) Terms

- Debt – Monies owed to the U.S. government constitute a "debt" only when certain conditions are met, namely that: the amount of the debt has been determined and a demand letter has been sent to the debtor. For purposes of this memorandum, the term "debt" is reserved to amounts owed that are subject to the Federal Claims Collection Act. Repayment arrangements do not change a debt's status. Once a debt is fully paid, it ceases being a debt, although it may be an "amount in controversy."

[NOTE: The FCCA itself uses the term "claim" alternatively to and synonymously with the term "debt." In this guidance, the term "claim" refers only to a Medicare "claim," as defined below, and the term "debt" is used throughout solely within the FCCA definition.]

- Compromise – A "compromise" is an agreement to settle a debt for an amount other than the full amount owed for the non-programmatic reasons of ability to pay, cost of collection, or risk of litigation. A compromise is distinct from a recomputation or adjustment of the amounts owed on a technical or programmatic basis.

- Debt settlement – A "debt settlement" is specifically the settlement of a debt. A debt settlement includes compromises and terminations of collection actions that resolve an established debt, so as to remove it from HCFA's books. A suspension of collection action is subject to the FCCA, but it is not a debt settlement. Debt settlements are distinct from other settlements such cost report settlements, the settlement of litigation, or the settlement of a Medicare claim or appeal under Title XVIII.

  [NOTE: The term "settlement" should never be used alone. It may refer to debt settlement, cost report settlement, litigation settlement, claim or appeal settlement, or some other matter, and must be appropriately modified to prevent misunderstanding.]

- Suspension or termination of collection action – A "suspension" or a "termination" of a collection action is a decision under the FCCA authority to stop or forgo collection for reasons such as cost of collection, or the inability to collect the debt, to locate the debtor, or to prove the case in court. These requests are always FCCA decisions. HCFA's delegations of authorities for these decisions are the same as for compromise decisions.

Medicare Terms

- Claim – The request for payment by a provider or supplier for services furnished under Title XVIII.

- Cost report settlement – The resolution by a fiscal intermediary, often in consultation with a provider or its representatives, of the final amount payable for services furnished by a provider during a particular cost reporting period. A cost report settlement may result in additional payments to the provider, or in the recovery of overpayments to the provider. When a cost report is settled, the intermediary sends the provider a Notice of Program Reimbursement (NPR). The Notice of Program Reimbursement may communicate an underpayment or an overpayment. If the Notice of Program Reimbursement communicates an overpayment, it includes a demand for repayment.

  [NOTE: Until repayment is made, an overpayment amount asserted in an NPR is a debt under the FCCA. If that debt is paid timely without disagreement, it never becomes "an amount in controversy."]

- Overpayment – An "overpayment" is the amount that the intermediary or carrier determines has paid to a provider above what is found to be allowable after review of the cost report or materials relevant to the provider's aggregated Medicare claims.

- Amount in controversy – The "amount in controversy" is the difference between what the intermediary or carrier asserts is correct under Title XVIII, and what the provider asserts is correct. An amount may be in controversy without establishing a debt. The controversy may regard one or a number of claims, a cost report that has not been settled, an overpayment that has been repaid or that is in the process of repayment, or an issue under appeal.

  [NOTE: An "amount in controversy" is a debt only if the monies owed meet the FCCA conditions; that is, that the amount of debt has been determined and repayment demanded.]

- Medicare appeal – A provider may appeal its NPR determination if there is an issue that meets certain threshold criteria. The subject of a Medicare appeal is almost always an "amount in controversy," but rarely a "debt" under the Federal Claims Collection Act. The settlement of an appeal does not generally come under the Federal Claims Collection Act because, if the amount in controversy is an overpayment, it is commonly repaid by the time of the settlement, and thus there is no debt under the Federal Claims Collection Act. There are many levels of appeal, including the fiscal intermediary hearing officer, the Provider Reimbursement Review Board, the Administrator, and the courts.

- Programmatic adjustment – A "programmatic adjustment" is a revision of amounts allowed or disallowed under a cost report settlement or collection action that is based on Title XVIII authority, as set forth in Medicare policy guidance, such as in the Social Security Act, our regulations, or our manuals. Thus, it is distinct from actions under the Federal Claims Collection Act (compromise, termination of collection, or suspension of collection) that are not under Title XVIII authority.

- Extended Repayment Plan (ERP) – An "extended repayment plan" is an arrangement by which a provider repays an overpayment on an agreed basis over a period of time. If there is an ERP, by definition there is a debt, and the debt continues to exist until the final payment.

Principles

There are two logical rules that identify which procedures to follow:

- First, is there a debt?

- Second, is the provider or its representative seeking a resolution of Medicare payment dispute by any means other than a programmatic adjustment to an amount in controversy (e.g., compromise or the suspension or termination of a collection action)?

All the above definitions are designed to make these two questions simple to answer. If the answer to the first question is "Yes," follow the FCCA procedures. If the answer to the first question is "No," the FCCA does not apply. Nonetheless, you should address the second question and, if the answer to it is "Yes," you should follow the FCCA procedures as though the matter were subject to the FCCA. That is, immediately contact OFM to begin the tracking of the case, and begin to prepare documentation for OFM.

REMEMBER - Only the Office of Financial Management (OFM) may agree to a compromise under the Federal Claims Collection Act, or to suspend or terminate collection. The Office of Financial Management and the Office of General Counsel (OGC) must coordinate with the Department of Justice (DOJ) the compromise, or suspension or termination of collection action, of any debt over $100,000, excluding interest.

ATTACHMENT B

WORKSHEET FOR ASSESSING WHAT PROCEDURES TO FOLLOW

Review the definitions and principles in Attachment A before using this worksheet.

1.0. If the amount in controversy is a debt:

1.1 Has the provider repaid the debt in full?
If **YES**, the FCCA does not apply; however, you should still go to 2.0.
If **NO**, go to 1.2. (This includes debts under an extended repayment plan.)

1.2 Is there a final determination of the amount owed?
If **YES**, go to 1.3.
If **NO**, the FCCA does not apply; however, you should still go to 2.0.

1.3 Has the intermediary made a formal demand for payment?
If **YES**, go to 3.0.
If **NO**, the FCCA does not apply; however, you should still go to 2.0.

2.0 If the provider or the provider's representative is proposing a resolution of a Medicare payment dispute by any means other than a programmatic adjustment to an amount in controversy (e.g., compromise or suspension or termination of a collection action):

2.1 Is the controversy over the amount based completely on program issues?
If **YES**, go to 4.0.
If **NO**, go to 3.0.

2.2 Does the provider or representative appear to want to find a dollar figure that will close the case, regardless of the program issues?
If **YES**, go to 3.0.
If **NO**, go to 4.0.

3.0 Consult with the Office of Financial Management (OFM).

This could be an FCCA case. However, even if it is not, contact OFM, and prepare a written summary of case facts for OFM review. An initial one-page summary should capture the provider name and address, provider number (if known), the provider contact name and telephone, the Fiscal Intermediary, the Region responsible for the Fiscal Intermediary, the amount of the debt and the date of the demand (if known), reasons offered for compromise (or suspension or termination), and a description of issues raised or offers made.

(If a debt is being collected in full, or referred for collection in full, existing procedures and delegations of authority continue to apply. Such actions do not require OFM consultation, but must be reported and tracked.)

4.0 Examine the request to determine if the provider or representative has mischaracterized the request. If the request is found on reexamination to be or to appear to be a request for a compromise, or for suspension or termination of collection action, go to 3.0.

Review the guidance in Attachments F and G to determine if any provisions apply to the case, and follow those instructions. Otherwise, document your communication for your component files. As needed, brief an authorized manager in your chain of command. If you have any residual doubt, obtain your manager's concurrence with the above analysis. We will issue further procedures for handling programmatic issues shortly.

If a matter does not appear to fall within either programmatic or FCCA authority, consult OGC.

ATTACHMENT C

EXAMPLE OF APPLICATION OF FCCA PRINCIPLES

Initial Situation

Fiscal Intermediary A identifies $300,000 as a probable overpayment in its review of the Provider X cost report. The cost report is not yet settled. A Notice of Program Reimbursement (NPR) has not been sent.

An auditor from Fiscal Intermediary A contacts Provider X and requests more documentation, letting the provider know that there is probably an overpayment.

Provider X asserts that, even if there is an overpayment, it cannot repay the full amount without going out of business.

Fiscal Intermediary A knows that it has some discretion on how to manage negotiations for program-based recomputation of the amount in controversy, but does not have the authority to forego collection of or compromise a debt once it is established. Fiscal Intermediary A decides to consult its Regional Office and Central Office staff in the Center for Health Plans and Providers (CHPP) on the programmatic issues.

The HCFA staff uses the Federal Claims Collection Act (FCCA) procedures assessment worksheet (Attachment B).

[NOTE: Both Regional Office staff and Center for Health Plans and Providers (CHPP) staff may apply the worksheet in coordination, or separately. All staff involved in the case are responsible for considering the FCCA applicability, and none should assume that another staff person or component has assessed it. Best practice is that Regional Office and Central Office staff coordinate and develop the facts together.]

The worksheet shows that, under the FCCA, no debt is established yet, and no resolution by means other than a programmatic adjustment is being sought, so they freely consult on the Title XVIII issues without notifying OFM.

A Change in Situation

After exchange of documents and discussion, Fiscal Intermediary A allows an additional $100,000 in costs, but still finds there is an overpayment of $200,000. Fiscal Intermediary A sends a Notice of Program Reimbursement (NPR), which establishes the amount of debt and the demand for repayment.

Provider X considers whether to repay the debt, or arrange an extended repayment plan. While it is doing this, it may appeal the FI decision on a programmatic basis. It may eventually win at some level of appeal and be repaid part or all of the amount in controversy. (While the case is on appeal, at the point at which the provider repays the debt - whether as a lump sum or at the end of an intermediary-imposed recoupment or extended repayment schedule - there is no debt, and the FCCA does not apply.)

However, after review of its financial situation, Provider X decides that even an extended repayment schedule would force it into bankruptcy or out of business.

The representative for Provider X proposes that the provider pay only $50,000 over two years, in order to continue its full operations. No programmatic basis is offered for the payment of less than the full amount of the debt.

Fiscal Intermediary A contacts the Division of Financial Management of its Regional Office.

The Division of Financial Management staff apply the FCCA assessment worksheet (Attachment B).

The worksheet shows that the FCCA procedures are to be followed on both bases: there is a debt, and a compromise has been proposed.

The Division of Financial Management contacts the Office of Financial Management in Central Office. From this point on, the case of Provider X is tracked as a Federal Claims Collection Act case. The Office of Financial Management has the sole lead, although Center for Health Plans and Providers, Regional Office, Office of General Counsel and other expert staff may be consulted and directly involved in the case. In the end, if it is determined by OFM to be a compromise of a debt in an amount over $100,000 (excluding interest), it is referred by OFM to OGC and, ultimately, the Department of Justice.

ATTACHMENT D

FREQUENTLY ASKED QUESTIONS

Q. What about cases before the Provider Reimbursement Review Board (PRRB)?

A. The same principles apply. Many of the cases before the PRRB do not involve a "debt" under the Federal Claims Collection Act (FCCA) because repayment has been made.

