APPENDIX A

112TH CONGRESS, 2nd SESSION
U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON ETHICS

IN THE MATTER OF ALLEGATIONS RELATING TO REPRESENTATIVE SHELLEY BERKLEY

DECEMBER 13, 2012

REPORT OF THE INVESTIGATIVE SUBCOMMITTEE

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I. INTRODUCTION

On June 29, 2012, based on information obtained during the Committee's initial investigation of this matter, the Committee empanelled this Investigative Subcommittee (ISC) to investigate allegations that Representative Shelley Berkley improperly used her official position for her financial interest, dispensed special favors or privileges to her husband, and allowed her husband to contact her or members of her staff on behalf of a third party. The ISC has now completed the tasks with which it was charged; this Report memorializes that effort and makes recommendations to the Committee regarding further action.

The ISC has concluded that information obtained during its investigation indicates that Representative Shelley Berkley violated House Rules and other laws, rules and standards of conduct by improperly using her official position for her beneficial interest by permitting her office to take official action specifically on behalf of her husband's practice. The ISC found that Representative Berkley mistakenly believed the rules governing what assistance her office could provide to her husband's practice required only that they treat him in the same manner by which they treated any other constitutent. This is incorrect. Relevant rules, Committee guidance and precedent require that Members refrain from acting in a manner which would benefit the Member's narrow financial interest, regardless as to whether the action is ordinary or extraordinary relative to the office's day-to-day activities. Additionally, the ISC found that Representative Berkley mistakenly believed that the assistance her office provided to her husband's practice in obtaining payments from the federal government was appropriate as long as it pertained only to payments properly due. This is also incorrect. Relevant rules, Committee guidance and precedent provide that a Member must refrain from acting in a manner that would benefit the Member's narrow financial interest regardless as to the merit of that interest. For matters pertaining directly to the business interests of a spouse, such matters should be directed to a Senator's office or, if such business is located in other districts, to the Representative of such other district.

Finally, the ISC has concluded that the evidence indicates that Representative Berkley did not violate House Rules and other laws, rules and standards of conduct by dispensing special

favors or privileges to her husband, Dr. Lawrence Lehrner, or with respect to her husband's contact with her office on behalf of third parties.

The ISC believes this investigation highlights the need for additional guidance from the full Committee to the House community regarding conflict of interest rules. A Member's primary responsibility in holding public office is to serve as a voice for their community and to represent the interests of their constituency. At times, those interests may coincide with the Member's personal interest. Whether a Member must refrain from taking official action on matters that not only impact the Member's constituents but also impact the Member personally is a question that does not lend itself to an all-or-nothing rule. The House has put into place mechanisms, such as Financial Disclosure Statements, to begin to regulate conflicts of interest. In some cases, the mere fact of disclosure eliminates a concern about any conflict of interest. In other cases, however, disclosure does not and cannot eliminate the concern. The only remedy a Member has under those circumstances is to refrain from taking official action.

The ISC recommends that this Report serve as a reproval of Representative Berkley for the violations described herein. The ISC was unable, however, to reach a consensus as to whether a formal letter of reproval should be issued to Representative Berkley. The ISC further recommends that the full Committee issue specific guidance to the House community to enable it to more easily identify and avoid conflicts of interest.

II. PROCEDURAL BACKGROUND

On September 5, 2011, *The New York Times* published an article entitled "A Congresswoman's Cause Is Often Her Husband's Gain," alleging that Representative Berkley used her official position to sponsor legislation and contact federal agencies that ultimately resulted in a benefit to her husband's financial interests. The article, published along with supporting documents, also raised questions about Representative Berkley's work to prevent the Centers for Medicare and Medicaid Services (CMS) from terminating the University Medical Center of Southern Nevada's (UMC) kidney transplant program's Medicare approval.

In early 2012, the Chairman and Ranking Member of the Committee for the 112th Congress authorized Committee staff to conduct an inquiry pursuant to Committee Rule 18(a). On February 9, 2012, during the course of the Committee's independent investigation into the allegations, the Committee received a referral from the Office of Congressional Ethics (OCE) regarding allegations that Representative Berkley violated House rules and standards regarding conflicts of interest by taking official action on behalf of UMC to prevent CMS from revoking UMC's kidney transplant program's Medicare approval. On February 14, 2012, the Chairman and Ranking Member notified Representative Berkley of OCE's referral by letter and offered her an opportunity to respond to OCE's allegations in writing.[1] Representative Berkley, through her counsel, provided a written response to OCE's allegations on February 29, 2012.[2] Following receipt of Representative Berkley's response, the Chairman and Ranking Member requested

[1] Letter from Chairman and Ranking Member to Representative Berkley (February 14, 2012).

[2] Letter from Marc Elias and Ezra Reese to Chairman and Ranking Member (February 29, 2012).

documents and records from Representative Berkley.[3] On March 23, 2012, pursuant to House Rule XI, clause 3(a)(8)(A) and Committee Rule 17A(b)(1)(A) and 17A(c)(1), the Chairman and Ranking Member issued a public statement and jointly extended the matter referred by OCE for an additional 45 days.

After requesting clarification from the Committee on the scope of its request for documents and records, on April 3, 2012, Representative Berkley, through her counsel, submitted approximately 1,000 pages of documents in response to the Committee's request. During the Committee's inquiry under Committee Rule 18(a), Committee staff reviewed the documents submitted by Representative Berkley and scheduled interviews with former and current members of Representative Berkley's official staff.

Based on the results of the 18(a) investigation, staff recommended that the Committee empanel an ISC to further investigate the allegations. On June 29, 2012, the Committee voted unanimously to empanel an ISC. The ISC met on 16 occasions and interviewed nine witnesses, including Representative Berkley's husband, Dr. Lawrence Lehrner. Further the ISC issued three subpoenas for the collection of documents resulting in the production of over 108,000 pages of materials.

On December 4, 2012, Representative Berkley voluntarily appeared before the ISC and answered questions under oath. In advance of this appearance, Representative Berkley, through counsel, submitted a letter and additional documentation relevant to the ISC's inquiry.[4]

III. FACTS

A. Background

Representative Berkley has served Nevada's 1st district since her election in 1998. Following the beginning of her first term in office, in March of 1999, Representative Berkley married Dr. Lawrence Lehrner.

During the 110th Congress, Representative Berkley served on the Committee on Veterans Affairs and the Committee on Ways and Means, among other committee assignments. Representative Berkley's committee assignments necessarily focused her work on issues pertaining directly to the medical community. During her time on the committees, Congress considered legislation pertaining to the Medicare Sustainable Growth Rate (SGR),[5] Medicare payments for doctors providing care to patients with End Stage Renal Disease (ESRD), and other major legislation pertaining to healthcare.

Dr. Lehrner is a practicing nephrologist. At the time of his marriage to Representative Berkley, he served as the president of a joint nephrology practice called Bernstein, Pokroy &

[3] Letter from Chairman and Ranking Member to Representative Berkley (March 6, 2012).

[4] Letter from Marc Elias, Ezra Reese, and Andrew Werbrock to Investigative Subcommittee (November 30, 2012).

[5] The Sustainable Growth Rate is a formula utilized by the Centers for Medicaid and Medicare Services to calculate payment to physicians for services provided to Medicare patients.

Lehrner, Ltd. d/b/a Kidney Specialists of Southern Nevada (KSSN), located in Las Vegas, Nevada. After a short break in service as president, he resumed the post and holds it today. As president, Dr. Lehrner supervises the day-to-day operations of KSSN's practice, maintains an active patient roster, supervises research projects, and completes daily hospital rounds.

In addition to the patients it serves through the practice, KSSN has also had a contract with UMC for over 10 years to provide nephrology services, including providing a transplant nephrologist, to UMC's kidney transplant program. KSSN has approximately nine office locations throughout Nevada, including at least one office location in each of the Nevada congressional districts. KSSN also has a business relationship with DaVita, a national dialysis provider. KSSN provides management services at several DaVita locations in Nevada on a fee-per-service basis. KSSN has also partnered with DaVita to open several dialysis centers in Nevada.

In addition to his work at KSSN, Dr. Lehrner was also involved with the Renal Physicians Association (RPA), an association dedicated to assisting nephrologists in their profession. Dr. Lehrner served as the initial Chairman of RPA's Political Action Committee; he also served as an uncompensated member of RPA's Board of Directors.[6]

Dr. Lehrner communicated with members of Representative Berkley's Washington, D.C. office staff at times, primarily through email. His communication with staff touched on matters as broad as issues pertaining to the entire medical community, or as narrow as issues pertaining specifically to his business. At times, Dr. Lehrner also contacted Representative Berkley's office on behalf of RPA. His communication with the staff also included subjects unrelated to medicine, such as internet gambling and its impact on the Nevada economy.

Representative Berkley did not establish a policy in her office for the manner by which her staff should interact with her husband on official matters and when her staff should refer him to another office or decline to provide him assistance. As described more fully below, in the absence of such a policy, Dr. Lehrner was free to contact Representative Berkley's office as he saw fit.

Representative Berkley's deputy chief of staff, Marcie Evans, informally served as the ethics point of contact for the office. Although no formal policy had been established in the office, if a member of Representative Berkley's staff had a question about an ethical issue, they would generally direct the question to Ms. Evans. If Ms. Evans was unable to answer the question, she would contact the House Ethics Committee for the answer. When Ms. Evans received information from the Committee she would advise Representative Berkley in turn.[7]

B. Dr. Lehrner's Interaction with Representative Berkley's Office

Dr. Lehrner had direct access to Representative Berkley's staff, and utilized this access at various times. The staffers interviewed by the ISC described their interaction with Dr. Lehrner

[6] ISC Interview of Dr. Lawrence Lehrner.

[7] ISC Interview of Representative Shelley Berkley.

as periodic, oftentimes peaking during certain periods and diminishing during others. Richard Urey, Representative Berkley's chief of staff noted in his interview before the ISC that Dr. Lehrner usually contacted him at least once a month on various topics, including issues pertaining to renal care:

> [COUNSEL] In your capacity as chief of staff, how often are you in contact with Dr. Lehrner?
>
> [MR.UREY] I would imagine, looking at the totality of the time that I have had this job, a few times a month. It's not a regular thing. In other words, there's not - if I had to make a bet that I'm going to hear from Dr. Lehrner today, I would bet no. If I had to bet that I'm going to hear from him once in a 2 week span of time, I probably would bet yes. But I'm just trying to illustrate the frequency of contact with him, and I'm looking at it broadly over time.
>
> . . .
>
> He is someone who uses email a lot. He periodically, but to a much lesser extent, will make a phone call to me, or I may call him occasionally. And, again, it wouldn't be something I would expect to see in any given week, but sometime in the course of a month I might expect to get some type of communication from Dr. Lehrner. Some months it could be a few times, some months none.
>
> . . .
>
> [COUNSEL] [D]oes Dr. Lehrner volunteer his input on [renal care or nephrology] issues ...?
>
> [MR.UREY] Yes, he does.
>
> [COUNSEL] If so, when?
>
> [MR.UREY] At his whim, I guess I would call it. He is well networked through professional organizations, and it's rather apparent that he's on the receiving end of various types of issues, briefings, or congressional issue briefings that he will forward to me. And this is broadly in the area of medicine but not confined to medicine. He comments, either by something he will say in an email or say to me, about his opinion of a news clip or something he has heard about.[8]

Matthew Coffron, a former legislative assistant for Representative Berkley, described the frequency of his interactions with Dr. Lehrner:

[8] ISC Interview of Richard Urey.

> [COUNSEL] When you were employed in Representative Berkley's office, how often were you in contact with him?
>
> [MR. COFFRON] It wasn't on a regular basis. There were some times when he would be in contact quite often, sometimes just forwarding articles or something. You know, I would say, on average, maybe monthly.[9]

The staffers also indicated that there was no office policy that in any way constrained contact with Dr. Lehrner regarding official matters.[10] Mr. Coffron testified that on certain matters he was encouraged to contact Dr. Lehrner.

