

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**



G A O

Accountability * Integrity * Reliability

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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 Act² 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.³ 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

³ 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. These 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 1996, 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 General¹⁸ 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 (1999).

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 (1999).

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.³⁰ 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

³⁰ 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 move 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(B); 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 criticized [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 1992³ 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 1989.

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.⁶ 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

⁶ 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.

Appendix I
Investigation of HCFA's 1995 Settlement
With a Home Health Agency

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 not [sic] otherwise receive until 1999. I believe the Administrator wants to at least have that 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 documentation. [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 [1996 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 Justice² 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.

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