Even while a case is before the Provider Reimbursement Review Board, the provider and the Fiscal Intermediary may agree to programmatic adjustments that result in the provider withdrawing the case. As long as these adjustments do not create a compromise under the FCCA, the case is not subject to the statutory FCCA requirements, such as consultation with the Department of Justice.[5]

However, HCFA is developing guidelines for contractors that will place new controls over intermediary (and carrier) determinations that meet criteria for significance. Those guidelines will provide that programmatic adjustments that meet the criteria must be approved by both an authorized program official and an authorized financial official.

Q. If a provider has a case before the PRRB regarding an amount in controversy that is being repaid under an extended repayment plan (ERP), does the FCCA apply?

A. Yes, until the final payment. After the provider makes its final payment under the ERP, there is no debt.

Q. What if the Fiscal Intermediary and the provider agree to a programmatic adjustment over $100,000? Does that need to be coordinated with the Department of Justice (DOJ)?

A. No. As long as the adjustment is clearly a redetermination of the amount in controversy under Title XVIII, it is within the authority of the Fiscal Intermediary. The Fiscal Intermediary may prudently confirm its interpretation with HCFA staff. In these situations, the Fiscal Intermediary is required to appropriately reopen the prior determination and issue a revised Notice of Program Reimbursement (NPR) reflecting the changed amounts.

[Note: Consistent with guidance elsewhere in this document, if this results in a HCFA decision on the programmatic adjustment, and that decision meets the criteria laid out, that decision must be documented in writing and approved by two appropriately authorized HCFA officials.]

Proper documentation is important. The execution of a programmatic adjustment without proper documentation through the reopening and NPR processes may inadvertently create a cost report settlement that on its face has the appearance of an improper and unauthorized compromise.

As noted above, HCFA will shortly issue additional guidelines to contractors requiring them to get HCFA approval for some programmatic adjustments.

Q. If a case is subject to the FCCA, does that mean that neither the Fiscal Intermediary nor HCFA can make Medicare-only programmatic adjustments without following FCCA-mandated procedures, such as consultation of the Department of Justice (DOJ)?

A. No. The amounts in controversy in a case may be in part resolved by programmatic adjustments and in part settled by FCCA compromise. However, if the case is subject to the FCCA, any compromise must be done in accordance with FCCA-mandated procedures.

Q. What if you are not sure whether the provider is fishing for a compromise? Sometimes this is very subjective.

A. If you are not sure, consult your manager and recommend involving the Office of Financial Management. The proper course of action is to be very conservative on the risk exposure because that risk may unfortunately fall partly on you. We would rather have some cases handled under the FCCA procedures when they may not need to be, than risk having cases settled without proper authority.

Q. I am an analyst in CHPP. What do I do if a Fiscal Intermediary or provider representative or regional office staff person calls me on the phone, describes a situation, and asks me if it is OK to take a certain amount as repayment in full?

A. You need to protect yourself by getting all the facts in the case. See the worksheet at Attachment B. If there is no debt, it is within the Fiscal Intermediary's authority to make a programmatic adjustment. While it is always permitted to make an appropriate programmatic adjustment, when there is a debt, certain FCCA procedures may apply. You should always make clear that you are merely advising on the justification of the programmatic basis, not agreeing to an amount (which might be misconstrued as an FCCA resolution). In any questionable case, conduct the consultation in writing.

If it appears to you that the guidance you propose to offer may result in a national policy decision, a precedent that may materially affect payment in other cases (especially open cases of disputed cost report settlements), or a significant difference in payment in a particular case, you should advise your managers and seek their guidance on whether the case should be coordinated with OFM.

Q. Does this mean that I should not share information with an intermediary or regional office staff member unless I know whether or not the case in question could be a Federal Claims Collection Act case?

A. No. There is a critical distinction between sharing knowledge and making a decision. Many of you are experts on very specific points of HCFA's policies, and you must be free to share your knowledge with your colleagues in other HCFA offices and with the contractors. You simply must be clear in these communications that you are not making the decision to resolve a Medicare payment dispute.

However, if you have reason to believe that your policy guidance in a case may have a material effect that should be coordinated with OFM (see Attachment F), you should raise the case to the attention of management. In CHPP, each Group Director is authorized to determine whether the materiality of guidance in a case necessitates coordination with OFM.

Q. If I can share knowledge freely, how do I know when I have to track a consultation and report it?

A. This has to remain a matter of judgment. The majority of issues of allowable costs and adjustments will not be related to FCCA cases, and it would impair consultation and slow progress on cost report settlement to treat all consultations as FCCA cases. The rule of thumb is that you may assume that any question that is specific to a program issue is not an FCCA issue until the inquirer shares information about the status of a debt, or, where there is a debt, a suggestion of a compromise or suspension or termination of collection that brings it under the FCCA.

With regard to non-FCCA cases, consult with your management if you believe that guidance offered in a particular case may have a material effect that warrants coordination with OFM.

[Note: Consistent with guidance elsewhere in this document, if this results in a HCFA decision on the programmatic adjustment, and that decision meets the criteria laid out, that decision must be documented in writing and approved by two appropriately authorized HCFA officials.]

Q. How does all this affect bankruptcy and insolvency cases?

A. As with Provider Reimbursement Review Board cases, the same principles apply. However, bankruptcy cases also are subject to a number of other Federal and State laws, tend to be very complex, and always involve the Department of Justice. Bankruptcy is litigation. Special rules apply to interfacing with entities in bankruptcy (called "debtors"). All bankruptcy matters must be coordinated

with DOJ through the Regional Chief Counsels' Offices (RCCOs) of the Office of the General Counsel. Further, since our ability to collect any debt is impaired by bankruptcy, almost any settlement will involve the exercise of FCCA authorities, rather than Title XVIII authorities. In all bankruptcy matters contact the Office of General Counsel for guidance.

Q. What about a provider ceasing to provide Medicare services due to health and safety issues?

A. These also tend to be complex cases, which may or may not involve the provider going out of business or undergoing bankruptcy proceedings. Any HCFA action on potential monies owed to Medicare must be coordinated with the regional Division of Financial Management. The regional Division of Financial Management will assess whether the case is to be treated as an FCCA case.

In the case of bankruptcy, proceed in accordance with Attachment F.

Q. Does this memorandum affect payments under demonstrations?

A. No. Because demonstrations are subject to intensive management review and oversight, including review by the Office of Management and Budget, this memorandum does not apply to demonstrations.

Q. I am a CHPP analyst. I have a case before me that does not appear to be an FCCA case, and I have established that to the best of my knowledge, there is no programmatic authority to address the problem at hand. What should I do?

A. Consult with your manager and recommend that your component seek the advice of OFM and OGC. These situations do arise, but they are very fact-specific, and need to be considered individually.

ATTACHMENT E

ORGANIZATIONAL RESPONSIBILITIES FOR FCCA REFERRALS IN THE MEDICARE FEE-FOR-SERVICE PROGRAM

1.0 General Responsibility for All Organizations and Staff

All HCFA staff are responsible for considering Federal Claims Collection Act (FCCA) applicability, and none should assume that another staff person or component has assessed it. Best practice is for Regional Office, the Center for Health Plans and Providers (CHPP) and Office of Financial Management (OFM) staff to coordinate and develop the facts together.

2.0 Fiscal Intermediaries and Carriers

2.1 Responsibilities

The Fiscal Intermediary or Carrier is responsible for the primary activity of debt determination and debt collection. The Fiscal Intermediary or Carrier does not have authority to suspend or terminate collection action on a debt, or to compromise a debt or otherwise make a debt settlement under the FCCA. The Fiscal Intermediary Claims Collection Point of Contact (CCPOC) or the Carrier Claims Collection Point of Contact must refer any suggestion of any of these actions to the Regional Office Claims Collection Point of Contact (RO CCPOC).

2.2 Points of Contact

Each Fiscal Intermediary or Carrier must identify a Claims Collection Point of Contact who is responsible for assessment of cases for appropriate referral to the Regional Office. This point of contact must be named to the Regional Office. The Fiscal Intermediary or Carrier must notify the Regional Office Claims Collection Point of Contact of any change in the Fiscal Intermediary or Carrier Claims Collection Point of Contact.

3.0 Regional Offices

3.1 Responsibilities

Each Regional Office shall appoint a Claims Collection Point of Contact from within its Division of Financial Management. This point of contact is responsible for ongoing communication and consultation with the FI and Carrier Claims Collection Point of Contact.

The regional Claims Collection Point of Contact is the lead for questions and referrals regarding the Federal Claims Collection Act. Any Regional Office staff who are pursuing or consulting on a collection case must refer any suggestion of a suspension or termination of collection action, or compromise or other debt settlement to the Regional Office Claims Collection Point of Contact.

Under HCFA delegations of authority, reflected in the AIS GUIDE, the Regional Administrator continues to have the authority to collect claims in full and to refer collections in full. This guidance does not alter those authorities for referrals. All such referrals must be reported to the OFM. Note that the AIS Guide has been superseded with respect to debt settlement authority; currently, only the Deputy Chief Financial Officer is authorized to approve any debt settlement, including any compromise under the Federal Claims Collection Act.

The Regional Office Claims Collection Point of Contact must maintain an up-to-date list of all potential suspension or termination of collection actions, and compromises or other debt settlements under discussion, including those referred for collection in full. The RO CCPOC must notify OFM of any change in the facts or status of a collection case that has been identified.

3.2 Points of Contact

Initially, the Regional Office Point of Contact shall be the Associate Regional Administrator who directs the Division of Financial Management.

REGION		POINT OF CONTACT	TELEPHONE
I.	BOSTON	Lynda F. Silva	617-565-1322
II.	NEW YORK	Peter Reisman	212-264-2505
III.	PHILADELPHIA	Bob Taylor	215-861-4261
IV.	ATLANTA	Dale Kendrick	404-562-7301
V.	CHICAGO	Opal Nealy	312-353-9817
VI.	DALLAS	Steve McAdoo	214-767-6402
VII.	KANSAS CITY	Phil Chiarelli	816-426-5033
VIII.	DENVER	Bernard Fellner	303-844-1993
IX.	SAN FRANCISCO	David Sayen	415-744-3661
X.	SEATTLE	David Haffie	206-615-2334

4.0 Office of Financial Management

4.1 Responsibilities

The Debt Collection Branch (DCB), Division of Financial Integrity (DFI), Financial Services Group (FSG), Office of Financial Management (OFM) is the central office lead for coordinating all HCFA collection activities. The Debt

Collection Branch may refer cases or issues to OFM staff as appropriate, but remains the center for all information on status.

The Director, Division of Accounting, FSG, the Office of Financial Management, is the Agency Claims Collection Officer (CCO) designated under the requirements of the Federal Claims Collection Act. The responsibilities of the Agency Claims Collection Officer are described in the Administrative Issuances Guide.

The Deputy Chief Financial Officer (DCFO) is the sole HCFA official authorized to suspend or terminate collection action, or to compromise or otherwise make a debt settlement under the FCCA.

The Deputy Chief Financial Officer shall be authorized to give financial concurrence to a CHPP decision on a programmatic adjustment, provided that approval is recommended in writing by a CHPP Group Director or Deputy.