> [MR. COFFRON] From my predecessor so from my very first days doing health care in the office, [Dr. Lehrner] was listed as, if end stage renal disease issues came up, that is one of the people you should talk to. I don't think anything about any specific timeline about responding to him. But I guess if your boss's spouse reaches out to you, you should at least acknowledge receipt of the email.
>
> . . . .
>
> Not long after I took over health care, I think the same month I started taking health care, Bryan George, my legislative director, told me to reach out to him when the issue came up. I believe that is when that happened. So it was just sort of how the office worked.[11]

Mr. Urey testified that Representative Berkley asked him to contact Dr. Lehrner regarding particular issues related to health care.

> [COUNSEL] And has there ever come a time where Representative Berkley has asked you to contact Dr. Lehrner or has told you that he will be contacting you?
>
> [MR.UREY] Yes.
>
> [COUNSEL] Can you give me an example of one of those occasions?
>
> [MR.UREY] I don't have a specific recall by topic or issue or what the predicate was for it. But, in general, the Congresswoman may be going about her duties here, learns of something that relates in some way to health care and may say,

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[9] ISC Interview of Matthew Coffron.

[10] *See* ISC Interview of Matthew Coffron; ISC Interview of Richard Urey; and ISC Interview of Marcie Evans.

[11] ISC Interview of Matthew Coffron.

could she may ask me, do I know about this issue, and I may say, no, I'm not familiar with that one, and she might say, you might want to call Larry everybody calls him "Larry" here informally in our office and ask him what he knows about this.[12]

Marcie Evans, Representative Berkley's deputy chief of staff, testified that Representative Berkley had never established any type of policy by which her staff should interact with her spouse.

> [COUNSEL] So you've been with her the entire time she has been a member of Congress?
>
> [MS. EVANS] Yes, I have.
>
> [COUNSEL] In your entire time in that office, have you ever been aware of a policy that Representative Berkley has put in place as to how to how her staff should communicate with her husband regarding any requests for official action?
>
> [MS. EVANS] No. [13]

C. KSSN's Issues with Payments from Federal Agencies

At times, Dr. Lehrner utilized his access to Representative Berkley's staff to request assistance for payment and reimbursement issues his business had with the federal government. These issues included obtaining payments from the Department of Veterans Affairs (VA) for services provided to veterans, obtaining timely payments from the regional Medicare administrator, and obtaining timely Medicare approval for new doctors that was causing delays in reimbursement for those doctors' services.

1. *Payments from the Department of Veterans Affairs*

In March of 2008, a KSSN employee contacted Representative Berkley's office regarding an issue KSSN was having receiving payments from the local office of the VA. Dr. Lehrner stated during his testimony before the ISC that his staff informed him that KSSN had outstanding claims with the VA that had not been paid and that the staff had exhausted all options to identify the problem that was preventing the VA from paying the claims. He then instructed his staff to contact Representative Berkley's office. Dr. Lehrner explained:

> [DR. LEHRNER] My billing staff said they had attempted through all the channels that they knew how to talk to the VA, to find out why we weren't being paid. We had provided the services, as I said. All the doctors in Las Vegas knew that I was married to a Congressperson.

[12] ISC Interview of Richard Urey.

[13] ISC Interview of Marcie Evans.

> And when we're in the doctor's lounge talking about problems physicians have with Medicare, the VA or any Federal agency my advice was always, "if you've exhausted all the possibilities you know, contact your Congressperson and ask them to see if they can help you with a solution to the problem." So when my staff came to me and said, "we can't seem to get through the VA bureaucracy," I said, "why don't you contact my wife's office and see if there's some way that they can break this logjam and figure out what the issue is?" We had provided the services, and all we were trying to do was to receive payment that was due us.[14]

KSSN's complaint centered on claims for services it had provided to individuals who were veterans that the VA had not paid since August of 2007. On April 1, 2008, a KSSN employee emailed notes from a meeting she had with a VA employee to Dr. Lehrner, and copied then-legislative assistant for Representative Berkley, Matthew Coffron. Shortly after the KSSN's employee's email was sent, Dr. Lehrner copied Mr. Urey in his response to the email and wrote, "Thanks. Could a more complex system be devised if they tried."[15] Mr. Urey forwarded the email to Mr. Coffron and legislative assistant Carrie Fiarman, to which Ms. Fiarman responded, "I also contacted the VA at the Congresswoman's request on why this is the system, etc."[16]

Members of Representative Berkley's staff interviewed by the ISC provided a description of how work was divided between the district office and the Washington, DC office. According to Representative Berkley's staff, the DC office handled mostly policy matters, while the district office handled most constituent requests, though the DC office would occasionally work on constituent matters.

> [MR.UREY] Yes. Typically those issues would be handled by an individual in the Las Vegas office but not exclusively. ...[17]

> [COUNSEL] In your work as the senior legislative assistant and a legislative assistant, do you handle any constituent requests?
>
> [MS. FIARMAN] Very rarely. Sometimes I will call back the constituent regarding unemployment or an issue that they are having with the VA or sometimes a healthcare issue. But for the

[14] ISC Interview of Dr. Larry Lehrner.

[15] Exhibit 1.

[16] Exhibit 1.

[17] ISC Interview of Richard Urey.

most part, constituent services are done in the district office, but there are exceptions to that.

[COUNSEL] So, for the most part, if it is a VA issue, is that still going to be handled in the district office?

[MS. FIARMAN] Yeah, we have had a little bit of transitioning with our district staffer over the years, so occasionally I will handle it. But, for the most part, our district staffer handles it.[18]

[COUNSEL] And as legislative staff, were you involved at all in handling constituent requests?

[MR. COFFRON] Occasionally.

[COUNSEL] So what was the process for that?

[MR. COFFRON] Typically, if it was, you know, I am not getting my Social Security check or something like that, it would be handled in the district office. Sometimes a request would come directly to our office, you know, someone had gotten ahold of my contact information or something. Or if it was something that affected a larger number of patients or a group of physicians or something like that, it might come to my desk.[19]

Indeed, Representative Berkley confirmed her staff's description of the work distribution in her office:[20]

[COUNSEL] Are constituent requests handled in your district office?

[REPRESENTATIVE BERKLEY] Yes, mostly.

[COUNSEL] Mostly. So are some of them handled in your D.C. office as well?

[REPRESENTATIVE BERKLEY] What would usually happen is people don't always understand the delineation that your district office is supposed to handle constituent matters, at least in my operation. They handle the day-to-day issues. Somebody calls up, they've got an immigration problem, a this problem, a that problem. Here we tend to do legislation.

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[18] ISC Interview of Carrie Fiarman.

[19] ISC Interview of Matthew Coffron.

[20] ISC Interview of Representative Shelley Berkley.

In contrast to Representative Berkley's office's general approach to constituent requests, Representative Berkley's policy staff worked directly on KSSN's payment issue. Representative Berkley's staffers attempted to distinguish how KSSN's repayment issue was handled from other constituent requests relating to payments from the federal government. Ms. Fiarman indicated KSSN's payment issue - what she described as an "institutional" issue - was assigned to her because it may have been indicative of a broader policy issue that needed to be addressed.[21] Generally, constituent issues touching on broader policy issues within her portfolio of work were assigned to her to review.[22] However, she acknowledged that KSSN's issue was the only "institutional" payment issue she handled that pertained to the VA:

> [COUNSEL] You said earlier that you spent some time, not a lot of time but some time, doing constituent casework. If you could, divide up the amount of time that you spend as a percentage between individuals who have casework issues, folks that, you know, aren't getting their unemployment, and sort of more institutional issues like this, where somebody is not getting paid or it is an institutional constituent.
>
> [MS. FIARMAN] It is hard to kind of quantify. I guess if it was a constituent issue where they needed to fill out privacy releases, somebody in the district office would deal with it. But if it was an institutional thing like this and trying to figure out if it was a broad issue as opposed to just one provider, then I would handle it.
>
> [COUNSEL] So I guess what I am asking is, are these sort of institutional casework requests, for lack of a better word, are they common? Do they come in a lot?
>
> [MS. FIARMAN] They come in occasionally. I know this is the only one I have dealt with with VA, but I can't say what other people might have dealt with or haven't dealt with.[23]

In fact, Ms. Fiarman only recalled one other instance where she worked on a constituent request concerning payment from a federal agency because of the potential policy implications. Ms. Fiarman indicated the other instance that she recalled involved an individual she referred to as "Dr. Saxe" and it pertained to an issue with the Centers for Medicaid and Medicare Services (CMS).[24] However, Ms. Fiarman's later testimony contradicted her statements regarding what Dr. Saxe's issue actually pertained to, and whether she, versus a staffer in the district office, actually provided assistance to Dr. Saxe:

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[21] ISC Interview of Carrie Fiarman.

[22] ISC Interview of Carrie Fiarman.

[23] ISC Interview of Carrie Fiarman.

[24] ISC Interview of Carrie Fiarman.

> [MS. FIARMAN] I think I had referred Dr. Saxe to Jan. And I don't know if I ever spoke to Dr. Saxe -- Jan Churchill. I'm sorry. Jan Churchill is our district office person who handles payment issues for Palmetto. But I -- maybe I am confusing two different things, but I do know that – I believe I referred to Dr. Saxe to Jan.[25]

Ms. Fiarman testified that she approached KSSN's problem as if it were an "institutional" problem, and stated that she initially tried to determine whether all clinics providing services to veterans were experiencing similar problems.[26] However, Ms. Fiarman acknowledged that at the time she became aware of KSSN's issue, and throughout the time that she worked on the issue, she was not aware of any other clinic that was experiencing the same issue, neither had any other clinic contacted the office about a similar issue.[27]

During her testimony before the ISC, Representative Berkley did not contradict Ms. Fiarman's account of the number of providers that contacted the office about the same issue KSSN was experiencing. In fact, despite Representative Berkley's description that in 2008, her office was handling complaints from multiple providers about payments from federal agencies in general, she was unaware of any provider specifically complaining about payment issues with the VA in Southern Nevada:

> [COUNSEL] -- can you recall as you sit here today whether or not you personally spoke with any other providers about this, this specific issue?
>
> [REPRESENTATIVE BERKLEY] I would not have spoken to any other providers. If they called the office, they would have -- it would have been in the ordinary course, and I understand there were other providers that did.
>
> [COUNSEL] How did you come to that understanding if you didn't speak with anyone on this specific issue?
>
> [RERPESENTATIVE BERKLEY] Recently in preparation for, for this meeting.
>
> [COUNSEL] Okay. But back at the time in that time frame did you, even if you didn't speak to them personally, were you aware of this issue with other providers at this specific time frame with the VA?
>
> [REPRESENTATIVE BERKLEY] I do not believe I was personally involved, but that doesn't mean that they didn't contact

[25] ISC Interview of Carrie Fiarman.

[26] ISC Interview of Carrie Fiarman.

[27] ISC Interview of Carrie Fiarman.

the office and that the office did, in fact, do what they were expected to do.[28]

The ISC found no evidence of any other clinic contacting Ms. Fiarman or anyone else on Representative Berkley's staff about non-payment from the VA in the March or April 2008 timeframe.

Despite the lack of evidence that KSSN's issue was broader reaching, Ms. Fiarman contacted two individuals at the VA: James Holley, a VA Congressional Affairs staffer, and John Bright, Director of the VA Southern Nevada Healthcare System. On April 1, 2008, Ms. Fiarman sent the following email to Mr. Holley regarding the issue:[29]

From: Fiarman, Carrie
Sent: Tuesday, April 1, 2008 3:33 PM
To: Holley, James <[redacted]@va.gov>
Subject: VA question

Hey James,

I am not sure who I should contact over at VA now that Ray is gone, so I figured I would send this your way and maybe you can help me get some answers.

