OPENING STATEMENT OF

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CHAIRMAN

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

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

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Today, the Permanent Subcommittee on Investigations convenes this hearing to examine the settlement practices of the Health Care Financing Administration ("HCFA"), the federal agency responsible for the Medicare program. This hearing is one of a series held by the Subcommittee during the past three years to examine instances of waste, fraud, and abuse that siphon money out of the Medicare trust fund, costing billions of dollars and jeopardizing health care for our disabled and elderly citizens. Previous Subcommittee hearings have focused on Medicare fraud prevention and enforcement efforts, flaws in the enrollment process, and the ability of criminals to bill Medicare for bogus claims.

The Inspector General of the Department of Health and Human Services recently found that improper Medicare payments to health care providers rose to $13.5 billion last year. I hope that the IG's report and oversight hearings, such as this one, will prompt HCFA to strengthen its financial controls. The continuing drain in Medicare is all the more urgent given projections that the Fund is threatened with insolvency in just 15 years.

Last spring, I asked the General Accounting Office to investigate HCFA's settlement of debts owed to Medicare. Today, GAO officials will discuss the findings of a comprehensive eight-month investigation in which they examined 96 settlements in which HCFA's claim exceeded $100,000.

In 93 of those agreements, the GAO found nothing improper. For the three largest settlements, however, the GAO uncovered many irregularities. In these three settlements, HCFA circumvented the normal administrative process for resolving reimbursement disputes. These three claims represent 66 percent of all Medicare overpayment settlements for the eight-and-a-half year period reviewed by GAO. Moreover, HCFA accepted payment of only $120 million, or 36 percent, of the $332 million owed the Medicare trust fund by the three providers.

Equally troubling, GAO found that HCFA agreed to reimburse two of the providers for certain future costs without documentation, special treatment that is contrary to the regulations and not allowed other health care providers. These findings raise serious concerns about the equity of the settlements.

The three settlement also included highly unusual secrecy provisions intended, it appears, to prevent other health care providers from finding out about the special deals.

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

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

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

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

The third questionable settlement identified by the GAO involves the Department of Health Services, County of Los Angeles ("LA County"). Between 1987 and 1993, LA County's fiscal intermediary disallowed its claimed reimbursement for certain costs because of missing documentation. In this case, HCFA agreed to accept $28 million in satisfaction of more than $79 million in overpayments in 1997.

The GAO's findings raise serious questions about these three settlements and the conduct of senior HCFA officials. Today, we will seek answers to a number of critical questions. First, why did HCFA officials agree to these settlements in the first place? Second, why weren't the standard rules followed? For example, why didn't HCFA officials seek the approval of the Department's own lawyers as well as the Department of Justice before compromising multi-million dollar claims for only 36 percent of what was owed? Finally, did pressure from the individual then serving as the HCFA Administrator cause settlements to be reached that were not in the government's best interest?

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

Finally, let me make clear the reasons for my concern about what appear to be improper settlements that may have cost the Medicare trust fund millions of dollars. As many health care providers and my colleagues know, no one has fought harder than I to ensure that Medicare

adequately reimburses our hospitals and home health care agencies for the essential services that they provide to our nation's elderly. One of my highest priorities last year was reversing excessive cuts in Medicare that were jeopardizing the ability of numerous well-run home health agencies and hospitals to care for our seniors and disabled citizens. Thanks to a bipartisan effort which involved Senator Levin, we were successful in restoring some of these funds.

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

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

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