The Chief Financial Officer and the Deputy Chief Financial Officer shall each serve as a contact point for any HCFA or contractor staff member who is unable to satisfy himself or herself that a proposed resolution of a Medicare payment dispute would not be improper where the proposed resolution would result in HCFA paying more or recouping less than it otherwise would have.

4.2 Points of Contact

POINT OF CONTACT	NAME	TELEPHONE
Debt Collection Branch	Maria Parmer	410-786-5465
Claims Collection Officer	Jeff Chaney	410-786-5412
Deputy Chief Financial Officer	Deborah Taylor	410-786-6427

5.0 Center for Health Plans and Providers

5.1 Responsibilities

The Deputy Director of the Center for Health Plans and Providers (CHPP) shall serve as a contact point for any HCFA or contractor staff who is unable to satisfy himself or herself that a proposed resolution of a Medicare payment dispute would not be improper where the proposed resolution would result in HCFA paying more or recouping less than it otherwise would have.

Each Group Director and Deputy in CHPP shall be authorized to give program approval to a CHPP decision on a programmatic adjustment, subject to concurrence from the Deputy Chief Financial Officer.

Each Group within the shall designate a Group Point of Contact (GPOC) for Federal Claims Collection Act assessments and referrals.

The Group Point of Contact shall be available to Group staff for training and consultation of the Federal Claims Collection Act requirements, assessment of FCCA applicability, and assistance in referral of potential Federal Claims Collection Act cases (requests to suspend or terminate collection action on a debt, or proposals to compromise a debt or otherwise effect a debt settlement under the FCCA) to OFM.Nonetheless, the Group Point of Contact's role does not relieve the CHPP staff person of the responsibility for being aware in all consultations with providersof the potential for a technical programmatic discussion to quickly transform into a Federal Claims Collection Act negotiation. Individual staff are always responsible for ascertaining the facts of a case in sufficient detail to apply the FCCA assessment worksheet.

All CHPP staff should be notified of the Group Point of Contact's identity and role, and of the responsibility of the staff to work with the Group Point of Contact to consult with and refer cases to the Office of Financial Management's Debt Collection Branch. In the absence of the Group Point of Contact, any CHPP manager may refer a case to the Debt Collection Branch.

5.2 Points of Contact

Initially, the GPOC for each CHPP group shall be the Group Director.

CHPP GROUP	GROUP POINT OF CONTACT (GPOC)	TELEPHONE
Purchasing Policy Group	Tom Gustafson/Parashar Patel	410-786-5674
Chronic Care Policy Group	Tom Hoyer/Janice Flaherty	410-786-5661
Health Plan Administration Group	Gary Bailey/Jean Lemasurier	410-786-4297
Provider Billing and Education Group	Chet Robinson/Joe Bruseker	410-786-6963
Demonstration and Data Analysis Group	Sharon Arnold/Sid Trieger	410-786-6451

6.0 Office of the General Counsel

6.1 Responsibilities

All matters that are referred to the Department of Justice under the FCCA must be reviewed by the Office of the General Counsel..

Two components of the Office of the General Counsel may be involved in Medicare collections: the Regional Chief Counsel's Offices (RCCOs), and the

Health Care Financing Division (HCFD). In addition, the Business and Administrative Law Division may be consulted if a case involves contract law. OGC is available to provide advice and assistance upon request.

Regional Office staff may consult the corresponding Regional Chief Counsel's Offices. In accordance with Attachment G, referrals to the Department of Justice for collection in full must be referred through the appropriate Regional Chief Counsel's Office.

The Health Care Financing Division attorneys may be consulted by Center for Health Plans and Providers or Office of Financial Management staff on Medicare programmatic issues in a case.

The Health Care Financing Division and Regional Chief Counsels' Offices have designated attorneys to be the initial points of contact for HCFA consultation. Those attorneys are listed in section 6.2, below.

6.2 Points of Contact

The initial points of contact are:

OGC COMPONENT	POINT OF CONTACT	TELEPHONE
HCF DIVISION	Thomas Stuber	410-786-8869
REGION I	Nancy Nemon	617-565-2382
REGION II	Annette Blum	212-264-6373
REGION III	Jim Newman	215-861-4461
REGION IV	Howard Lewis	404-562-7830
REGION V	Alan Dorn – IN, IL, MN	312-886-1707
	Al Jaffe – WI, MI, OH	312-886-1699
REGION VI	Joel Lerner	214-767-3463
	Backup - Gayla Fuller	214-767-2995
REGION VII	Sam Borin	816-426-6513, ext. 221
REGION VIII	Jay Swope	303-844-5101
REGION IX	Dick Waterman	415-437-8189
REGION X	Evelyn McChesney	206-615-2278

ATTACHMENT F

PROCEDURES CONCERNING CERTAIN NON-FCCA ISSUES RELEVANT TO MEDICARE COLLECTION ACTIONS

Introduction

HCFA's need for stronger financial controls and accountability in fiscal management goes beyond the coordination of Federal Claims Collection Act (FCCA) and Title XVIII authorities and procedures. Several further steps are needed, but this guidance cannot provide a full revision of all the affected procedures. However, certain specific concerns require improved operations immediately.

The guidance below applies to collections and cost report settlements under Title XVIII generally, including programmatic adjustments. This guidance applies whether or not a case is found to be subject to FCCA requirements.

Approval of Certain Programmatic Adjustments to Amounts in Controversy

As this guidance makes clear, all matters involving a debt must be referred to the Deputy Chief Financial Officer for appropriate disposition. Similarly, all matters for which there is no programmatic authority to resolve the amounts in controversy must be referred to the Deputy Chief Financial officer for appropriate disposition. Upon referral, the Deputy Chief Financial Officer must determine whether a matter involves both a debt and a compromise or a suspension or termination of a collection action.

- If the matter involves both a debt and a compromise or a suspension or termination of a collection action, the FCCA applies, and, if the amount of the debt exceeds $100,000, the DCFO must ensure that OGC and, ultimately, DOJ, review the matter.

- If the matter is one for which there is no programmatic authority to resolve the amount in controversy, but involves no debt, the FCCA does not apply. The DCFO, however, must ensure that OGC reviews the matter.

- If the matter involves a debt, but not a compromise or a suspension or termination of a collection action, the FCCA does not require referral to the Department of Justice, regardless of amount. In such cases, a programmatic adjustment may be proposed. The DCFO and the Deputy Director of the Center for Health Plans and Providers, however, must approve the resolution as a proper programmatic adjustment where the proposed adjustment would result in HCFA paying out more or recoup less than it otherwise would have.

As implied by the discussion above, if a matter involves neither a debt nor a compromise or a suspension or termination of a collection action, it need not be referred to the DCFO for disposition. Therefore, we are implementing the following additional procedural safeguard:

- In such a situation, if any agency or contractor employee has not satisfied himself or herself that a proposed resolution of a Medicare payment dispute would not be an improper programmatic adjustment, he or she may request that the DCFO and the Deputy Director, CHPP, approve the proposed resolution as a proper programmatic adjustment where the proposed adjustment would result in HCFA paying out more or recoup less than it otherwise would have.

Six months from the issuance of this memorandum, the CFO will reevaluate all of these procedural safeguards and advise the Administrator whether modifications are warranted and, if so, what those modifications should be.

Consideration of Potential Financial Significance of Programmatic Adjustments

CHPP staff are often consulted as experts on payment policy. Many, but not all, of these consultations may result in programmatic adjustments, and the staff consulted may not be given the information needed to make a determination whether information, advice, or even a correction conveyed to a provider or intermediary has a significant effect on payment.

Requiring the coordination of all such consultations with OFM is unnecessarily burdensome. However, it is necessary that all CHPP staff be vigilant to identify any case that may result in a national policy decision, a precedent that may materially affect payment in other cases (especially open cases of disputed cost report settlements), or a significant difference in payment in a particular case. OGC is available to provide advice and assistance upon request. OFM is responsible for maintaining the Agency's financial controls and producing its financial statements. Coordination with OFM is necessary for any HCFA decision that significantly affects those controls and statements. OFM actions on such cases will be based on those financial responsibilities, and will not abrogate CHPP's authority on policy matters.

The required procedure mirrors established practice: each CHPP staff member is responsible for identifying potential cases and consulting Division or Group managers. Each Group Director shall decide whether particular cases must be coordinated with OFM.

CHPP shall develop guidelines for the assessment and referral of cases to OFM, and shall train all CHPP staff in those guidelines and the supporting procedures.

Once a case is referred to OFM, DFI shall retain the responsibility for tracking the case until it is closed or settled, and CHPP and regional DFM staff may be required to regularly update the status with DFI.

Identification of Potential Precedential Impact of Programmatic Adjustments

OFM will work with the CHPP and the Regions to establish a forum for discussion and identification of issues and cases under consideration that may have precedential impact on other cases. OGC will provide advice and assistance upon request.

OFM shall develop a means of notifying FIs and carriers of issues that have been identified as having precedential risk. Once this means of notification is established, FIs and Carriers will report on a regular basis to the RO Claims Collection Point of Contact (RO CCPOC) the status of any cases involving those issues. These reports will be consolidated regionally, and forwarded to OFM. OFM shall consolidate and analyze the regional reports and provide the resulting information to CHPP and the Regions.

Before this identification, notification and tracking system is established, FIs, Carriers, and Regions are required to regularly review cases on hand to assess precedental risk, and to report any such cases informally to their regular points of contact.

Programmatic Adjustments in Cases Before the Provider Reimbursement Review Board

An FI and a provider may agree to programmatic adjustments under Title XVIII that resolve a cost report settlement that is already before the PRRB.

If the provider owes a debt to Medicare, the FCCA procedures must be followed regarding any action to compromise or suspend or terminate collection. This would apply even if the provider were actively repaying the debt under an extended repayment plan. However, cases before the PRRB are not subject to the FCCA if the debt has been repaid.

Programmatic adjustments not subject to the FCCA must be coordinated with the Office of Hearings (the component of HCFA's Office of Internal Customer Support that provides staff support to the PRRB), and, to the extent that they have been consulted regarding the programmatic adjustment, with OFM and any involved CHPP Group. The FI must document that only programmatic adjustments were made, and must observe the applicable rules regarding reopening and the issuance of a revised determination through a new Notice of Program Reimbursement (NPR). The Regional Office Claims Collection Point of Contact must be notified to assure that any affected reports are appropriately updated.

Stipulation Agreements

HCFA employees may be confronted by proposals from providers or their representatives in the form of legal documents, requiring an authorized signature, and designated by names such as "stipulation agreement"or "stipulation of settlement." These agreements have most often arisen in cases with providers who are in an appeal status, such as before the PRRB, or in litigation, but may involve providers who have not yet been issued a final NPR. In some cases the agreement deals with the applicability of a particular ruling or decision (e.g., a circuit court decision) to one or more providers who may or may not have appealed the issue decided in the ruling or decision. Some such agreements may refer to specific amounts in controversy, others simply to application of particular policies or guidelines.

HCFA is concerned that in some cases signing such an agreement may jeopardize future appeals of court decisions in other circuits and districts. Any HCFA employee who is asked to execute such an agreement must consult OGC and notify the appropriate CCPOC.

We have concluded that confidentiality clauses, while not illegal, are contrary to public policy, and therefore, no agreement may contain such a clause, unless we are instructed to do otherwise, in the course of litigation, by the Department of Justice.