Since August 2007, 556 claims were submitted by the Kidney Specialists of Southern Nevada to the VA. As of 3/31/08, none of them have been paid. These 556 claims total over $115,000. Of those 556, about 60% have been initially denied for various reasons. Of the other approx. $40,000 worth in claims, $20,000 in claims were approved and to be paid immediately. According to the VA, another $20,000 in claims are waiting for approval from the hospital in order to be paid by the VA. The other approx. $60,000 may or may not be paid in the future. The doctors have to go back and see if the patients have a primary insurance.

The clinic is being told to bill the patient and the VA.

Why are the payments being held?
Is this the correct way to bill? Should we really be billing the patient and the VA? How can we resolve this? How can we make sure this doesn't happen again in the future? How can we make sure that this clinic and other clinics are paid in a timely manner for services provided to veterans?

Thanks for your help as always!

Carrie

Ms. Fiarman stated she contacted Mr. Holley because she believed he could provide specific information regarding the VA's payment policies.[30] Two days later, on April 3, 2008, Ms. Fiarman sent Mr. Bright, who was at the time the interim director of the VA in Las Vegas, the following email:[31]

[28] ISC Interview of Representative Shelley Berkley.

[29] Exhibit 2.

[30] ISC Interview of Carrie Fiarman.

[31] Exhibit 3.

From: Fiarman, Carrie <[redacted]@mail.house.gov>
To: Bright, John B
Sent: Thu Apr 03 10:12:47 2008
Subject: clinics and reimbursement issues

Hey there,

How is your new position treating you?? Busy I am sure! I do have a question for you and I wasn t really sure who else to contact.

I have heard from some dialysis clinics that there are reimbursement issues with the VA. Clinics are not getting reimbursed for a number of reasons. They are also being told that they should bill both the VA and the patient because the VA is not always the primary insurance and other reasons. We ve also been told there is no way of knowing prior to billing the VA if the patient is eligible for coverage. Has this always been the practice of the VA or is this a new policy? Also, Is this an isolated incident or is this happening to other clinics as well?

I know you are probably very busy with your new position, so if this is not something you are aware of could you redirect me to someone that can help me? J There is a strong likelihood that the boss will be meeting with Mansfield pretty soon on this issue so we are looking for some insight on this as soon as we can get it.

Thank you for your help and expertise as always!!!

-Carrie

Carrie Fiarman
Legislative Assistant
Office of Congresswoman Shelley Berkley
(202) 225-[redacted] (phone)
(202) 225-[redacted] (Fax)
[redacted]@mail.house.gov <mailto:[redacted]@mail.house.gov>

Ms. Fiarman stated that when she wrote in her email to Mr. Bright, "I have heard from some dialysis clinics that there are reimbursement issues with the VA," she was generalizing the information KSSN had provided her, and had not actually heard from any other clinics.[32]

On April 8, 2008, Ms. Fiarman forwarded the following email from a congressional relations officer with the VA to Mr. Urey, Mr. Coffron, Representative Berkley's legislative director, and Representative Berkley's press secretary:[33]

[32] ISC Interview of Carrie Fiarman.

[33] Exhibit 4.

From: Fiarman, Carrie
Sent: Tuesday, April 8, 2008 5:52 PM
To: Coffron, Matthew <[redacted]@mail.house.gov>; George, Bryan <[redacted]house.gov>; Urey, Richard <[redacted]mail.house.gov>; Cherry, David <[redacted]@mail.house.gov>
Subject: FW: Kidney Specialist of So Nevada - VA Payments
Attach: Issue Brief Kidney Specialist of So Nevada update 4-7-08 (2).doc

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Just an fyi...this is a great summary of what the final outcome of the situation is after VA (national) looked into it

Carrie Fiarman
Legislative Assistant
Office of Congresswoman Shelley Berkley
(202) 225[redacted] (phone)
(202) 225[redacted] (fax)
[redacted]@mail.house.gov

-----Original Message-----
From: Vasquez, Stacy [mailto:[redacted]@va.gov]
Sent: Tuesday, April 08, 2008 1:58 PM
To: Fiarman, Carrie
Cc: Ballenger, David; Holley, James
Subject: Kidney Specialist of So Nevada - VA Payments

Hello Carrie:

David is preparing for a budget hearing so I am follow up with you about your vendor payment question. I have attached a detailed explanation. Please let me know if you have any questions.

Best,

Stacy J. Vasquez
Congressional Relations Officer
Office of Congressional and Legislative Affairs
Department of Veterans Affairs
[redacted]Vermont Ave NW, Suite [redacted]
Washington, DC 20420
(202) 461[redacted]
[redacted]@va.gov

Attached to the e-mail was a memorandum entitled "VHA Issue Brief" that described in detail the VA's review specifically of KSSN's payment claims and the factors that contributed to KSSN's claims not being processed.[34]

[34] Exhibit 4.

VHA ISSUE BRIEF

Issue Title: Outstanding VA payments to Kidney Specialists of Southern Nevada for care provided to VA patients in Las Vegas.

Date of Report: 4/8/08

Brief Statement of Issue and Status:
The Director, VA Southern Nevada Healthcare System (VASNHS) was notified on Thursday, 3/27/08 that Kidney Specialists of Southern Nevada allegedly had more than 500 outstanding, unpaid, invoices for veteran care. Following the initial notification, Carrie Fiarman, Legislative Assistant, Office of Congresswoman Shelley Berkley contacted VACO officials with a similar complaint.

Actions, Progress, and Resolution Date:
At the direction of the Medical Center Director, the Acting Fee Basis Supervisor immediately contacted the Kidney Specialist of Southern Nevada to investigate the status of all outstanding bills to the VASNHS. He contacted their Business Manager, Betty Shnur, and arranged to personally pick up copies of the outstanding claims before noon that day. All claims were reviewed on Friday, 3/28/08, and Saturday, 3/29/08. On Monday, 3/31/08 the Acting Fee Supervisor went to the Kidney Specialist of Southern Nevada and personally spoke with Ms. Shnur, discussing the information provided below and explaining the process for unauthorized claims.

The memorandum also indicated that Representative Berkley's office has inquired specifically about the status of KSSN's claims.[35]

Although the VA had provided, in Ms. Fiarman's words "a summary of the final outcome of the situation," Ms. Fiarman continued to contact Mr. Bright, at Representative Berkley's request, about KSSN's payment issue.[36] On April 10, 2008, Ms. Fiarman sent the following email to Mr. Bright asking additional questions about the VA's system to process payment claims:[37]

[35] Exhibit 4.

[36] Exhibit 4.

[37] Exhibit 5.

From: Bright, John B [redacted]@va.gov>
Sent: Thursday, April 10, 2008 12:01 PM
To: Fiarman, Carrie <[redacted]@mail.house.gov>
Subject: Re: more follow-up

I'm told she asked a question at a hearing about payments to mental health providers. Was this question anecdotal to this issue or related to a specific issue. I'll get you some answers.

----- Original Message -----
From: Fiarman, Carrie <[redacted]@mail.house.gov>
To: Bright, John B
Sent: Thu Apr 10 10:45:58 2008
Subject: more follow-up

It seems the Congresswoman still has some more questions

1) Have you heard specific complaints from any other clinics or facilities that non-payment is an issue?

2) How can we prevent wide-spread fraud of people claiming they have VA insurance if there is no identifier/ insurance card? It seems that the burden of proof relies on the clinics and they are left with no recourse when the patient turns out to be a non-veteran. What can the clinics do to be sure the patient is a veteran? She is looking at wanting to meet with Mansfield on this issue so I am trying to clear it up for her.

You almost got away without follow up on this one! Haha. Hope your trip is going well!

-Carrie

When Ms. Fiarman was asked about the conversation with Representative Berkley that she referenced in her email to Mr. Bright, Ms. Fiarman stated she could not recall the conversation.[38]

On April 15, 2008, the Subcommittee on Health of the Committee on Veterans' Affairs (HCVA) held a hearing on several bills introduced during the 110th Congress. During the hearing, Representative Berkley made the following comment:

> And let me mention something else that we are working on. And let me give an effort to give full disclosure. My husband is a nephrologist. And they have a very, very busy practice. It is a kidney doctor. They have a very, very busy practice in Las Vegas. They also contract with the VA. They have not been paid in over a year. And talk about people not enlisting and volunteering to serve this Nation. If these doctors don't get paid, I mean I am not talking in a timely manner. I am talking about not getting paid. You are not going to get any doctors treating these veterans when they get home, especially those that are contracting with the VA.
>
> So we have a ton of problems in the VA right now. And we are going to have to work through those. And, again, give the VA the necessary resources in order to provide the services.[39]

[38] ISC Interview of Carrie Fiarman.

Immediately following Representative Berkley's comments, Ms. Fiarman sent an email to Richard Urey, Representative Berkley's chief of staff, and Bryan George, Representative Berkley's legislative director, informing them, "She just mentioned the situation and her husband by name saying they haven't been paid over a year."[40] During her interview before the ISC, Ms. Fiarman said she informed her supervisors of Representative Berkley's comments because she thought it was important.[41] She was also concerned that Representative Berkley's comments would bring more attention to the issue, and she believed the VA was working to correct the situation.[42] Ms. Fiarman did not want the fact that the issue involved Representative Berkley's husband's practice to bring extra attention to it.[43]

Later that same day, Mr. Bright responded to an email from Ms. Fiarman regarding "Kidney Specialist of So Nevada – VA Payments" and noted, "Ms. Berkley brought this up at the HCVA meeting this morning with Dr. Cross. There will be a flurry of activity now. . . ."[44] Ms. Fiarman forwarded Mr. Bright's email to Mr. Urey and wrote the following:[45]

From: Fiarman, Carrie
Sent: Tuesday, April 15, 2008 4:27 PM
To: Urey, Richard <[redacted]@mail.house.gov>
Subject: FW: Kidney Specialist of So Nevada - VA Payments

Problem....

Everyone will now be quite aware of the fact that her husband is the one who needs to get paid.

Also she has now brought ridiculous amounts of attention to something that needs to be handled locally first. I personally feel that John Bright is doing everything he can to curb this before it gets out of hand.

Not sure what to do...

Carrie Fiarman
Legislative Assistant
Office of Congresswoman Shelley Berkley
(202) 225-[redacted] (phone)
(202) 225-[redacted] (fax)
[redacted]@mail.house.gov

Initially, Ms. Fiarman stated she was concerned about Representative Berkley's comment during the hearing because she believed it would reflect poorly on the efforts she had made to resolve

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[39] *Legislative Hearing on H.R. 2818, H.R. 5554, H.R. 5595, H.R. 5622, H.R. 5729, and H.R. 5730,* 110th Congress (2008) (statement of Representative Shelley Berkley, from Nevada's 1st district).

[40] Exhibit 6.

[41] ISC Interview of Carrie Fiarman.

[42] ISC Interview of Carrie Fiarman.

[43] ISC Interview of Carrie Fiarman.

[44] Exhibit 7.