The form of these agreements is irrelevant to the determination of whether or not the FCCA applies. Although some are entitled as stipulating a settlement, the facts of the case must be considered to assess whether or not the proposed agreement would constitute a debt settlement or other action subject to the Federal Claims Collection Act.

The Office of Financial Management shall prepare instructions under which each regional Division of Financial Management (DFM) is to consult with its FIs and carriers as to the frequency and nature of such stipulations, and report the results back to the Office of Financial Management. Based on that information collection, future guidelines will be developed.

Bankruptcy and Insolvency

HCFA routinely encounters situations in which a provider, managed care organization, or insurer is insolvent and owes Medicare monies. All bankruptcies and insolvencies are litigation, for the purposes of these procedures are treated as subject to the FCCA, and must be coordinated with DOJ.

Bankruptcies and insolvencies of managed care organizations and other payers differ in key ways from provider bankruptcies. State insurance departments are the primary sources of information in managed care organization or insurer bankruptcy and insolvency situations. Typically, a State insolvency proceeding is called a receivership.

Although these guidelines are specific to fee for service Medicare operations, it is necessary to discuss Medicare managed care contracts in this context, since organizations with Medicare managed contracts may also be other payers with which Medicare benefits must be coordinated, or may also provide services to some beneficiaries on a fee for service basis. To assure proper coordination, CHPP shall develop appropriate procedures consistent with these guidelines to be followed when a managed care organization with a Medicare contract is declared insolvent by the State insurance department or begins bankruptcy or insolvency proceedings. CHPP shall immediately inform DFI about managed care organization bankruptcy and insolvency filings, noting the dates the referrals occurred. If regional staff are first to learn of an insolvency, they shall similarly inform the regional DFM of such filings, which shall in turn inform the RCCO and DFI. DFI shall coordinate with CHPP, the Regional DFM and OGC or the RCCO to assure that the litigation is effectively coordinated.

HCFA is generally notified of provider bankruptcies by its fiscal intermediaries and carriers or by DOJ through OGC. FIs and carriers shall immediately refer all provider bankruptcy cases to DFM, which in turn shall immediately refer the case to the RCCO for coordination of the litigation with DOJ. At the same time, the Regional DFM shall report the case to the Office of Financial Management's Division of Financial Integrity (DFI), noting the dates the referrals occurred.

Timing is very important in bankruptcy and insolvency matters. Time constraints prohibit central control by DFI of all responses, but HCFA must maintain a central repository of identifying and tracking information. If issues require coordination of responses with Central Office components, that coordination must be referred to DFI, unless court deadlines prohibit. DFI shall notify and coordinate with any necessary CO components, and shall coordinate with OGC (HCF Division) to assure the litigation is being handled appropriately. Similarly, in the Regions, DFM shall notify and coordinate with any necessary RO components, and shall coordinate with the RCCO.

RCCOs shall refer all directly received (whether from DOJ or otherwise) bankruptcy and insolvency cases to their Regional DFM. DFM shall coordinate as appropriate with the FI, carrier, or regional staff who are responsible for a particular Medicare managed care plan, and report to and coordinate with DFI. OGC shall refer all directly received (whether from DOJ or otherwise) bankruptcy and insolvency cases to DFI and coordinate with the RCCOs for handling and coordination with DOJ.

To summarize, DFI in central office and DFM in the regional offices shall track all bankruptcy and insolvency cases and jointly ensure the referrals to the responsible central office, regional office and OGC components as appropriate. DFI shall assure that HCFA provides DOJ (through the RCCOs or OGC) adequate bankruptcy support, including necessary supporting documents and analysis from FIs and carriers.

All provider bankruptcy supporting document and analysis requests to the FI or carrier shall be coordinated through the regional DFM. Requests to Medicare managed care plans for supporting documents and analysis shall be referred to the plans through the

regional staff responsible for those managed care contracts, but shall be coordinated with DFM, so that DFI may rely on a common contact point for status information on all bankruptcies and insolvencies.

If a Region receives a bankruptcy referral from a Regional Attorney in the RCCO or an Assistant US Attorney, and has not received notice of the case from DFI, the RO CCPOC shall report the case to DFI.

Appeal of Adverse Court Decisions

There has been inconsistency in handling decisions of whether to appeal adverse court decisions.

CHPP, OFM and the Office of the Attorney Advisor shall form an Appeal Review Committee to establish criteria for deciding whether to appeal. The Appeal Review Committee shall consider each adverse court decision and apply its criteria to determine whether an appeal should be taken. OGC shall advise the Committee without a vote.

The Committee shall be authorized to refer a case to OGC (HCF Division) requesting appeal on behalf of HCFA. HCFA recognizes that OGC must coordinate any such decision first with the General Counsel's office and secondly with DOJ.

The Committee shall work with OGC to assure adequate briefing and explanation of the issues under consideration, and shall coordinate technical support from HCFA staff in assessing potential risk exposures from a decision not to appeal or the failure of an appeal.

In the event that OGC informs the Committee that it does not believe HCFA's decision to appeal is advisable, the Committee shall notify and brief the EC. If HCFA disagrees with OGC's recommendation after discussion with OGC, the Committee will, on the Administrator's request, coordinate the preparation and clearance of a decision memorandum, if necessary, requesting the Deputy Secretary to revisit the OGC decision in discussion with the General Counsel's office and HCFA.

Senate Permanent Subcommittee
On Investigations

EXHIBIT # 27

CHARLES B. RANGEL
16TH CONGRESSIONAL DISTRICT
NEW YORK

DEPUTY WHIP

COMMITTEE:
WAYS AND MEANS
RANKING MEMBER
SUBCOMMITTEE ON TRADE
JOINT COMMITTEE ON TAXATION

Congress of the United States
House of Representatives
Washington, DC 20515–3215

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DISTRICT OFFICES:
MS. VIVIAN E. JONES
DISTRICT ADMINISTRATOR

163 WEST 125TH STREET
NEW YORK, NY 10027
TELEPHONE: (212) 663-3900

2110 FIRST AVENUE
NEW YORK, NY 10029
TELEPHONE: (212) 348-9630

PLEASE RESPOND TO
OFFICE CHECKED

March 27, 2000

Honorable Susan Collins
United States Senate
Washington, D.C. 20510

Dear Senator Collins:

It has come to my attention that the Permanent Investigations Subcommitte will be holding a hearing on the Health Care Financing Administration's (HCFA) settlement of three claims, two of which were with major New York health care providers. I want to make sure that your Subcommittee understands my support for these institutions and the leadership of HCFA, in particular it's former Director, Bruce Vladeck.

I can attest, without reservation to the integrity of Mr. Vladeck and his dedication to assuring access to quality health care for all. Bruce Vladeck worked in New York for many years before his appointment to HCFA. The President's choice was a good one. Mr. Vladeck has an extensive knowledge in the complex issues of health care finance. I am sure that if he believed that the matters at hand should have been settled, then they most likely should have been.

The General Accounting Office report appears to make no accusations of conflict of interest. Instead, the report alleges that proper procedure was not followed. Given the experience of Mr. Vladeck and the senior HCFA professionals who he assigned to negotiate these settlements and the crucial role the institutions in question play in providing health care, especially for the poor and uninsured, I see no reason to believe no matter what fair procedure would have been followed the result would have been virtually the same.

I hope that you will see that Mr. Vladeck knows not only the price of health care, but the value of assuring it for all who need it.

Sincerely,

Charlie

CHARLES B. RANGEL
Member of Congress

CBR:jrs

Cc: Hon. William Roth
Hon. Ted Stevens
Hon. George Voinavich
Hon. Pete Domenci
Hon. Thad Cochran
Hon Arlen Spector

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Senate Permanent Subcommittee
On Investigations
EXHIBIT # 28

RANKING MEMBER
COMMITTEE ON GOVERNMENT REFORM
MEMBER
COMMITTEE ON COMMERCE
DEMOCRATIC STEERING COMMITTEE

Congress of the United States
House of Representatives
Washington, DC 20515–0529

HENRY A. WAXMAN
29TH DISTRICT, CALIFORNIA

March 27, 2000

Senator Carl Levin
Ranking Member
Committee on Governmental Affairs
Permanent Subcommittee on Investigations
Senate Russell Building, Room 100
Washington, D.C. 20510-6262

Dear Carl:

It has come to my attention that the Senate Governmental Affairs Subcommittee on Investigations is conducting a hearing tomorrow concerning how the Health Care Financing Administration (HCFA) settled certain Medicare claims in 1996, including some claims relating to public hospitals in L.A. County.

I thought it might be useful to give you some context on this issue. During the 1995-1996 period, L.A. county was in a period of severe fiscal crisis, with alarming implications for the continued viability of the public hospital system. There were threats of bankruptcy, and some were even suggesting that the county would have to walk away entirely from their obligations to serve the poor.

There was probably not a member of the L.A. delegation of either party who was not aware of the serious threat posed to continuing health care services to the many poor and uninsured persons who were served by these providers.

During that period, the California State administration under Governor Wilson supported and forwarded to HCFA proposals for a waiver of certain Medicaid requirements, and during the discussions of the county and State with HCFA, the severity of the problem facing the L.A. health system was undoubtedly impressed on HCFA, and other officials in the Administration.

Many members of the delegation, I am sure, urged HCFA officials to act appropriately and responsively in whatever areas were before them to aid the county in avoiding what loomed as a public health disaster. In other words, we wanted to assure that inattention or bureaucratic delays in resolving resolvable issues were avoided to the extent possible.

I understand that the actions of Dr. Bruce Vladeck, who was head of HCFA at that time, to press his staff to resolve certain Medicare reimbursement disputes in 1996, are now being called into question.

I know Dr. Vladeck as a dedicated and able Administrator of the agency, who was totally committed to the protection and strengthening of both the Medicare and Medicaid programs. He was and is committed to the beneficiaries of these vital health care programs–the aged and disabled persons who depend on Medicare and the low-income aged and disabled, and children and families, who are served by Medicaid. It is inconceivable to me that he would have taken an action that would have endangered or compromised the Medicare Trust Fund, or inappropriately settled claims.

I cannot speak to the procedures that were followed in the agency when the final amounts were negotiated with the county. I can say again that the public health system of the county was in crisis, and it would have been indefensible of HHS if it did not attempt to respond legally and appropriately in a timely manner to act on all pending matters to ease the crisis.

I hope these views might be of assistance to you as you proceed with the Subcommittee hearing tomorrow.

With kind regards, I am

Sincerely,

HENRY A. WAXMAN
Member of Congress

Senate Permanent Subcommittee
On Investigations

EXHIBIT # 29

STATEMENT OF THE VISITING NURSE SERVICE OF NEW YORK

MARCH 28, 2000

The Visiting Nurse Services of New York (VNS) is extremely distressed about the March, 2000 GAO Report entitled, "HCFA - - Three Largest Medicare Overpayment Settlements Were Improper". As part of its attack against the Health Care Financing Administration (HCFA) and its allegedly inappropriate settlement of disputes with three providers, inaccurate and very damaging statements are made in the Report about the behavior of VNS. This statement seeks to correct some of the most egregious and inaccurate allegations in the Report.