[45] Exhibit 7.

the issue and reflect poorly on Mr. Bright and his office's work toward resolving the issue.[46] However, after additional questioning, Ms. Fiarman stated the following:

> [MS. FIARMAN] But I think that the fact yes, the fact that it had her husband in it I think would bring extra attention from the VA, saying you know, the Congresswoman is upset. Why is this going on in the district? Why haven't these people been paid?
>
> I thought that it would kind of make the situation balloon out of hand when it was already being handled and I was taking care of it.
>
> . . .
>
> [COUNSEL] I think we're still having trouble understanding, so I don't think it's as clear to us as you're trying to make it. What we want to understand is if the Congresswoman were to mention any other constituent, so John Smith, if she were to mention them by name at a hearing, why wouldn't that get the exact same reaction from the VA, the reaction you just described to us, which is, Oh, my goodness, the Congresswoman is very upset. There's a specific person that isn't getting paid and it now has her personal attention. Why does it matter that it was her husband as opposed to any other person by name?
>
> [MS.FIARMAN] I think my perception is that the VA would put extra pressure, knowing it was her husband. I felt that is how the VA would react, personally. Yeah, they get involved when the Member mentions anybody. But I think the fact that she mentioned her husband, I think VA would have looked more at it and said, Okay, it's the Congresswoman's husband. Why isn't he getting paid?
>
> And it was already being handled. So I took it as okay, we don't need the VA getting involved extra. This is already taken care of. I've taken care of it. John Bright is taking care of it. I was kind of annoyed because it was already being handled. And I thought that invoking the name of her husband would bring extra effort from the VA. That's just how I felt the VA would respond.[47]

Ms. Fiarman testified that she had purposefully avoided using Dr. Lehrner's name when she contacted the VA about KSSN's payment issue.[48] She believed it was appropriate to assist KSSN by contacting the VA about the payment issues because the practice included other

[46] ISC Interview of Carrie Fiarman.

[47] ISC Interview of Carrie Fiarman.

[48] ISC Interview of Carrie Fiarman.

doctors. However, Ms. Fiarman was concerned the issue would be treated differently by the VA if she highlighted the fact that KSSN was Representative Berkley's husband's business.[49]

In his testimony before the ISC, Mr. Bright explained his reaction to Representative Berkley's comment and what he meant when he wrote to Ms. Fiarman, "there will be a flurry of activity now" as follows: [50]

> [MR. BRIGHT] Well, I meant the wrath from Washington, D.C., is coming our way with instructions to fix it. You know, in our system, stuff runs downhill pretty fast. And the fact that this was brought up, whether it was specific to Kidney Specialists or not, it was brought up that the VA in Las Vegas is not paying its bills, and I was going to get a flurry of activity from Washington, D.C., which I did.[51]

Mr. Urey testified during his interview before the ISC that Representative Berkley's comment during the hearing did not raise a concern. Mr. Urey stated:

> [COUNSEL] Did you observe -- in your opinion, would it have been a problem even from an appearance perspective for the public to know that the office was spending time and resources attempting to resolve a payment issue for her husband's company?
>
> [MR. UREY] The Congresswoman called attention to this in a very open hearing. Typically media is present at those. She stated this, for what reason I don't know, but it was in the context of a very broad discussion of VA things. And it struck me in having looked at that record, that she was illustrating the kinds of problems the VA has that ultimately are going to wind up in less care for veterans. She clearly, by stating it there, had no desire to keep this a secret, didn't bother her, and by stating it, she's made, you know, a very public disclosure. So, to me, it's fine. I mean, she's made this a public matter, so it's not something that particularly bothers me.[52]

Representative Berkley testified that the purpose of her comment at the HCVA hearing was to illustrate some of the issues within the VA and highlight the need for sufficient funding. Specifically, Representative Berkley explained:

> [REPRESENTATIVE BERKLEY] I remember that hearing. It was in the context of a budget meeting, and I was using my

[49] ISC Interview of Carrie Fiarman.

[50] Exhibit 7.

[51] ISC Interview of John Bright.

[52] ISC Interview of Richard Urey.

> husband as an example of why we have to give the VA more money so they could actually do the job that we had hired them to do, and if you read the entire transcript, you will see that I was using Larry as an example. I was not suggesting that he should get paid, I was not suggesting that he was the victim of anything, I was not suggesting anything regarding Larry other than using him as a prime example of the fact that the VA did not have enough staff, we needed to provide them with more staff and give them more money so they could actually do their job, and if they're not doing their job, they're not serving my veterans, and if they're not serving my veterans, it's my job as their representative in Congress to bring this to the attention of my colleagues and other personnel, staff personnel.[53]

Mr. Bright testified that as a result of Representative Berkley's comments, the VA sent resources to his branch to help identify and remedy any issues that contributed to claims not being processed or denied.[54] Following an internal review of its procedures, Mr. Bright's office implemented a new procedure for processing claims.

Over the course of the following months, Mr. Bright provided periodic updates to Representative Berkley's office regarding the status of KSSN's VA claims, through June 2008:[55]

[53] ISC Interview of Representative Shelley Berkley.

[54] ISC Interview of John Bright.

[55] Exhibit 8.

From: Fiarman, Carrie
Sent: Tuesday, June 3, 2008 1:04 PM
To: Coffron, Matthew <[redacted]@mail.house.gov>
Subject: FW: Kidney Specialist of So. Nevada
Attach: Issue Brief Kidney Specialist of So Nevada (4).doc

fyi

Carrie Fiarman
Legislative Assistant
Office of Congresswoman Shelley Berkley
(202) 225-[redacted] (phone)
(202) 225-[redacted] (fax)
[redacted]@mail.house.gov

From: Bright, John B [mailt[redacted]@va.gov]
Sent: Tuesday, June 03, 2008 1:01 PM
To: Fiarman, Carrie
Subject: FW: Kidney Specialist of So. Nevada

Here is another update. Not a lot of progress but we are continuing to work with them. I'm leaving on vacation to Mexico Thursday night and will be gone until June 23. This is the first 2-week vacation of my career.

We continue to play with the OIG on the colonoscopy issue. Of course, they haven't found anything but continue to interview staff and are a nuisance. This is there second week and hopefully their last.

Hope all is well with you. Thanks

JOHN B. BRIGHT
Director
VA Southern Nevada Healthcare System
702-636-[redacted]

According to these updates, by early April, 2008, the VA had approved over $20,000 worth of KSSN's claims and processed them for payment:[56]

Status of claims on 4/4/08:

On 3/29/08 196 claims were approved and processed for payment in the amount of $20,004.29. Payment processing normally takes between 30-45 days, however, VASNHS will request expedited payments.

In late April, the VA approved an additional $12,000 worth of unpaid claims:[57]

[56] Exhibit 8.

[57] Exhibit 8.

Status as of 4/24/08

Kidney Specialist of Southern Nevada submitted 261 claims for review for potential payment from the VASNHS. The value of these claims was $50,662.81.

Of the 261 claims, 60 have been reviewed, found to be valid, and processed for payment in the amount of $12,210.81. Payments will be received during the month of May, 2008. VASNHS currently has 30 claims in the review process for a total of $4,530.

By June, the VA had reviewed the final group of bills regarding unauthorized inpatient medical care:[58]

Status as of 6/3/08

Unauthorized inpatient medical care must be supported with copies of the hospitalization records. There were 135 bills which were tied to seven inpatient stays for a total of $27,280.

We received records for one patient and payment for 16 claims in the amount of $1,300 will be received during the month of June 2008. Three (3) claims were denied as they are associated with a motor vehicle accident and the veteran is pursuing a tort claim. There are 116 claims for which we have not received a copy of the records. We had previously contacted the vendor to provide the needed information and will now contact the veterans.

Based on this documentation, KSSN received payment for at least approximately $32,000 in claims with the VA after Representative Berkley's staff contacted the agency. Additionally, the documentation makes clear that the VA sought to update Representative Berkley's office on the status of processing claims for KSSN separate from any efforts for a broad systemic fix to the VA's claim processing procedure.

2. *Medicare Payments Processed by Palmetto*

Later that same year, in August of 2008, Dr. Lehrner contacted Representative Berkley's office regarding issues his practice was experiencing with Palmetto GBA Medicare (Palmetto), a Medicaid administrator for CMS. A disruption in claim payments had occurred during the transition from Noridian, the former Medicaid administrator, to Palmetto. On August 5, 2008, Dr. Lehrner sent the following email to Mr. Urey, Representative Berkley, and KSSN's billing specialist:[59]

[58] Exhibit 8.

[59] Exhibit 9.

From: Lawrence Lehrner [mailto:[redacted]@ksosn.com]
Sent: Tuesday, August 05, 2008 1:58 PM
To: Urey, Richard
Cc: Lehrner, Mrs.; Lori M. LeBlanc
Subject: Palmetto Medicare

Richard-

The transition from Noridian to Palmetto as the Medicare claims processor for the state of Nevada is not going well. Palmetto will not provide information to allow transmission of claims. For details of the problem please call my administrator- Lori LeBlanc- 775 287[redacted] and than any fire you can light under Palmetto would be greatly appreciated.

Thanks

Larry

The following day, on August 6, 2008, Dr. Lehrner forwarded an email to Mr. Coffron which included details regarding the issues Nevada providers were experiencing. In his email, Dr. Lehrner notified Mr. Coffron that Representative Berkley was going to discuss the issue with him.[60]

From: Larry Lehrner <[redacted]@nande.org>
Sent: Wednesday, August 6, 2008 9:46 AM
To: Coffron, Matthew <[redacted]@mail.house.gov>
Subject: FW: Palmetto Medicare

Matt-

Shelley asked me to send this to you. She will discuss it with you today.

In advance thanks for your help.

Larry

Although his email indicated he discussed the issue with Representative Berkley, Dr. Lehrner did not recall a conversation with Representative Berkley about this issue.

> [COUNSEL] Now, if you go back to the first page, about halfway down you forwarded this email chain to Matt Coffron and you say, Matt, Shelley asked me to send this to you. She will discuss it with you today. In advance thanks for your help. Larry.
>
> Do you recall a conversation with Representative Berkley about the switch from Noridian to Palmetto?
>
> [DR. LEHRNER] No, I don't.
>
> [COUNSEL] Do you recall discussing with her the idea of assigning staff to this issue?

[60] Exhibit 9.

[DR. LEHRNER] No, I do not.

[COUNSEL] And do you recall her - do you recall her directing or asking you to forward an email to Matt Coffron?

[DR. LEHRNER] No, I do not.

[COUNSEL] The last line is in advance thanks for your help. Do you recall what sort of help you were looking for from the congressional office on this issue?

[DR. LEHRNER] We were hoping that Medicare could fix the problems and all physicians could get their payments.[61]

The following day, Dr. Lehrner sent an email to Mr. Coffron thanking him for his "quick response to our problems with Palmetto. A senior VP called us and promised to fix all the issues by today."[62] Mr. Coffron testified that he recalled making a phone call to Palmetto, but he did not recall the details of his conversation with Palmetto representatives, recall whether he specifically mentioned KSSN during the call, or recall whether he presented the issue as one impacting multiple providers in Nevada.[63]

Mr. Coffron also stated that at the time, he knew that other providers were experiencing similar issues with Palmetto. However, he did not recall being contacted by any other providers or recall receiving any information about any particular providers from the district office that had complained about the same problem.[64] He recalled that sometime after his call to Palmetto on behalf of Dr. Lehrner, he worked with Representative Pete Stark's office on issues related to Palmetto's claim processing procedures. Specifically, he attended a meeting held by Representative Stark's staff with Palmetto officials to discuss some of the issues that were impacting providers.[65] Mr. Coffron testified that over time, Palmetto began to improve its services and eliminate some of the issues providers had lodged complaints regarding.[66]

Approximately three months later, on November 7, 2008, Dr. Lehrner again emailed Representative Berkley and her chief of staff about the problems his practice experienced when submitting, or following up on, Medicare payments claims with Palmetto:[67]

[61] ISC Interview of Dr. Lawrence Lehrner.

[62] Exhibit 10.

[63] ISC Interview of Matthew Coffron.

[64] ISC Interview of Matthew Coffron.

[65] ISC Interview of Matthew Coffron.

[66] ISC Interview of Matthew Coffron.

[67] Exhibit 11.

From: Urey, Richard <[redacted]@mail.house.gov>
Sent: Saturday, November 8, 2008 2:06 PM
To: [redacted]ksosn.com'
Subject: Re: Medicare Issues

Thanx larry. Will review.