The GAO Report is the subject of the United States Senate Permanent Subcommittee on Investigation's hearing today. The report refers to a settlement agreement between HCFA and VNS. This settlement was reached in 1995 and followed a lengthy and serious policy disagreement between VNS and HCFA.

The source of this protracted disagreement was the appropriate methodology for determining the average cost per visit for home health aide visits used in calculating Medicare reimbursement for certified home health care services. The methodology prescribed by HCFA was to be used by all New York State Certified Home Health Agencies and by certified agencies throughout the nation.

VNS scrupulously followed the HCFA regulation that had been in place since 1965, only to discover in 1991 that the Fiscal Intermediary (FI) was reinterpreting HCFA's regulation—and retroactively recalculating its reimbursement methodology—when the FI discovered that it resulted in higher than expected Medicare reimbursement for home health care in some states.

The policy that formed the basis for the FI's recalculation had never been clearly articulated, nor had this same FI used such policy in reviewing VNS's previously filed cost reports. Indeed, it was not until HCFA's issuance of HCFA Pub. 60A/B, Transmittal No.AB-97-11 (August 1997) - - over two years after the final settlement agreement with VNS was signed - - that HCFA finally clarified its policy in this regard. Contrary to the implication in the GAO Report that VNS had received favored treatment, it is important to note that the enforcement of this policy clarification was made prospective only with respect to home health agencies whose fiscal intermediaries had been using a "less stringent"policy in the counting of non-Medicare home health visits and the reporting of associated costs. This is exactly the situation in which VNS found itself in 1991.

Under HCFA's regulations governing home health agencies, agencies are required to use a "cost per visit by type-of-service" cost apportionment methodology . Under this method, the total allowable cost of all visits (Medicare and non-Medicare) for each category of visit (including home health aide visits) is divided by the total number of visits for that type of service in order to determine the average cost per visit for each type of service. Then, for each category of service, the number of Medicare-covered visits is multiplied by the average cost per visit, with the resulting figure used in computing the cost report.(42CFR413.53(a)(3)). As it was required to do, VNS followed this methodology in filing its cost reports.

As it had done in the past, VNS included all Medicare and all non-Medicare (including Medicaid) home health aide visit costs in determining the average cost per visit. According to the existing regulations and manual instructions, home health agencies were to include all costs of all home health aide visits, including those that were Medicaid reimbursed, as long as they were Medicare-like in nature. That included home health aide tasks such as assistance with medication administration and personal care including bathing, transferring, etc. Such tasks were performed during all home health aide visits, both Medicare and non-Medicare, and thus it was perfectly appropriate to include the cost of such visits in VNS's cost report regardless of the actual visit length.

Historically, VNS has taken under care patients who are often seriously ill, functionally impaired, and unable to leave their homes. VNS serves an unusually high percentage of patients with congestive heart failure, pulmonary disease, cancer, advanced arthritis and other diseases with serious complications. VNS tends to receive and serve very sick "high acuity" cases because of its clinical expertise and vast experience in such cases as wound care and cardiac care. VNS also has historically served an enormous number of patients with AIDS. An unusually high percentage of its patients have two or more diagnoses and are cognitively impaired.

Contrary to the implication in the GAO Report, the difference in length between Medicare and non-Medicare visits does not make it inappropriate for VNS to include such visits in its cost report. While HCFA's methodology in this case may not have apportioned costs perfectly between Medicare and non-Medicare patients, that methodology was the approach that HCFA chose to use. To now paint VNS as having in some fashion acted inappropriately is baseless. In essence, there is no "correct" cost per visit from agency to agency, and there is no benchmark figure that applies across the board; this depends on the characteristics and size of an agency's overall caseload.

We resent and take issue with the implication in the GAO Report that the settlement agreement with HCFA would permit provider reimbursement for costs for which the provider would not otherwise be entitled. This conclusary

statement is extremely damaging and totally inaccurate. The very nature and uncertainty of the policy which was the subject of the protracted dispute belies the allegation that there was any "correct" number of hours for a home health aide visit.

The GAO Report asserts that the fiscal intermediary had sought guidance and support from HCFA's Central Office "based upon the home health agency's angry and hostile posture . . .". This is unfair and untrue. In fact, HCFA was brought in by the Fiscal Intermediary to give guidance in resolving the issue of what constituted "Medicare-like" services, since the intermediary and VNS continued to disagree on how to resolve this issue.

The GAO Report accepts at face value the assertion by the Fiscal Intermediary that it engaged in a substantive review of the nature of the non-Medicare home health aide visits to determine whether they were of "like-kind". That is not the case. The Fiscal Intermediary never undertook any review of a valid sample of cases, instead "reviewing" 65 non-Medicare case records out of a census of approximately 45,000 patients. Even in that review, the Fiscal Intermediary used an erroneous standard to make its findings.

With years of open cost reports still awaiting closure while HCFA and the Fiscal Intermediary were engaged in a three-year debate about what policy should be applied in this case, VNS pursued the approach of trying to find a way to settle this policy dispute and to find an acceptable and supportable way to proceed in the future. It was against this backdrop that the FI issued its February Notice of Program Reimbursement (NPR), FI for the years 1988-1991, which in VNS' view was contrary to existing HCFA rules and guidance on this very issue given to the Fiscal Intermediary. Faced with the prospect of having to go through years of appeals, and with the uncertainty that HCFA would again allow the FI to retroactively change its policy, VNS again decided to attempt to settle this matter.

The only contacts VNS ever made to seek guidance and resolution of this difficult policy issue were with individuals at HCFA itself. VNS at no time exerted undue pressure on any HCFA official, nor did it seek special or favored consideration from the FI or HCFA. There was one brief telephone discussion with the HCFA Administrator seeking a fair hearing by HCFA so that VNS's position could be aired. Even this contact was made after the issuance of the NPR, in the midst of a protracted settlement discussion, demanding the repayment of an enormous sum of money. We fail to understand how this constitutes an inappropriate action given the emergency nature of this development and our perceived need to attempt to move to resolve this issue expeditiously.

While VNS could have waited for this matter to wend its way through the administrative (PRRB) process, that would have left the matter unresolved for many years, thus resulting in total uncertainty about reimbursement for ten or

more years on both a retroactive and prospective basis. It would have been impossible for VNS to endure this process, given the magnitude of the amount in issue and the uncertainty concerning fundamental issues relating to its overall reimbursement. In effect, this would have been like trying to run a business without knowing much how much and when the business would be paid. We believed at the time, and still believe that this would have been an untenable position for us to be in.

Finally, contrary to the GAO Report, the agreement with HCFA does not permit VNS to add a specified number of hours to its Medicare average "regardless of the number of hours of service actually rendered". Instead, the agreement caps the non-Medicare home health visits that can be included in the cost apportionment methodology as the lesser of the actual non-Medicare home health aide visit length or the actual Medicare home health visit length plus 1.63 hours.

RECEIVED APR 1 0 2000

Senate Permanent Subcommittee
On Investigations
EXHIBIT # 30

Mary Suther
Chairman of the Board
Val J. Halamandaris
President

NATIONAL ASSOCIATION FOR HOME CARE
228 Seventh Street, SE, Washington, DC 20003 • 202/547-7424 • 202/547-3540 fax

Honorable Frank E. Moss
Senior Counsel
Stanley M. Brand
General Counsel

April 6, 2000

VIA FACSIMILE AND U.S. MAIL

Senator Susan M. Collins
Chairman, Permanent Subcommittee
on Investigations
Committee on Governmental Affairs
United States Senate
SR-100 Russell Senate Office Building
Washington, DC 20510-1904

Re: GAO Report: "Three Largest Medicare Overpayment Settlements Were Improper" and March 28 Subcommittee Hearing

Dear Senator Collins:

The National Association for Home Care (NAHC) fully supports your efforts to evaluate the Medicare overpayment settlement process utilized by the Health Care Financing Administration (HCFA). We are requesting that you include this letter in the record of your hearing of March 28.

As part of its analysis, the General Accounting Office (GAO) focused on a settlement involving a home health agency; the particulars of the settlement relate to a Medicare reimbursement issue that affects providers nationwide. As part of your evaluation of the actions undertaken by HCFA to settle a controversy with that home health agency, we urge that you include in your examination the following considerations as to the nature of the reimbursement concern.

At issue in the settlement for the home health agency was an application of a Medicare cost reporting policy that is intended to distinguish between Medicare like-kind services and services which are not similar to a Medicare type of home health service. The distinction is

necessary for purposes of calculating the average cost of Medicare visits under the cost reporting formula devised by HCFA. During the time period in issue, the early 1990s, neither HCFA nor its fiscal intermediaries maintained a written, consistent policy definition that could be applied by home health agencies. It was not until 1997 that HCFA issued a nationwide policy definition setting out the standards for determining "like-kind" services.

As a result of the application of ad hoc standards for determining like-kind services prior to the policy issuance, a number of home health agencies have been subject to reimbursement disallowances. Recently, two of those instances led to reversals of their reimbursement disallowances by the Provider Reimbursement Review Board, the administrative appeals forum for Medicare reimbursement disputes.

The settlement of an issue that is surrounded by confusion, ambiguity, and a lack of definitive standards makes sense. HCFA should have considered settlement of more of these contested matters than just the one at issue in the GAO report. It was in the best interest of all parties to address the matter prospectively to achieve uniform administration of the Medicare home health benefit.

On a secondary note, we urge you to take steps to avoid HCFA abandoning any consideration of overpayment settlements. As you are well aware, the home health community has been devastated by the effects of the interim payment system, with many home health agencies hit with overpayments due to the retroactive nature of the payment limits. HCFA should be authorized to compromise the IPS-related overpayments as a means to reestablish a firm foundation for the delivery of home health services. A compromise settlement opportunity for IPS-related overpayments, combined with your efforts and those of your colleagues to bring refinement to the Balanced Budget Act of 1997, could go a long way toward restoring access to home health services for Medicare beneficiaries nationwide.

As always, our staff stands ready to assist you in further exploration of this and other issues of importance to home care. Thank you for all of the good work that you do.

Sincerely,

Val J. Halamandaris
President

CC: Senator Fred Thompson
Senator Carl Levin
K. Lee Blalack, Majority Staff Director
Linda J. Gustitus, Minority Staff Director
Priscilla Hanley

Senate Permanent Subcommittee
On Investigations

EXHIBIT # 31

NATIONAL ASSOCIATION of PUBLIC HOSPITALS and HEALTH SYSTEMS
1301 PENNSYLVANIA AVENUE, NW, SUITE 950, WASHINGTON DC 20004 | 202.585.0100 | FAX 202.585.0101

April 10, 2000

The Honorable Susan Collins
Chair, Permanent Subcommittee on Investigations
Governmental Affairs Committee
Russell Senate Office Building
Washington, DC 20510

Dear Chairwoman Collins:

The National Association of Public Hospitals (NAPH) is writing to comment on the hearing you held on Tuesday, March 28 on the General Accounting Office (GAO) report entitled "Three Largest Medicare Overpayment Settlements Were Improper." We are submitting our comments for inclusion in the record. We would like to provide some perspective on the situations of two of the three providers discussed in the report, the New York City Health and Hospitals Corporation (HHC) and the County of Los Angeles Department of Health Services (DHS). NAPH strongly supports efforts by the Administration and members of Congress to ensure that Medicare funds are used appropriately. However, we think that the GAO report unfairly characterized the two providers in question. We think the following points deserve to be clarified for the record:

- HHC and DHS are two of the largest providers of care in the country. In 1997, eleven HHC acute care hospitals provided over 200,000 inpatient discharges and over 4.8 million outpatient visits. Six DHS hospitals provided over 106,000 inpatient discharges and 3 million outpatient visits. Both of these systems treat predominantly low-income patients, mostly Medicaid, uninsured and low income Medicare individuals. HHC had annual patient revenues of over $2.3 billion and DHS had patient revenues of $1.5 billion in 1997. While they may treat relatively fewer Medicare patients than the average hospital, their annual Medicare revenues are nevertheless substantial (over $601 million for HHC and over $150 million for DHS in 1997). Thus, given their size and the number of years in question, the magnitude of these settlements was not excessive.