Sent from my BlackBerry Wireless Handheld

----- Original Message -----
From: Lawrence Lehrner [redacted]@ksosn.com>
To: Lehrner, Mrs.; Urey, Richard
Sent: Fri Nov 07 14:11:12 2008
Subject: FW: Medicare Issues

Shelley and Richard-

A summary of the problems we are having with Palmetto (the Medicare MAC for NV). Any help is greatly appreciated. In case you cannot open a Microsoft Word file I have inserted a copy of the letter in the body of this e-mail.

Thanks

Your favorite constituent

Larry

Dr. Lehrner's email forwarded a summary of the problems with Palmetto that his billing specialist had prepared. The summary included information regarding specific issues including not receiving answers to questions about claims that had been denied, poor customer service, and conflicting information about the status of claims.[68]

A few days later, on November 11, 2008, Dr. Lehrner forwarded an email to Mr. Urey with a copy to Representative Berkley regarding the number of claim processing problems Nevada providers were experiencing with Palmetto.[69] In his email, Dr. Lehrner noted "Not just my practice. Shelley can further cement her reputation as the doctor's friend by getting CMS to move on this issue."[70] During their interviews before the ISC, both Mr. Urey and Dr. Lehrner could not recall much detail about the emails or the issues with Palmetto. Mr. Urey stated he did not recall discussing the issue with staff or with Representative Berkley.[71] He also did not recall whether Representative Berkley's office took any legislative action or other official action

[68] Exhibit 11.

[69] Exhibit 12.

[70] Exhibit 12.

[71] ISC Interview of Richard Urey.

regarding the issue.[72] Dr. Lehrner could not recall whether the issue was eventually resolved although he presumed that it had been.[73]

Representative Berkley shared her view of the Palmetto issue and the assistance her office provided to Dr. Lehrner's practice:

> [REPRESENTATIVE BERKLEY] To let you know how intense the situation this was in the Las Vegas area, not only, and you also see that the executive director of the AMA was also contacting us. He is an old friend of mine, and he was both running into me at various occasions, and telling me, we have got to get this fixed. We have got to get this fixed. My doctors aren't getting paid. This was when Medicare changed vendors, and they went to Palmetto.
>
> The pay -- the doctors were just not getting paid. . . . they were sole practitioners like Dr. Hoffman that were besides himself. I mean, he was I am going to have to close my doors. I can't -- Medicare owes me this much money. I can't pay my rent. I can't pay my nurses. I can't keep my doors open unless I get paid. And I think Dr. Hoffman was the first one that called me because he has my cell phone.
>
> Dr. Steinberg has a much bigger practice. He inherited, or he has his father's practice. They are radiologists . . . Dr. Steinberg turned around, the usual greeting at the Jewish New Year is either Happy New Year, Good Yontiff. He says to me, he walks over, I'm looking at him, he is looking at me, he says, you're killing me. I mean, this - even in synagogue on High Holiday services, I got the doctors yelling, ranting, and raving about the fact that they are not getting paid so.
>
> So this is something I didn't escape ever. And so Larry was such a small part of this, but yes, he also had problems with Palmetto getting paid. So did Dr. Steinberg; so did Dr. Hoffman; so did Dr. Licata; so did Dr. Sa[xe]. I mean, you name it, they were having problems. And the head of the AMA was also having -- he's not AMA, the Nevada State Medical Society. They were all contacting my office.[74]

[72] ISC Interview of Richard Urey.

[73] ISC Interview of Dr. Lawrence Lehrner.

[74] ISC Interview of Representative Shelley Berkley.

3. *Medicare Approval of New Physicians*

In December of 2010, Dr. Lehrner emailed Representative Berkley and Mr. Urey about an issue with Medicare. Dr. Lehrner had just been notified that Medicare had extended its review period for approving new doctors from 60 days to 90 days.[75]

From: Larry Lehrner [redacted]@ksosn.com>
To: Urey, Richard; Lehrner, Mrs.
Sent: Mon Dec 06 19:36:49 2010
Subject: FW: Medicare Provider Hotline #'s

For the past 6 months or so Medicare (at least our provider- Palmetto) was taking less than 60 days to approve our new doctors. We are now told that it will be 90 days before they can approve our new doctors. Our latest new doctor does interventional procedures and we calculate that we are owed over 100,000 (Medicare Allowable) for his services. We cannot bill until we get his Medicare number and then it will take at least another 14 days to be paid. Did Congress mandate a time limit on how long the Medicare Carriers can take to approve doctors for their Medicare number?

Thanks

Larry

According to Dr. Lehrner's e-mail, this presented a problem for his practice because the practice was not receiving payment for work performed by a doctor that had not yet obtained a Medicare billing number. This resulted in the practice being owed approximately $100,000. Dr. Lehrner explained his reasoning for contacting Representative Berkley's office:

> [COUNSEL] So Palmetto, which is the Nevada Medicare provider, had historically been taking 60 days to get doctors that code?
>
> [DR. LEHRNER] Yes.
>
> [COUNSEL] And then for a variety of reasons that began to, the backlog became 90 days?
>
> [DR. LEHRNER] Yes.
>
> [COUNSEL] And you list as a for example your new doctor that does interventional procedures was owed $100,000 for his services and you couldn't bill until he got his code?
>
> [DR. LEHRNER] Correct.
>
> [COUNSEL] And you asked was there something in the law that would address this?
>
> [DR. LEHRNER] I was just asking in this case information on what the Federal law was so if actually it was a Federal law, I don't know if I ever got an answer, that Palmetto had violated their requirement then I knew we had a basis to call and complain to

[75] Exhibit 13.

> their administrator, or if they had a statutory 90 days then we had to continue to wait. And instead of me trying to dig through all the rules and regulations I thought staff might be able to get me the answer quicker.[76]

Dr. Lehrner's response to the ISC's questions about his purpose for contacting the office demonstrated his view of Representative Berkley's office's resources as they related to his practice.

Representative Berkley shared her view of the issue:

> [REPRESENTATIVE BERKLEY] [KSSN] recruited a doctor, and in order to actually bill Medicare, the doctor has to have a number because you need a number to be able to bill to, a Medicare number. Ordinarily, it took 60 days from what I learned. It had been 90 days if I'm not mistaken, and they still didn't have a number for the doctor. So they were providing the services. The doctor, new doctor was working and providing the services, but they weren't getting paid for the services. And after trying on many occasions to get the number, and so he can start actually billing for the services he was providing, he obviously contacted -- my husband obviously contacted my office.
>
> [COUNSEL] And did you have a discussion directly with Dr. Lehrner about this issue?
>
> [REPRESENTATIVE BERKLEY] He told me that there was an issue with that.
>
> [COUNSEL] And then in your discussion with him, did you say that you would do anything regarding this issue?
>
> [REPRESENTATIVE BERKLEY] What I usually tell him is get ahold of the office. See if there is anything they can do. I didn't directly, I don't believe, get involved in this. But I would tell him, you know, contact Richard, you know, call Carrie, see what, if anything, they can do.[77]

Mr. Urey responded to Dr. Lehrner's email by stating that staff would find out and emailed Dr. Lehrner's question to Ms. Fiarman.[78] The next day, in response to an email from Ms. Fiarman, Dr. Lehrner responded by asking whether Ms. Fiarman had gotten an answer to his question. Two days later, Dr. Lehrner emailed Ms. Fiarman again to ask if she had gotten a response to his question.[79]

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[76] ISC Interview of Dr. Lawrence Lehrner.

[77] ISC Interview of Representative Shelley Berkley.

[78] Exhibit 13.

[79] Exhibit 14.

D. University Medical Center of Southern Nevada

In March of 2008, the Centers for Medicare and Medicaid Services (CMS) conducted an on-site survey of the kidney transplant program at University Medical Center of Southern Nevada (UMC).[80] As a result of the on-site survey, CMS determined that UMC was not in compliance with several conditions of participation.[81] Chief among these conditions was UMC's failure to meet certain requirements related to patient outcomes – specifically, there had been more patient deaths in UMC's program than CMS permitted for certified kidney transplant programs.[82] On May 28, 2008, the CMS Regional Office sent a letter notifying UMC of the survey results and identified the deficiencies. CMS set a prospective termination date of July 14, 2008, for all conditions that UMC did not meet, except the outcome requirements.[83] October 13, 2008, was the prospective termination date set if the July data from the Scientific Registry of Transplant Recipients (SRTR) report showed the program was not in compliance.[84]

In an August 5, 2008 phone call with UMC officials, Thomas Hamilton, Director of Survey and Certification for CMS, explained that UMC had still not met all the requirements for Medicare participation and explained three options UMC had in light of the continued failure to meet participations requirements: (1) UMC could voluntarily withdraw from Medicare participation; (2) UMC could request approval based on mitigating factors; or (3) UMC could choose to not take any action and allow CMS to proceed terminating UMC's transplant program.[85] On September 11, 2008, UMC submitted a "Request for Approval Based on Mitigating Factors" outlining a number of reasons it believed CMS should consider continuing its Medicare participation.[86] Following a review by a panel designated to review requests for approval based on mitigating factors, CMS notified UMC that its request had been denied and that de-certification would continue on the previously scheduled timetable, with decertification scheduled for December 3, 2008.[87] Mr. Hamilton testified that during this time period, CMS had not been contacted by congressional officials about its decision to terminate UMC.[88]

On October 23, 2008, CMS notified UMC by letter that Medicare approval for the transplant center would be revoked effective December 3, 2008.[89] Seven days after the October 23, 2008 letter, CMS sent another letter to UMC, this time extending the effective termination

[80] ISC Interview of Thomas Hamilton.

[81] ISC Interview of Thomas Hamilton.

[82] ISC Interview of Thomas Hamilton.

[83] Exhibit 15.

[84] Exhibit 15.

[85] Exhibit 16.

[86] Exhibit 17

[87] Exhibit 18.

[88] ISC Interview of Thomas Hamilton.

[89] Exhibit 19.

date to January 8, 2009, subject to certain conditions being met, including that UMC and CMS would enter into a mutual, binding agreement regarding the kidney transplant program.[90]

On or about October 22, 2008, Kathy Silver, then-CEO of UMC called Dr. Lehrner about CMS' decision to terminate the transplant center's Medicare participation and asked him whether Representative Berkley could help with the situation.[91] Dr. Lehrner provided Representative Berkley's telephone number to Ms. Silver.[92] In her interview before the ISC, Ms. Silver stated that she called Representative Berkley and briefly described the issue that UMC faced.[93] According to Ms. Silver, Representative Berkley offered her assistance and directed Ms. Silver to contact one of her staffers.[94]

Later that day, Matthew Coffron spoke with UMC's counsel regarding the matter.[95] Mr. Coffron testified that UMC's counsel explained the issue UMC was facing and pointed out that UMC's kidney transplant program was the only one in the state.[96] The next day, in response to a follow-up email from UMC's attorney, Mr. Coffron provided an update on Representative Berkley's plan of action.[97]

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[90] Exhibit 20.

[91] ISC Interview of Kathy Silver.

[92] ISC Interview of Kathy Silver.

[93] ISC Interview of Kathy Silver.

[94] ISC Interview of Kathy Silver; Exhibit 21.

[95] Exhibit 22.

[96] ISC Interview of Matthew Coffron.

[97] Exhibit 22.

-----Original Message-----
From: Coffron, Matthew [mailto:[redacted]@mail.house.gov]
Sent: Thursday, October 23, 2008 1:29 PM
To: Luband, Charles A.
Subject: RE: UMC Conference Call

Hello Charlie,

I spoke with the Congresswoman this morning. She confirmed that she is happy to send a letter (which I am currently drafting) and would be open to doing something as a delegation in the future. She also mentioned having spoken with Senator Reid on this issue.

I also tried to call Ed Japitana at CMS to get some clarification on their position, but learned that he is out this week.

Please keep me posted on the response you get from other offices if you can.

Thanks,

-Matt

Matthew Coffron
Legislative Assistant
Office of Congresswoman Shelley Berkley
405 Cannon House Office Building
202-225-[redacted]

Mr. Coffron testified that, prior to hearing from any other member of the Nevada delegation, Representative Berkley had decided to write a letter to CMS regarding its decision.[98] He stated that because UMC was in Representative Berkley's district, "she would have done it either way."[99] Shortly after his email to UMC's counsel, at approximately 1:54 pm, Mr. Coffron received an email from Alanna Porter, a staffer for former Representative Jon Porter, about joining together to send a letter to CMS.[100] Just over two hours later, at 4:04 pm, Mr. Coffron sent Ms. Porter an email and included the draft letter in the body of the email.[101] Mr. Coffron confirmed that he drafted the letter and sent it to each Member's office for review and final approval.[102] He stated that at the time this issue came up, he did not contact Dr. Lehrner for his input.[103] He could not recall whether or not he was aware at the time that Dr. Lehrner's practice contracted with UMC to provide dialysis services, but he did not consider it relevant in making the decision to assist UMC.[104]

[98] ISC Interview of Matthew Coffron.

[99] ISC Interview of Matthew Coffron.

[100] Exhibit 23.

[101] Exhibit 24.

[102] ISC Interview of Matthew Coffron.

[103] ISC Interview of Matthew Coffron.

[104] ISC Interview of Matthew Coffron.

On October 24, 2008, the three Members of the Nevada House delegation – then-Representative Dean Heller, then-Representative Jon Porter, and Representative Berkley – sent a joint letter to Kerry Weems, the Acting Administrator of CMS, regarding CMS' decision to terminate Medicare approval of UMC's kidney transplant program.[105] The letter expressed the Members' "strong disagreement" with CMS' decision and requested that CMS reconsider its decision.[106]

Press articles covering the matter noted that Representative Porter held two discussions with CMS officials about UMC's kidney transplant program.[107] According to the articles, Representative Berkley was also scheduled to talk to CMS officials about UMC's program.[108] On October 30, 2008, Representative Berkley spoke to Mr. Weems about the issue and, according to a member of her staff, was "OK'd to say they are close to deal."[109] Mr. Weems, in his testimony before the ISC, recalled receiving a phone call from Representative Berkley about the issue. He described the call - what he considered a *pro forma* step - as relatively short, and stated he provided a "comforting" answer to her.[110] Mr. Weems also stated at some point during this timeframe he became aware of Dr. Lehrner's practice's contract with UMC, but could not recall whether Representative Berkley actually disclosed this fact to him.[111] Mr. Weems also recalled speaking with Representative Porter - who he described as leading the delegation on this issue – regarding CMS' decision.[112]

Representative Berkley testified she first became aware of CMS's decision to terminate Medicare approval of UMC's kidney transplant program when Ms. Silver contacted her.[113] After her conversation with Ms. Silver, Representative Berkley contacted her staff about the issue, and her office drafted the letter that was eventually sent to CMS.[114] Representative Berkley believed that, because UMC was located within her congressional district, it was her duty to her constituents to help.[115]

> [REPRESENTATIVE BERKLEY] I can tell you at the time there was not a hesitation. I did it. I thought it was the right thing to do. I was going to save that program. I -- under my watch, I wasn't going to let the only kidney transplant program in the entire State of Nevada with 200 people waiting for a kidney transplant close, if

[105] Exhibit 25.

[106] Exhibit 25.

[107] Exhibit 26.

[108] Exhibit 26.

[109] Exhibit 27.

[110] ISC Interview of Kerry Weems.

[111] ISC Interview of Kerry Weems.

[112] ISC Interview of Kerry Weems.

[113] ISC Interview of Representative Shelley Berkley.

[114] ISC Interview of Representative Shelley Berkley.

[115] ISC Interview of Representative Shelley Berkley.

I could do anything in my power to stop it. We did everything above board. We took care of the problem. It is functioning and it is successful.[116]

Representative Berkley explained that when she was contacted by UMC about CMS' decision, she knew that KSSN provided dialysis services at UMC pursuant to a contract, but was not aware of the details of the contract.[117] Specifically, she did not know that KSSN provided transplant services, such as preoperative and postoperative care, under its contract.

[COUNSEL] Ms. Berkley, I just want to follow up, because you told us you didn't really know the specifics of what your husband was doing. He is a busy doctor, obviously, you are a very busy Congresswoman. At the time -- and I understand you have learned more since all of this has come up -- back at the time that this was going on, what did you know about the contract that KSSN had with UMC?

[REPRESENTATIVE BERKLEY] I knew that Larry's group had a contract where they would provide dialysis service. And the reason I knew that was not -- it was, again, an interesting side line, side of this, but it came through illegal immigration issues. And the

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[116] ISC Interview of Representative Shelley Berkley.

[117] When Representative Berkley initially described KSSN's contract in her testimony, she revealed her understanding of some of the details of the contract. Specifically she testified:

> [REPRESENTATIVE BERKLEY] Larry's contract, Larry's group's contract was to provide kidney care for the county hospital. . . . If the program was wildly successful and doubled and tripled and quadrupled, their contract would remain the same. If the kidney transplant program closed, their contract remains the same. Larry does the dialysis. He makes money from dialysis, not from kidney transplant. They were part of the consulting group. They didn't do the transplant, but you need to have a nephrologist in order to have a transplant program.
>
> ---
>
> [REPRESENTATIVE BERKLEY] I do know that his contract was, even though they tangentially did work for the kidney transplant program, they – his compensation under the contract didn't change one bit. If it closed it was of no consequence to them other than they wouldn't be able to provide good kidney care for their patients. And some of their dialysis patients are eligible for kidney transplants. As I said, if the -- if it doubled in size, his contract doesn't change

ISC Interview of Representative Shelley Berkley. However, when specifically asked at what time she became aware of the details of KSSN's contract with UMC, Representative Berkley made clear that she only learned of these details after Ms. Silver contacted her for assistance on behalf of UMC's kidney transplant program.

fact that a number of undocumented people show up at the county hospital to be dialysized, and with their contract, they were expected to dialysize these patients with no questions asked. So I knew he had the dialysis unit. I knew he oversaw the dialysis unit at the county hospital because I was dealing with this in a completely different issue on illegal immigration.

[COUNSEL] Did you know at the time, because you mentioned just a moment ago that this contract also required KSSN to provide preoperative and postoperative --

[REPRESENTATIVE BERKLEY] I learned that after.

. . .

[COUNSEL] We understand that. I just want to focus on sort of what you knew about the contract at the time?

[REPRESENTATIVE BERKLEY] Very little.

[COUNSEL] Okay, and so what you just told us about the contract not going up in terms of compensation or not adjusting, is that all stuff that you learned afterwards; is that right?

[REPRESENTATIVE BERKLEY] Yes. Yes.[118]

Representative Berkley testified that, in taking action to intervene on behalf of UMC's kidney transplant program, she was only motivated by the needs of her constituents.

[REPRESENTATIVE BERKLEY] But I also said at the time, and would say it again today, that I couldn't have lived with myself if I did [take a pass on the UMC program]. I had a responsibility to my constituents, and that was the responsibility I wanted to fulfill. I didn't check whether Larry had a benefit, and it wouldn't have occurred to me that he had. I learned in subsequent discussions exactly what the extent of the contract was, what he did under the contract, what his group did under the contract and what services they provided. But at no time did I have any other concern but for the welfare of the people I represent.

. . .

[ISC MEMBER] And you were never motivated by what would be financially beneficial or not beneficial to you or your husband?

[REPRESENTATIVE BERKLEY] The answer is yes . . . Decidedly, absolutely without fear of contradiction, yes.[119]

[118] ISC Interview of Representative Shelley Berkley.

[119] ISC Interview of Representative Berkley.

Throughout her interview, Representative Berkley reiterated her pride in the assistance that she, and the other members of the Nevada delegation, provided to UMC. [120]

> [REPRESENTATIVE BERKLEY] There are hundreds of people alive today because that program exists. I'm very, very proud of that. And frankly, if there hadn't been an ethics complaint, I suspect that would have been one of the things that I would have spoke about with the greatest pride, that I saved the kidney transplant program.[121]
>
> I understood immediately the importance of keeping that program open, and as I said in the opening statement, . . . nothing makes me happier then when somebody comes over to me now, and thanks me for saving their loved one's life[.].[122]

In 2010, KSSN submitted a bid proposal to UMC for a renewed contract to provide nephrology services. KSSN's proposal stated, "When UNOS threatened to decertify the UMC transplant program, Dr. Lehrner contacted the Nevada Congressional delegation, including Senator Harry Reid. The Nevada Congressional delegation was instrumental in the CMS decision to allow the program to continue."[123] KSSN was the only practice to submit a proposal and UMC renewed KSSN's contract to provide nephrology services.

IV. HOUSE RULES, REGULATIONS, LAWS OR OTHER STANDARDS OF CONDUCT

The following are laws or rules that are implicated in this matter.

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[120] ISC Interview of Representative Shelley Berkley.

[121] ISC Interview of Representative Shelley Berkley.

[122] ISC Interview of Representative Shelley Berkley.

[123] Exhibit 28. In his testimony, Dr. Lehrner explained that KSSN's proposal referred to his efforts to contact the Nevada delegation on behalf of UMC only to enhance its proposal. Dr. Lehrner stated:

> [DR. LEHRNER] We've established that I did contact people. I don't remember specific conversations, so I would say the sentence is correct. I think in writing an RFP, we give ourselves a little pat on the back by using the word "instrumental" because again, I never spoke to the CMS administration to see what actually caused them to change their mind.
>
> [COUNSEL] So as you sit here today, you don't know whether or not Nevada Congressional delegation was instrumental in the CMS decision?
>
> [DR. LEHRNER] No, we puffed it up.
>
> [COUNSEL] And I think you've implied this with that answer, about why didn't you include it for both?
>
> [DR. LEHRNER] I think any time you're responding to a request for a proposal you want to put yourself in the best light, so we took credit for a good outcome.

ISC Interview of Dr. Lawrence Lehrner.

First, House Rule XXIII, clause 1 states that "[a] Member, Delegate, resident Commissioner, officer or employee of the House shall behave at all times in a manner that shall reflect creditably on the House," and clause 2 states that "[a] Member, Delegate, Resident commissioner, officer, or employee of the House shall adhere to the *spirit and the letter* of the Rules of the House...." (emphasis added).

Second, House Rule XXIII, clause 3 states that "a Member, Delegate, Resident Commissioner, officer or employee of the House may not receive compensation and may not permit compensation to accrue to the beneficial interest of such individual from any source, the receipt of which would occur by virtue of influence improperly exerted from the position of such individual in Congress."

Third, Section 5 of the Code of Ethics for Government Service states that "Any person in Government service should . . . never accept for himself or his family, favors or benefits under circumstances which might be construed by reasonable persons as influencing the performance of his governmental duties." Section 5 of the Code of Ethics for Government Service also prohibits a government official from "discriminat[ing] unfairly by the dispensing of special favors or privileges to anyone, whether for remuneration or not[.]"

V. ANALYSIS

The information obtained by the ISC through witness testimony, as well as documentary evidence, indicates that Representative Berkley violated House Rules, regulations, laws or other standards of conduct when she permitted her office to take official action specifically on behalf of her husband's practice. However, the ISC did not find that Representative Berkley violated any such rules or laws when she intervened on behalf of UMC in an effort to prevent CMS from terminating Medicare approval of UMC's kidney transplant program, or when she permitted her husband to contact her office on behalf of other business entities, fellow members of a professional association, or other third parties seeking official action.

A. House Rule XXIII, clauses 1 and 2

The ISC begins from two basic principles. First, Members must at all times act in a manner that reflects creditably upon the House. This standard was created to provide the Committee "the ability to deal with any given act or accumulation of acts which, in the judgment of the [C]ommittee, are severe enough to reflect discredit on the Congress."[124] Clause 1 "encompass[es] violations of law and abuses of one's official position."[125] It is a "purposefully...subjective" standard.[126]

Second, the ISC notes the proposition that the Code of Conduct and other standards of conduct governing the ethical behavior of the House community are not criminal statutes to be construed strictly, but rather – under clause 2 of House Rule XXIII – must be read to prohibit

[124] 114 Cong. Rec. 8778 (Statement of Representative Price).