- A point that was repeatedly misstated throughout the hearing, and in the report, relates to the nature of Medicare cost report disputes. These were not amounts that the providers owed HCFA, nor are the amounts described as "in dispute" correct. Every year, hospitals file cost reports. Once the fiscal intermediary finalizes their audit of the report; they make adjustments to Medicare payments based on what they believe are appropriate Medicare costs, and those amounts are deducted from future payments by HCFA. Often providers will dispute the findings of the intermediary

and they will appeal those findings to the PPRB, which is what these two provider systems did. Thus, the providers did not owe HCFA. The providers believed that HCFA owed them the disputed amounts. Further, the amount that these providers believed that they had been underpaid was far higher than the amounts of the final settlements – in HHC's case, the total amount of claims in dispute was $350 million and in DHS's case, the total was $79.4 million. Thus, both providers settled these claims for far less than they believe that they had been underpaid.

- The "special treatment" received by these two provider systems did not include timely treatment of their settlements. In both cases, these providers waited many years for these claims to be settled. In HHC's case, the years in dispute were 1983 through 1993 and in DHS's case, the years in dispute were from the mid-1980's through 1993. HHC's settlement occurred in 1996 and DHS's settlement occurred in 1997. It is hard to imagine how these settlements could possibly be considered "sweetheart" deals when providers had to wait so many years for settlement. Also, it is perfectly reasonable for providers to request assistance in moving the bureaucracy by contacting the Administrator or having their members of Congress intercede for them when the "standard process" takes this long.

- In both situations, as Bruce Vladeck, the former HCFA Administrator, testified, urgency was necessary. In 1995, the Los Angeles County Board of Supervisors was giving serious consideration to closing one or more LAC hospitals, due to a fiscal crisis. Similarly, HHC was experiencing substantial shortfalls at about this time. Both systems' finances were in jeopardy. These systems provide care to many low-income patients without any other health care alternatives. Additionally, they provide unique and costly trauma, burn, neonatal intensive care, and other services on which their entire communities rely.

- The nature of the claims in dispute also requires some clarification. Most of the claims were for reimbursement of the costs of bad debt. A hospital incurs bad debt when a patient is unable or unwilling to make co-payments or pay deductibles for which they are responsible. Typically, hospitals must demonstrate that either the Medicare patient was indigent or that two bills were sent to the patient before any amounts can be written off. According to the report, these two systems were unable to provide adequate documentation that either of these two conditions was met. While we are not familiar with the level of documentation provided, the patients that these providers treat are almost always indigent and almost always unable to pay.

In summary, we believe that the GAO report was unfair and inaccurate in its portrayal of these two systems. We were also very sorry to see how unfairly the report portrayed Dr. Vladeck, who has been a dedicated, intelligent, and caring public servant. Dr. Vladeck has been devoted throughout his career to improving access to health care for all Americans, and particularly to meeting the needs of the poorest and most vulnerable in our nation. Please do not hesitate to call if you have any questions, at 202-585-0100.

Sincerely,

Larry S. Gage

Larry S. Gage

cc: Senator Carl Levin

Senate Permanent Subcommittee
On Investigations

EXHIBIT # 32

United States General Accounting Office
Washington, DC 20548

Office of Special Investigations

April 10, 2000

The Honorable Susan M. Collins
Chairman
Permanent Subcommittee on Investigations
Committee on Governmental Affairs
United States Senate
Washington, DC 20510-6250

Dear Senator Collins:

I am writing to you at your staff's request that GAO respond to the implication some raised during the Subcommittee's March 28, 2000, hearing entitled "*Oversight of HCFA's Settlement Policies: Did HCFA Give Three Providers Special Treatment?*" that GAO did not give one of the witnesses, Bruce Vladeck, an adequate opportunity for an interview prior to the publication of our report on this matter.[1] In a letter written on March 27, 2000, by Mr. Vladeck's attorney to you and during the hearing it was suggested that GAO was "wholly unfair" and had "labeled" Mr. Vladeck as a "reluctant witness." Mr. Vladeck's attorney went on to write that it appeared to him that William Hamel of my staff "was personally vested in this matter" and suggested that Mr. Hamel's participation in our investigation violated Rule 6(e) of the Federal Rules of Criminal Procedure. Lastly, he wrote that the Subcommittee "should resist Mr. Hamel's efforts to portray Mr. Vladeck as an uncooperative witness."

From the outset, as you know, neither Mr. Hamel, nor the report and testimony GAO issued in this matter characterized Mr. Vladeck as uncooperative. However, as I testified before the Subcommittee, GAO made fifteen contacts with Mr. Vladeck and his attorney between July and October 1999, in an attempt to interview Mr. Vladeck and afford him the opportunity to discuss his involvement with the settlements, without success. To address any concern Mr. Vladeck may have had about ongoing grand jury proceedings, we also offered Mr. Vladeck the opportunity to only answer questions about the settlements that were not the subject of any prior investigation. This was also unacceptable to Mr. Vladeck or his attorney. Three times Mr. Vladeck's attorney set dates for an interview, only to postpone it twice and finally cancel the scheduled interview at the last minute. Indeed, it was not until two weeks prior to the hearing that Mr. Vladeck was questioned about the matters we investigated, and that was at a deposition conducted by Subcommittee staff.

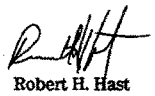
[1] See GAO/OSI-00-4 *HCFA: Three Largest Medicare Overpayment Settlements Were Improper.*

Although Mr. Hamel was the principle investigator assigned to our investigation, he was not the principle author of our report. The report was a joint effort between the Office of Special Investigations and our Office of General Counsel and it had numerous layers of senior GAO management review, including an Associate General Counsel, the General Counsel, the Assistant Comptroller General for Quality and Risk Management, and myself.

Lastly Mr. Vladeck's attorney alleged that Mr. Hamel was "personally vested" in this matter, and there were ensuing suggestions at the hearing that Mr. Hamel was on a "personal crusade," implying that his participation in our investigation was in some way improper or unethical. You will recall that I also provided testimony at the hearing demonstrating the vetting process we went through for Mr. Hamel to participate in this investigation. This included several communications with officials from the Department of Justice and from Mr. Hamel's former employer, the Office of Inspector General at the Department of Health and Human Services. The Department of Justice explicitly sanctioned Mr. Hamel's participation in this matter, and the Office of Inspector General had no objection provided Mr. Hamel adhered to certain guidelines, which he did. GAO's Office of General Counsel also reviewed his participation and concluded that it would be lawful. Finally, it should be noted that you requested this investigation be made, and in response I assigned Mr. Hamel to it. Our process in investigating this matter belies any notion of a "personal crusade" as some might allege.

I appreciate the opportunity to address how Mr. Vladeck's attorney has characterized GAO's report, testimony, and staffing decisions on this matter, and respectfully request that you make this letter a part of the official hearing record.

Sincerely yours,



Robert H. Hast
Assistant Comptroller General
for Special Investigations

cc: The Honorable Carl Levin
Ranking Minority Member

MARK FINUCANE, Director

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
313 N. Figueroa, Los Angeles, CA 90012

Senate Permanent Subcommittee
On Investigations

EXHIBIT #__33__

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April 11, 2000

Honorable Susan Collins, Chair
Honorable Carl Levin, Ranking Member
Committee on Governmental Affairs
Permanent Subcommittee on Investigations
Senate Russell Building, Room 100
Washington, D.C. 20510-6262

Dear Senators Collins and Levin:

As the Director of the Los Angeles County Department of Health Services (LAC DHS), I am writing to respond to the testimony presented at your March 28, 2000, hearing regarding the General Accounting Office report on three Medicare settlements. I am concerned that the hearing created a perception that the settlement with LA County was improper. In response, my department has developed the following summary. I hope this additional information, submitted for the record, helps clarify a number of the key issues addressed in the hearing.

As way of background, LA County operates six acute care hospitals, six comprehensive health centers, and 42 health centers with an operating budget of $2.6 billion. The County provides almost three million outpatient visits and 660,000 inpatient days to the poor and indigent population of Los Angeles. Most of the patients treated by LAC DHS are low-income or uninsured, and Medicare constitutes a relatively small share of our overall payer mix. LA County hospitals are designated disproportionate share hospitals.

1. <u>The settlement concerned funds that the Health Care Financing Administration (HCFA) owed to LA County.</u>

The settlement involved Medicare funds that HCFA owed to the County. In general, the County files Medicare cost reports to HCFA on an annual basis. The Fiscal Intermediary, on audit, disallowed certain amounts on various cost reports, dating back to 1981 and withheld payment. The County appealed these cases in a timely manner to the Provider Reimbursement Review Board (PRRB). By early 1997, the County had over 130 appeals pending at the PRRB, which involved over $100 million.

The settlement at issue involved 45 cases/fiscal years totaling $79.4 million. These appeals involved Medicare bad debt claims, the methodology for determining the relative value units used to apportion costs on the cost report, intern and resident counts for medical education costs, and payment for ancillary/diagnostic services. In order to resolve the appeals, the County accepted a final settlement of $51 million from HCFA—36 percent less than the total value of the appeals. Prolonging the appeals process would have cost the County additional administrative and potential legal expenses.

2. Many of the appeals had been pending for more than ten years.

The settlement covered appeals related to costs incurred as early as 1980/81. Fourteen of the cases in the settlement involved fiscal years before 1990. During the pendency of these appeals, HCFA held all the disputed funds. Although many of the appeals had been pending for many years, HCFA is not required to pay interest on any amounts that the County eventually would receive through an administrative resolution or PRRB decision. Accordingly, further delay in the receipt of the funds would have diminished the real value of the any recovery.

3. The pending appeals had merit.

In general, many of the appeals resulted from the rate and billing structure used by the County. Specifically, the County hospitals use a form of all inclusive charges for both inpatient and outpatient services instead of the itemized charges method. The Medicare rules specifically allow providers to use all inclusive rates. This rate structure is more cost effective than an itemized charge system, and it allows the County to focus its limited, public resources on patient care rather than administration. However, this all inclusive charge structure results in billing and documentation issues that are different from other providers.

- Before the PRRB received notice of the settlement, it decided one of the pending appeals. The PRRB ruled in favor of the County, finding that the County was not obligated to provide the documentation required by the Fiscal Intermediary. However, that appeal had already been included as part of the settlement. Therefore, the County did not receive the full value of the PRRB's decision.