[125] *House Ethics Manual* (2008) (*Ethics Manual*) at 16.

[126] 114 Cong. Rec. 8778 (Statement of Representative Price).

violations not only of the letter of the rules, but of the spirit of the rules. Ethical rules governing the conduct of Members were created to assure the public of "the importance of the precedents of decorum and consideration that have evolved in the House over the years."[127] The standard "provide[s] the House with the means to deal with infractions that rise to trouble it without burdening it with defining specific charges that would be difficult to state with precision."[128] The practical effect of Clause 2 is to allow the Committee to construe ethical rules broadly, and prohibit Members, officers and employees of the House from doing indirectly what they would be barred from doing directly. The *Ethics Manual* states that "a narrow technical reading of a House Rule should not overcome its 'spirit' and the intent of the House in adopting that and other rules of conduct."[129]

The ISC has incorporated both of these basic principles throughout its analysis of the more specific rules and guidelines to follow. We viewed all relevant facts from the perspective of whether they would bring discredit to the House. We also construed the laws, rules, and standards of conduct broadly, examining whether there were violations of either the spirit or the letter of the rule.

B. Conflicts of Interest

Based on the ISC's investigation, the ISC found that Representative Berkley violated the letter or spirit of House Rule XXIII, clause 3 and Section 5 of the Code of Ethics for Government Service, when she intervened on behalf of KSSN to assist it in obtaining payments for claims from the federal government. The ISC concluded that Representative Berkley should have avoided acting on matters that pertained to monetary collections by her husband's business and also should have refrained from allowing her staff to have a unique and significant level of interaction with him on such matters. However, the ISC did not find sufficient evidence that Representative Berkley's conduct with respect to the UMC kidney transplant program violated these same rules. Recent media reports have given the American people the false impression that the House of Representatives does not have ethical standards governing conflicts of interest for Members.[130] This is not true. There are conflicts of interest standards in the House of Representatives, and although they are slightly more complicated than comparable standards in other professions such as the executive branch[131] or state bars,[132] in the end, they articulate a common-sense standard that is widely understood in this community. Representative Berkley herself provided an example of her understanding of the standard in her testimony:

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[127] House Comm. on Standards of Official Conduct, *Report under the Authority of H. Res. 418*, H. Rep. 1176, 90th Cong. 2d Sess. 17 (1968).

[128] 114 Cong. Rec. 8778 (Apr. 3, 1968) (statement of Representative Price).

[129] *Ethics Manual* at 17 (citing House Select Comm. on Ethics, *Advisory Opinion No. 4*, H. Rep. 95-1837, 95th Cong. 2d Sess. app. 61 (1979)).

[130] *See, e.g., 60 Minutes: Insiders* (CBS television broadcast Nov. 13, 2011) ("Corporate executives, members of the executive branch and all federal judges are subject to strict conflict of interest rules. But not the people who write the laws.").

[131] *Cf.* 18 U.S.C. § 208; 5 C.F.R. §§ 2640.101-304.

[132] *Cf.* American Bar Association, *Model Rules of Prof'l Conduct* R. 1.7-1.11 (2012).

> [REPRESENTATIVE BERKLEY] I understood that -- and again, I'm being very vague because this is -- it has been a while. That if it had -- that you could not do anything that would have a direct -- look, if [Dr. Lehrner] had a dialysis unit at the end of the street, and I got an earmark to pave the road to the end of the street, I would say that is a pretty substantial violation, and would be held accountable for that, and wouldn't even consider doing that.[133]

A number of rules govern official action on matters of personal financial interest; while there are rules governing the specific legislative duties of Members on voting[134] and earmarks,[135] two general rules govern all official activity and are relevant to this case. We address them in turn guided by the Committee's interpretation of these rules provided in the *Ethics Manual* as they pertain to a Member's actions on behalf of a spouses's business interest:

> [House Rule XXIII, clause 3 and Section 5 of the Code of Ethics for Government Service are] triggered by a spouse's employment [when] a Member or staff person exerts influence or performs official acts in order to obtain compensation for, or as a result of compensation paid to, his or her spouse.[136]

1. *House Rule XXIII, clause 3*

House Rule XXIII, clause 3 states that "a Member, Delegate, Resident Commissioner, officer or employee of the House may not receive compensation and may not permit compensation to accrue to the beneficial interest of such individual from any source, the receipt of which would occur by virtue of influence improperly exerted from the position of such individual in Congress." A respondent violates the letter of clause 3 where she (1) receives or accrues compensation; and (2) that compensation resulted from the "improper" exercise of respondent's influence.

With respect to the first element, historically, the Committee has defined "compensation" to include the service of a Member's own "narrow, financial interests as distinct from those of their constituents."[137] In prior cases, the Committee has found that a narrow financial interest exists where a Member acts to remove restrictions on federal land that an entity in which the

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[133] ISC Interview of Representative Shelley Berkley at 82.

[134] House Rule III (Members "shall vote on each question put, unless having *a direct personal or pecuniary interest in the event of such question*") (emphasis added).

[135] House Rule XXIII, clause 17(a).

[136] *Ethics Manual* at 245.

[137] *Ethics Manual* at 314.

Member has an interest seeks to develop that same land,[138] and where a Member's staff acts to protect a bank from failure in which his Member has an ownership stake.[139]

With respect to the second element, the Committee has determined that it is improper to "provid[e] official assistance to entities in which the Member has a significant financial interest."[140] The Committee's guidance on this point has advised members to engage in "added circumspection" any time they are deciding whether to take official action "on a matter that may affect his or her personal financial interests."[141] Plainly, official action under this definition may be improper even where it is not independently wrongful (i.e., the standard does not require evidence that the respondent's exercise of influence would violate some other law or standard of conduct), or it is not taken with a corrupt intent; the impropriety of official action in this context would be based solely on whether the action would inure to their narrow personal financial benefit.

The nature of Members as proxies for their constituents in the federal government makes it impossible to require recusal on every issue in which a Member has a financial interest. The House community and the Committee, therefore, view conflicts of interest differently based on the nature of the personal financial interest relative to the scope of the action. If a Member seeks to act on a matter where he might benefit as a member of a large class, the Committee has taken the position that such action does not require recusal. The quintessential example is "Members who happen to be farmers may nonetheless represent their constituents in communicating views on farm policy to the Department of Agriculture."[142] By contrast, where a Member's actions would serve her own narrow financial interests the Member should refrain from acting.[143] As noted by the Bipartisan Task Force on Ethics, "[t]he problem is identifying those instances in which an official allows his personal economic interests to impair his independence of judgment in the conduct of his public duties."[144]

In previous matters, in an effort to shed light on the question raised by the Bipartisan Task Force, the Committee has provided specific guidance on a Member taking official action on matters that relate to the Member's financial interest. In *The Matter of Robert L.F. Sikes*, the Committee found that Representative Sikes should not have sponsored legislation to remove certain restrictions on government-owned land in Florida when he was part of a group seeking to develop that same land after the restrictions were lifted.[145]

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[138] House Comm. on Standards of Official Conduct, *In the Matter of a Complaint Against Representative Robert L.F. Sikes*, H. Rep. 94-1364, 94th Cong., 2d Sess. 15 (1976) (hereinafter *Sikes*).

[139] Comm. on Ethics, *In the Matter of Representative Maxine Waters*, H.Rep. 112-690, 112th Cong. 2d Sess. 11 (2012) (hereinafter *Waters*).

[140] *Waters* at 15.

[141] *Ethics Manual* at 237.

[142] *See Ethics Manual* at 314.

[143] *Id.*

[144] House Bipartisan Task Force on Ethics, *Report on H.R. 3360*, 101st Cong. 1st Sess. 22 (Comm. Print, Comm. On Rules 1989), *reprinted in* 135 Cong. Rec. H9253, H9259 (daily ed. Nov. 21, 1989).

[145] *Sikes* at 4.

The Committee, in *The Matter of Representative Maxine Waters*, reiterated the commonly understood guidance that Members "cannot take official actions that would assist a single entity in which the Member has a significant interest, particularly when that interest would clearly be affected by the assistance sought."[146] In that case, while the Committee believed that the Member had properly recused herself from issues related directly to a single bank in which she had a financial interest, and had provided clear instruction to her staff to refrain from working on those issues, her Chief of Staff nevertheless persisted in official activity on that bank's behalf. Based on his actions, the Committee issued the Chief of Staff a letter of reproval.

In *The Matter of Representative Sam Graves*, the Committee dismissed a referral from the OCE alleging that Representative Graves had violated the rules regarding conflicts of interest by inviting a friend to testify before the Committee on Small Business, on behalf of the Missouri Soybean Association. Representative Graves' friend had an investment in two renewable fuel cooperatives in which Representative Graves' wife had also invested. Representative Graves did not appear on behalf of either of those cooperatives, and the Small Business Committee had not convened with the intent to take any action with respect to either of those cooperatives. The Committee noted that Representative Graves' wife held a "minimal" interest in those cooperatives and that, because Representative Graves' friend had testified regarding renewable fuels generally, "Representative Graves' putative interest was not an interest unique to him but was instead an interest that he held as part of a large class of investors [in renewable fuel companies represented by the Missouri Soybean Association]."

In *Waters,* the Committee, in addressing misinterpretations of the *Graves* report discussed the clear guidance the Committee has issued on several occasions that "Members and their staff were prohibited from providing official assistance to entities in which the Member has a significant financial interest."[147] The *Waters* report went on to say, "*Graves* should not be read to permit Members free rein to act on behalf of a single entity in which they have a publicly disclosed financial interest, merely because there are numerous shareholders."[148]

When applying the above body of precedent and guidance to the facts of this case, the ISC found some instances of action by Representative Berkley and her office troublingly intertwined with her financial interest, and other instances that were more benign. The ISC found greater concern, in general, when Representative Berkley assisted KSSN in obtaining payment from federal health insurers such as the VA and Medicare. By contrast, when Representative Berkley assisted UMC in retaining certification for its kidney transplant program, the ISC found insufficient evidence that Representative Berkley acted in a manner that would benefit her own financial interest.

First, in March 2008, Dr. Lehrner contacted Representative Berkley's staff to inquire regarding approximately $110,000 in claims KSSN had made to VA that were in arrears for over a year. Representative Berkley apparently also addressed this matter with her staff directly. Representative Berkley's staff contacted the VA's Office of Legislative Affairs and the regional

[146] *Waters* at 11.

[147] *Waters* at 15.

[148] *Waters* at 14.

administrator of the VA in Las Vegas on numerous occasions to attempt to resolve the issue. Representative Berkley herself referenced the issue during a HCVA hearing, and while this certainly constituted a disclosure of her interest, it also had the practical effect of pressuring the VA to respond. Representative Berkley's staff continued periodic contact with the VA regarding KSSN's claims until they had been resolved – with the final result including payment of significant amounts outstanding.

Second, in August 2008, Dr. Lehrner contacted Representative Berkley's staff regarding issues his practice was experiencing during a transition between Medicare/Medicaid administrators in Nevada. Dr. Lehrner referenced a delay in payments, and Representative Berkley's staff promised to "make some calls around to see what's up."[149] The day after staff had made those telephone calls, Dr. Lehrner informed Representative Berkley's staff that the administrator's vice president had called and promised to fix the issues KSSN was having.

Third, in November 2008, Dr. Lehrner contacted Representative Berkley and her staff regarding renewed problems with the Medicare/Medicaid administrator in Nevada, and specifically referenced issues with processing up to $443,000 in claims.