- Several of the cases in the settlement related to the issue of relative value units. The Fiscal Intermediary settled a similar issue with the County for two prior years. The appeal for an additional year was heard by the PRRB in December of 1994; however, due to the complexity of the issue, the PRRB still had not reached a decision March of 1997. If the PRRB believed that the County's position was clearly without merit, it would have been able to render its decision by the time of the settlement.

- A significant number of the cases in the settlement concerned bad debts. The population served by LAC DHS is predominantly poor; therefore, most of our Medicare patients are not able to pay their coinsurance or deductibles, resulting in bad debts. However, the County was paid for only a portion of these Medicare bad debts. Even though the Fiscal Intermediary confirmed that LAC DHS makes reasonable collection efforts, payment was withheld pending development of detailed documentation.

4. The settlement was unanimously approved by the Board of Supervisors in open session.

On March 11, 1997, at an open, publicly noticed meeting, the Los Angeles County Board of Supervisors unanimously approved the settlement of its Medicare cost report appeals.

I appreciate the opportunity to provide this summary for you. I hope this helps clarify the settlement.

Sincerely,

Mark Finucane
Director

Cc: Senator Feinstein
Senator Boxer
Los Angeles Congressional delegation
Board of Supervisors
Chief Administrative Officer
County Counsel

Senate Permanent Subcommittee
On Investigations

EXHIBIT # 34

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Assistant Secretary
for Legislation

Washington, D.C. 20201

May 11, 2000

Ms. Mary Robertson
Staff Director
Senate Committee on Governmental Affairs
Permanent Subcommittee on Investigations
100 Russell Senate Office Building
Washington, D.C. 20510

Dear Ms. Robertson:

Enclosed please find a copy of correspondence from Assistant Secretary John Callahan of the Department of Health and Human Services to David Walker, Comptroller General concerning a March 2000 GAO Report about the Health Care Financing Administration (HCFA).

This GAO Report, "HCFA: Three Largest Medicare Overpayment Settlements Were Improper," was the subject of a March 28, 2000 Subcommittee hearing.

I would respectfully request that this correspondence be made a part of the permanent hearing record. Please call me at 690-7450 if you have any questions or if there is a problem fulfilling this request.

Sincerely,

Jane Horvath
Deputy Assistant Secretary
for Health Legislation

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

MAY - 8 2000

The Honorable David M. Walker
Comptroller General
General Accounting Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Walker:

As you know, the General Accounting Office (GAO) recently released a report entitled "HCFA: Three Largest Medicare Overpayment Settlements Were Improper." In addition, on March 28, 2000, GAO representatives testified before the Senate Permanent Subcommittee on Investigations (Subcommittee) as to the report's findings. The report contained criticisms of decisions made by former and current officials of the Health Care Financing Administration (HCFA), including allegations of wrongdoing by specific individuals. We are deeply troubled that the GAO, in releasing the report, did not follow its usual procedures and thereby denied both HCFA and the specific individuals mentioned in the report an opportunity to review and comment on the report's findings before they were made public. Indeed, the published report, unlike other GAO reports, does not reflect or otherwise reference HCFA's views, notwithstanding HCFA's full cooperation with the GAO's inquiry.

The GAO's conduct in this matter is particularly disappointing because the report is replete with seriously misleading and plainly erroneous characterizations of law and fact. The following are some examples of the problems embedded in the report:

- The report repeatedly misrepresents that regulations implementing the Federal Claims Collection Act (FCCA) required HCFA officials to refer these Medicare payment dispute resolutions to the Department of Justice (DOJ). Our view of the circumstances in which referral is required is summarized below and in the enclosed document. These circumstances are not present here.

  - The FCCA requires referral to DOJ only where there is a compromise of a claim. A situation in which the federal government owes a provider (as opposed to one in which a provider owes the federal government) is not a "claim" for purposes of the FCCA. Moreover, a programmatic adjustment to or correction of a cost report is not a "compromise" for purposes of the FCCA.

  - HCFA's cost reporting scheme functions as an alternative dispute resolution process to which the FCCA is inapplicable. There are approximately 10,000 cost report appeals pending before the Provider Reimbursement Review Board (PRRB), the administrative tribunal to which the approximately 30,000 cost reporting providers in the Medicare program may petition for relief. Approximately 95 percent of these appeals settle before they are heard by the PRRB. It is inconceivable that Congress, in structuring the Medicare program, intended that DOJ would have the expertise, and personnel and other resources to review and negotiate the final amounts payable in each of these settlements.

The report, itself, concedes that "the issue of whether HCFA complied with the Federal Claims Collection Act is not free from doubt." Report at 20. Despite its uncertainty about the applicability of the FCCA, the GAO engaged in an intensive investigation occasioning significant cost to this Department and to individuals involved, and culminating in a hearing before the Subcommittee.

- The report extraneously discusses compromise criteria (i.e., litigation risk, inability to pay, cost of collection) that are inapplicable to these Medicare payment dispute resolutions. The attached document describes the relevant analysis.

- The report misconstrues HCFA's policies and practices concerning waiver of interest and extended repayment plans. In fact, HCFA has considerable discretion to waive interest and negotiate extended repayment plans, and exercises this discretion not infrequently.

- The report mischaracterizes the legal advice rendered by the Department's Office of the General Counsel with respect to one of the Medicare payment disputes. In fact, the Office of the General Counsel indicated that the course of action suggested by the fiscal intermediary was a legally permissible one, but not the only legally permissible one.

- The report treats these three agreements as unique. It fails, however, to acknowledge that there were at least six other agreements that contained non-disclosure provisions (Hearing Transcript at 64) and that a 1985 agreement involved one of the same three providers, addressed one of the same types of payment disputes, and contained an identical non-disclosure provision. A copy of the agreement that memorialized this resolution, which was signed by the then HCFA Administrator, was provided to the GAO in response to its request for documents prior to the issuance of its report.

- The report repeatedly asserts that HCFA official Charles Booth did not believe that each of the Medicare payment dispute resolutions was in the best interests of the federal government at the time of resolution. This assertion, however, is contradicted by Mr. Booth's testimony before the Subcommittee. Hearing Transcript at 120.

- The report implies that then HCFA Administrator Bruce Vladeck indicated the terms on which to resolve the Medicare payment disputes. Dr. Vladeck's testimony before the Subcommittee, to the contrary, makes clear that he indicated only the desire to resolve the payment disputes promptly. Hearing Transcript at 137, 139.

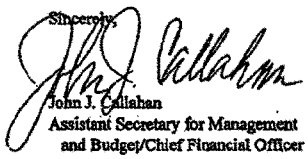
- The report implies that Dr. Vladeck violated ethical rules by involving himself in certain of the Medicare payment disputes. This suggestion, however, is wholly at odds with the legal conclusion of the GAO's General Counsel articulated in his testimony before the Subcommittee in which he flatly stated that there was no such violation. Hearing Transcript at 33.

- The report states that Dr. Vladeck should have sought advice on the propriety of his involvement in matters concerning certain of the providers at issue. The GAO, however, did not even contact Department ethics officials to determine whether that advice had been sought or received. In fact, Dr. Vladeck testified before the Subcommittee that he had obtained an opinion from Department ethics officials that made clear that there was no conflict of interest in matters such as these. Hearing Transcript at 152.

While there is no evidence in the GAO's report to support a conclusion of any wrongdoing, it should be noted that HCFA has taken a number of steps to clarify and strengthen its financial management practices in this area. In addition to appointing a Chief Financial Officer (CFO) in 1997, HCFA recently appointed a Deputy CFO to oversee its debt collection activities. At the recommendation of the Department's Inspector General, the Deputy CFO is a Certified Public Accountant. Furthermore, HCFA recently clarified existing procedures and implemented new safeguards to ensure that debt collection activities continue to comply with the law and to reflect sound and consistent policy. For example, certain agreements now may not be executed without the approval of both the Deputy CFO and HCFA's senior career Medicare payment policy official. In addition, if any HCFA or contractor employee is unable to satisfy himself or herself that a proposed resolution of a Medicare payment dispute would not be improper, and the proposed resolution would result in HCFA paying more or recouping less that it otherwise would have, he or she may ask that the proposed resolution be approved by both the Deputy CFO and HCFA's senior career Medicare payment policy official. HCFA has also prohibited the future use of non-disclosure provisions.

The GAO's report should include the corrections made here summarily and regrettably after its publication. We request that this letter and attachment be filed with and referenced in the GAO's report for any and all future use.

Sincerely,



John J. Callahan
Assistant Secretary for Management
and Budget/Chief Financial Officer

Enclosure

ENCLOSURE

ADMINISTRATIVE RESOLUTION OF MEDICARE PAYMENT DISPUTES

Background

Certain Medicare providers, such as hospitals and home health agencies, receive payment for services rendered by filing an annual cost report with a HCFA contractor known as a fiscal intermediary (FI). When a cost report is filed, the FI applies HCFA's Medicare payment policies to determine the amount owed to the provider. At this point, discussions often take place between the FI and the provider about the costs and policies at issue. Once the FI determines the amount owed to the provider, the FI issues to the provider a Notice of Program Reimbursement (NPR), which details, among other things, the costs that were claimed but disallowed. The amount owed to the provider is compared with the amount paid to the provider in periodic interim payments (PIP), if any, during the cost year at issue. If the amount paid to the provider in PIP is greater than the amount owed to the provider in the NPR, the FI makes a written demand for payment, and, thirty days thereafter, interest begins to accrue. In most cases, the amount owed by the provider is offset against the future PIP paid to the provider. Through such offsets against continuing payments, the demand for payment is totally satisfied.

The provider may challenge the FI's determination of the amount of the Medicare payment owed through an appeal to the Provider Reimbursement Review Board (PRRB) and, thereafter, to federal court. Such an appeal does not stay the recovery of the overpayment. Because of the large number of matters pending before the PRRB, several years may elapse before the case is heard. During this time, further discussions often take place between the FI and the provider about the costs and policies at issue. The issuance of the NPR notwithstanding, the FI may reopen the cost report and thereby alter the amount to be paid to the provider if a conclusion is reached that the FI misapplied HCFA's policies to the provider's costs. In fact, many matters pending before the PRRB are settled in this manner.

Claims by providers against the federal government are not claims for purposes of the FCCA

The FCCA, 42 U.S.C. § 3711, by its own terms, applies only to claims by the federal government against a provider; it does not apply to claims by a provider against the federal government. See Debt Collection Improvement Act of 1996, Pub. L. No. 104-134, § 31001(z)(1)(B), 110 Stat. 1321-58 (1996); 4 C.F.R. § 101.2(a). As described above, in most cases in which the amount of the PIP paid to the provider is greater than the amount owed to the provider in the NPR, the amount owed by the provider is offset against the future PIP paid to the provider.

The offset against the future PIP paid to a provider is almost always complete by the time a matter pending before the PRRB is settled. This is particularly so given the number of years that may elapse before a docketed case is heard. In such a case, there is a claim by the provider against the federal government, and, therefore, the FCCA is inapplicable.

Adjustments to cost reports by FIs are not compromises as defined by the FCCA

The GAO, itself, has distinguished the term "compromise" from the term "settlement," which strongly suggests that adjustments to cost reports by FIs are not compromises as defined by the FCCA:

> While the term "settlement" in the litigation context means compromise, it has a different meaning in the administrative claims context. The Supreme Court has defined the term "settlement" as denoting the appropriate administrative determination with respect to the amount due. Thus, to settle a claim means to administratively determine the validity of that claim. Settlement includes the making of both factual and legal determinations. The authority to settle and adjust claims does not, however, include the authority to compromise. In the claims context, compromise means accepting less than the full amount owed in full satisfaction of the claim.

Letter from Robert P. Murphy, General Counsel, GAO, to The Honorable Carolyn B. Maloney, House of Representatives 7 (Sept. 30, 1997) (citing Illinois Surety Co. v. United States ex rel. Peeler, 240 U.S. 214, 219-21 (1916); Cooke v. United States, 91 U.S. 389, 399 (1875); Antrim Lumber Co. v. Hannan, 18 F.2d 548, 549 (8th Cir. 1927); Secretary of the Interior, 20 Comp. Gen. 573, 577 (1941); GAO Legal Opinion B-200112 (May 5, 1983)). The GAO has suggested that even a document entitled "Compromise and Settlement Agreement" made "for the purpose of compromising and settling claims and disputes" does not necessarily involve a compromise as defined by the FCCA. Id. at 7-8.

Consistent with this reasoning, "settlements" in the cost reporting context are not "compromises" for purposes of the FCCA. As indicated above, the issuance of an NPR notwithstanding, an FI may reopen a cost report and thereby alter the amount to be paid to a provider if a conclusion is reached that the FI misapplied HCFA's policies to the provider's costs. This is not a compromise, but rather an adjustment or correction; it ensures that the amount of the claim has been properly determined.

The cost reporting process is an alternative dispute resolution process to which the FCCA is inapplicable

Congress did not contemplate subjecting the administrative resolution of Medicare payment disputes to the FCCA. There are approximately 1.3 million health care providers that participate in the Medicare program. Of these providers, approximately 30,000 receive payment for services rendered through the cost reporting process described above. (Although the remaining types of providers, such as physicians and suppliers, do not file cost reports, their payments, nonetheless, may be subjected to comparable adjustments.) Currently, there are approximately 10,000 appeals pending before the PRRB. Approximately 95 percent of these appeals, which often involve disputed amounts in excess of $100,000, are settled before they are heard by the PRRB. It is inconceivable that Congress, in structuring the Medicare program, intended that the Department of Justice would have the resources and the expertise to review each of these dispute resolutions. Moreover, it is clear that, should each of these dispute resolutions be subjected to the FCCA, HCFA would be unable to make payments to providers efficiently, thereby jeopardizing the quality of services to beneficiaries and the infrastructure of the Medicare program generally.

Senate Permanent Subcommittee
On Investigations
EXHIBIT # 35

DEPARTMENT OF HE TH & HUMAN SERVICES

Office of the Secretary

Office of the General Counsel
Washington, D.C. 20201

AUG 30 1993

Mr. Stephen D. Potts
Director
Office of Government Ethics
1201 New York Avenue, N.W., Suite 500
Washington, D.C. 20005-3917

Dear Mr. Potts:

Pursuant to section 103(c) of the Ethics in Government Act, as amended by the Ethics Reform Act of 1989, 5 U.S.C. App. 6, § 103(c), I am transmitting herewith a copy of the certified Public Financial Disclosure Report, SF 278, of Bruce C. Vladeck, who has been nominated by the President to serve as the Administrator of the Health Care Financing Administration (HCFA) at the Department of Health and Human Services.

This Office has reviewed Mr. Vladeck's financial disclosure report and advised him of the need to take certain actions in order to avoid the potential for any conflict of interest or appearance thereof. Mr. Vladeck has agreed to take the actions outlined herein to deal with any problematic interest or relationship. The contents of this letter constitute an ethics agreement pursuant to 5 C.F.R. Part 2634, Subpart H.

Mr. Vladeck is currently employed as president of the United Hospital Fund of New York (UHFNY), a charitable organization which focuses on health care improvements in New York City through research activities, information services, grantmaking, volunteer services, and publications. Mr. Vladeck will resign from his UHFNY position without retaining re-employment rights under a leave of absence; however, he will retain his accrued interests in the organization's defined benefits pension plan. As a charitable organization which does not operate hospitals or other health care facilities, it is not expected that particular health care financing matters involving UHFNY will come before the Administrator. Nevertheless, because Mr. Vladeck's continuing pension relationship with UHFNY is considered a financial interest under 18 U.S.C. § 208(a), he will recuse himself, for the duration of his appointment, if confirmed, from participating in his official capacity in any particular matter that arises involving UHFNY. I will recommend, however, that the Secretary grant Mr. Vladeck a waiver under 18 U.S.C. § 208(b)(1), to permit him to participate in general policy matters, such as legislation and regulations, dealing with health care issues that would affect UHFNY only to the same extent that similarly situated entities would be affected.

Mr. Vladeck has resigned or will resign from, and sever his relationships with, all other institutions and organizations listed on Schedule D, Part I, of his report for which he serves as a commissioner, board member, director, trustee, chair, or member:

New York City Health and Hospitals Corporation
The Henry J. Kaiser Family Foundation
Health Care for the Homeless
National Academy of Social Insurance[1]
Greater New York Blood Center
Pew Charitable Trusts
Primary Care Development Corporation
New York Academy of Medicine[1]
Wagner School of Public Service, New York University
Graduate School of Management and Urban Policy, The New School, New York
Inquiry
Journal of Health Politics, Policy, and Law
Greater New York Hospital Association
Human Services Council of New York
JDC-Brookdale Health Policy Research Center, Jerusalem, Israel
International Center of Longevity and Society
National Academy on Aging, Syracuse University
The Alpha Center
New York State Council on Health Care Financing
Mayor's Child Health Advisory Management Task Force
Governor's Health Care Advisory Board, New York State
New York State AIDS Advisory Council

As required by 5 C.F.R. § 2635.502, for a period of one year following his resignation, Mr. Vladeck will consider the need for a recusal from personal and substantial participation in an official capacity in any particular matter involving specific parties where the above enumerated organizations are either parties, or represent a party or parties, to such matter, if the circumstances would cause a reasonable person with knowledge of the relevant facts to question his impartiality in the matter. If he concludes that his impartiality might reasonably be questioned, he will inform the Designated Agency Ethics Official

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[1] While resigning as Chairman of the Study Group on Health, Mr. Vladeck's intention is to retain membership in this organization, which is primarily honorary or professional in nature.

[2] Mr. Vladeck will resign as trustee of the organization, but remain as a member.

(DAEO) and will not participate unless authorized to do so pursuant to 5 C.F.R. § 2635.502(d).

Mr. Vladeck also will resign from the Prospective Payment Assessment Commission, a legislative branch agency. Section 502 procedures are not necessary for such prior federal service.

With respect to problematic financial assets, only one item reported on the disclosure form poses any significant potential for a conflict: Boston Company New York Tax-Free Income Fund. While this fund is an "excepted investment fund" for reporting purposes, it is focused on governmental bonds and other financial instruments issued solely by New York State and local governments. If a particular matter involving specific parties arises where the personal and substantial participation of the HCFA Administrator would have a direct and predictable effect on the continued financial viability of those State or municipal governments in New York which issued the bonds and other instruments in the fund portfolio, and their consequent ability to back the bonds and otherwise meet their obligations, then the need for a recusal would need to be considered. Mr. Vladeck has chosen to deal with this situation by agreeing to divest himself of all holdings in the fund upon receipt of a certificate of divestiture.

In discussions with the nominee, he indicated that there are some close familial connections which constitute covered relationships under 5 C.F.R. § 2635.502(b)(1)(iv). Each situation requires action by the nominee or the covered party.

Mr. Vladeck's wife, Fredda Wellin Vladeck, is a member of the Board of Directors of the Medicare Beneficiaries Defense Fund (MBDF), an advocacy organization that seeks to influence public policy and legislative action, and that provides guidance and assistance to Medicare beneficiaries, health care providers, and attorneys who serve Medicare clients. Inasmuch as the HCFA Administrator is the chief federal officer in charge of the Medicare program, Ms. Vladeck's continued service with MBDF creates a significant appearance problem. Accordingly, Ms. Vladeck has agreed to resign her position with MBDF effective upon her husband's appointment.

David Vladeck, the nominee's brother, is a salaried attorney with the Public Citizen Litigation Group, a component of the Public Citizen Foundation (PCF). PCF has been involved in litigation with the Department, most recently in Food and Drug Administration (FDA) matters. David Vladeck recused from these matters as a result of his spouse's employment with FDA. To avoid any potential for appearance problems, David Vladeck also has agreed to extend his recusal to any matter involving HCFA

Mr. Vladeck's mother and sister are both partners in the New York law firm of Vladeck, Waldman, Elias, and Engelhard. The firm maintains an active practice as plaintiffs' lawyers in employment discrimination cases, and has brought actions against both corporations and public agencies. Since the focus of their practice is unlikely to involve health care financing matters, the potential for conflict does not appear significant. Should such a matter arise, however, Mr. Vladeck will consult with the DAEO and recuse where appropriate.

With the actions indicated above, I am satisfied that the disclosure report of the HCFA Administrator-Designate, Bruce C. Vladeck, indicates no unresolvable conflict of interest or other problem under applicable laws and regulations.

Sincerely,

Jack M. Kress

Jack M. Kress
Special Counsel for Ethics and
Designated Agency Ethics Official

Enclosure

cc: Bruce C. Vladeck

UNITED STATES OFFICE OF GOVERNMENT ETHICS DATE: 03/01/
FINIANCIAL DISCLOSURE TRACKING SYSTEM
SF278 REVIEW SHEET

SF278 FILER: VLADECK BRUCE C
REPORTING STATUS: NOMINEE
REPORTING YEAR: 93
PUBLICLY AVAILABLE: YES
DEPARTMENT/AGENCY: HE70 HEALTH CARE FINANCING ADMINISTRATION
POSITION: ADMINISTRATOR
DAEO: NO

CONFIRMATION COMMITTEE: FINANCE

CABINET LEVEL: NO
ADD'L POSITION: NO
TYPE OF POSITION: FULL TIME

DRAFT RECEIVED: 02/26/93
ORIGINAL FROM AGENCY: / /
AGENCY EXTENSION GRANTED: ___ (Y/N)
OGE EXTENSION GRANTED: ___ (Y/N)

NOMINATION: / / HEARING: / / RECESS APPOINTMENT: / /
CONFIRM/ENTR: / / WITHDRAWN: / / TERMINATION: / /

ASSIGNED TO: REVIEW STARTED REVIEW COMPLETED FORWARDED
MULLEN-ROTH, BARBARA BMR 3/10/93 4/30/93 4/30/93

RECOMMENDATION: A (A)..APPROVE AS SUBMITTED (T)..TECHNICAL MODIFICATIONS
(S)..SUBSTANTIVE MODIFICATION (B)..BOTH (O)..OTHER

ANY CONFIRMATION AGREEMENTS: __ (Y/N)
DATE ALL SATISFIED: / /

COMMENTS OF REVIEWING OFFICIAL:

OGE OFFICIAL	REVIEWED	DATE	SIGNED SF278	DATE
CHIEF PDB				
CHIEF MCD				
STAFF ATTORNEY				

COMMENTS OF OGE OFFICIAL