Fourth, in December 2010, Dr. Lehrner contacted Representative Berkley and her staff regarding the approval of doctors in his practice for Medicare billing, which was costing his practice approximately $100,000 in unpaid services at the time. Staff received repeated inquiries over a series of days from Dr. Lehrner about this issue.

Taken together, these contacts demonstrate that Representative Berkley (1) obtained compensation (in the form of increased and more timely revenue to her husband's business); and (2) the compensation resulted at least in part from official action taken on behalf of her narrowly tailored financial interests. Accordingly, these contacts violated House Rule XXIII, clause 3, as summarized in this Section of the Report.

Representative Berkley argued the actions she took on behalf of KSSN were not prohibited because (1) she publicly disclosed her husband's interest in KSSN; (2) the issues she addressed for KSSN were issues it faced as a part of a large class of similarly situated medical providers, who would have received the same intercession from her office if requested; (3) her action on behalf of KSSN was simply to inquire as to the nature of the problem and urge a quick resolution, as opposed to arguing that KSSN should indeed be paid for the entire amount it was allegedly owed; and (4) KSSN contacted her office about payments already due and owing based on work it had already performed, as opposed to some new benefit it was seeking prospectively. The ISC did not find Representative Berkley's arguments persuasive.

First, in this case, Representative Berkley did disclose her husband's financial interest in KSSN. However, such disclosure would not automatically alleviate a conflict of interest. As noted below, Representative Berkley's actions accrued to her benefit based on the financial interest of a single entity, not a large class. This is distinguishable from *Graves*, for example, where the action contemplated affected an entire industry. Certainly, the ISC discovered

[149] Exhibit 9.

instances of Representative Berkley's office taking positions on healthcare issues generally, and even nephrology issues in particular, and found that those actions were perfectly appropriate as compared to the ones with a direct and singular nexus to her husband's practice. Thus, the ISC finds that Representative Berkley was simply prohibited from taking action on behalf of KSSN because of her husband's financial interest in KSSN.

Precedent on conflicts of interest do contemplate that disclosure, especially in instances where a Member's interests are in line with the Member's constituents, is the "preferred method of regulating possible conflicts of interest."[150] However, such disclosure must be full and complete and, even if complete, does not always alleviate a conflict or permit a Member to act. As noted in *Waters*, "it has never been suggested that disclosure is the only method for addressing conflicts, and that the House has no rules prohibiting acting in conflict."[151] Whether a Member's personal financial interest affects her constituents or not, the principles regarding recusal are the same, and they were not followed in this case.

Second, Representative Berkley (as well as members of her staff and Dr. Lehrner) argued that many of these intercessions were based on systemic problems at the agencies and were not specific to KSSN. Representative Berkley provided documentation showing that her office had dealt with payment delays for other doctors, and testified that these sorts of issues were a constant refrain when providers in the community would approach her from time to time. Some of the staff inquiries did focus on the potential that there might be a problem for other providers.[152] Nevertheless, Dr. Lehrner made quite clear in the above-mentioned entreaties to Representative Berkley's staff that he was having an issue receiving payment, whether or not there was a systemic issue. He referenced specific dollar amounts outstanding. Often, Dr. Lehrner relied on his accounting staff (not his attorney or the trade association at which he used to serve as President) to prepare facts for transmission to Representative Berkley's staff. Additionally, Representative Berkley's staff often monitored the situation until Dr. Lehrner received at least partial payment from the agencies, suggesting that their goal was more narrowly focused than a systemic fix.

Moreover, Representative Berkley is incorrect that assistance to KSSN in particular was permissible under the rules if it was assistance that the office would have and on occasion even did provide to other constituents on the same or similar issues. The "large class" exception to the conflict of interest rules permits Members to take actions that *affect* a large class of individuals or entities *all at once*, not to act on behalf of their narrow financial interest alone just because that interest is facing a systemic problem.[153] If this were not the case, the Member could see financial trouble for their entities on the horizon based on systemic issues that were sensitive to their intervention, and act on their own interest before addressing the systemic concern (or, perhaps, leaving it unaddressed once their interests were addressed). This is the very root of the concern the Committee has previously expressed about a Member's personal financial interest

[150] *Ethics Manual* at 251.

[151] *Waters* at 14.

[152] *See* Exhibit 2 ("how can we make sure that this clinic and other clinics are paid in a timely manner for services provided to veterans?"); Exhibit 3("I have heard from some dialysis clinics…").

[153] *Cf. Graves* at 14.

influencing the performance of their duties. And even if other constituents would be treated similarly, the Member's choice is between handling the matter on a macrocosmic level (such that all class members receive the same benefit as a result of the same action), or to address each constituent individually but recuse themselves from their own matter and direct that their spouse contact the offices of their Senators or, if appropriate, the offices of another Member.

For example, if Representative Berkley's standard were correct, then Members whose spouses owned companies that contracted with the Department of Defense could intercede with the Pentagon on behalf of those contracts, and use a general complaint regarding contract selection processes as cover for improper influence. In essence most, if not all such contacts could be labeled as "addressing systemic concerns" thus gutting the core principal of conflicts, that a Member may not use their official position to benefit their personal interest. On the other hand, all of Representative Berkley's and her staff's comments and communications regarding the systemic problems would be entirely appropriate on their own. It is only the portions that exert influence to address the processing, approval or payment of claims specifically to KSSN that are in violation of conflict rules.

Third, Representative Berkley argued that she was simply inquiring as to the status of the payments in arrears. It certainly appears from the evidence that Representative Berkley and her staff never made a demand that the VA or Medicare or any other regulator pay every cent of every bill that KSSN claimed was due and owing. The ISC did not find evidence of any such specific request for payment from Representative Berkley's office and certainly such a request would have been profoundly more troubling than the conduct at issue here. Nevertheless, the evidence also shows that the staff did inquire about specific dollar amounts and asked about why the payments had not been made. Representative Berkley herself testified that the office's interest went beyond simply determining the status of the matter to urging the VA to "get the process moving, move this along, make your decisions, but contact him and figure out what you're going to do."[154] This sort of activity goes beyond the sort of "status check" that has been found by the Committee in other matters to be an appropriate deployment of official influence.[155] Furthermore, the general advice on status checks is not made as an exception to the prohibition on using one's official position for one's own benefit.

Fourth, Representative Berkley, in her submission and testimony, argued that the payments to KSSN were not "compensation" since they represented payment for services already rendered. This is an inappropriately narrow reading of the term "compensation." The ISC sees no relevant basis upon which to distinguish the benefit an entity receives when the government pays it money to which it is entitled under the law, and the benefit an entity might receive based on some future government action. To take Representative Berkley's own example, KSSN can increase its revenue by collecting payment on late bills from the government, and it can increase its revenue by obtaining new patients based on the existence of new road construction, and there

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[154] ISC Interview of Representative Shelley Berkley; Representative Berkley also testified that it was her understanding that KSSN was unable to reach anyone at the VA who could answer their questions, *see* ISC Interview of Representative Berkley, but according to the initial email sent by KSSN's business manager and forwarded by Dr. Lehrner, KSSN officials had spoken with VA officials to get the relevant information in the first place. *See* Exhibit 1.

[155] *See Staff Report In the Matter of Representative William H. Boner*, 100th Cong., 1st Sess. 28 (1987).

is no rational manner in which to distinguish the two revenue increases. Moreover, even if this distinction did hold weight, it is irrelevant to evaluating the actions of Representative Berkley and her staff at the time they were taken. When KSSN approached Representative Berkley's staff about its claims issues with the VA, for example, it was making an as-yet unproven assertion that it was entitled to the money, but that assertion required a determination on the merits from the VA before the money could actually be paid. In the end, KSSN received payment of a significant portion of the $110,000 in VA unpaid claims in question after Representative Berkley's staff contacted the VA. In fact, the narrow financial benefit at stake in this case (cash payments) is far less speculative or contingent than the benefits in *Sikes*. Representative Berkley's spouse's business had money in the coffers it did not have prior to the intervention. It does not matter that she believed the money was due and owing. To be clear, relevant rules, Committee guidance and precedent provide that a Member must refrain from acting in a manner that would benefit the Member's narrow financial interest regardless as to the merit of that interest.

In contrast to the issues of KSSN's payment from federal agencies, the ISC did not find sufficient evidence to conclude that Representative Berkley's actions with respect to the UMC kidney transplant center violated any House Rule, law, regulation, or other standard of conduct. In late October, 2008, Representative Berkley received a telephone call from Kathy Silver, CEO of UMC, a county hospital in her district. This sort of call is unremarkable in Member offices, and would have been unremarkable in this case as well, were it not for a contract between UMC and KSSN to provide services, some of which were related to the program in question. The ISC credits Representative Berkley's testimony that she was not engaged in the day-to-day operations of KSSN, and had, at best, a limited understanding of the contract that KSSN had with UMC.

Once Ms. Silver made this telephone call to Representative Berkley, the Nevada delegation engaged on the issue for approximately eight days, writing a letter to CMS Acting Administrator Kerry Weems and making telephone calls (including one call between Mr. Weems and Representative Berkley). The ISC credits Representative Berkley's testimony that she acted purely out of a desire to save a program that, in her view, was essential for the health of her constituents.

More significantly, from a conflicts perspective, however, it is unclear precisely what the consequences of the kidney transplant center's continued operations were on KSSN's existing contract. On the one hand, Dr. Lehrner and the rest of KSSN obviously thought the congressional intervention was relevant to whether their contract was renewed, because it was included in their bid proposal in 2010. Moreover, while the contract was a fixed-fee contract, it did include services provided to the kidney transplant center, which would presumably have been priced out of the contract in 2010 had UMC ceased performing transplants. Ms. Silver testified that the contract actually increased in price based on the need for a fellowship trained transplant nephrologist.[156] On the other hand, the true nature of the financial benefit is somewhat speculative given the fact that the contract renewal took place two years after the congressional intervention and was placed for competitive bidding.

[156] ISC Interview of Kathy Silver.

While the ISC has concerns about the appearance created by the renewal of KSSN's contract with UMC, and the fact that KSSN's bid proposal mentioned the intercession of the congressional delegation as a reason why its contract should be renewed, the ISC was simply unable to establish that Representative Berkley, when she participated in a delegation-wide effort to save a program which had a connection to her husband she did not fully understand, violated the conflict of interest rules. None of the above factors was in itself dispositive to the ISC's conclusion, and the ISC limits its findings to the facts of this case.

2. *Section 5 of the Code of Ethics for Government Service*

The second general rule governing conflicts of interest in the House, Section 5 of the Code of Ethics for Government Service, states that Members shall "Never discriminate unfairly by the dispensing of special favors or privileges to anyone, whether for remuneration or not; and never accept for himself or his family, favors or benefits under circumstances which might be construed by reasonable persons as influencing the performance of his governmental duties."[157] While the ISC finds that Representative Berkley did not violate the first clause of Section 5, because she did not dispense "special favors" in this matter, the ISC finds that she did violate the second clause of section 5, because she did accept "benefits under circumstances which might be construed by reasonable persons as influencing the performance of [her] governmental duties."

Representative Berkley did not dispense "special favors" in this matter. It is clear that her husband enjoyed an unusually close relationship with her office, calling from time to time to inquire about a variety of issues. Dr. Lehrner acknowledged that his amount of contact with the office was unique:

> [COUNSEL] [D]o you think you had greater access to Representative Berkley's office because of your marriage?
>
> [DR. LEHRNER] No. She provides excellent constituent service to anybody who contacts her.
>
> [COUNSEL] I'm going to show you a bunch of exhibits that we don't really need to go through. They're marked 25, 26, 27 and 28. . . . .
>
> These are emails between I'll just represent to you, and you're free to review them as you wish, I'll represent to you that those are four emails between you and Mr. Urey about a variety of topics, anything from gambling to town halls to campaign advice. As you sit here today can you think of another constituent in Representative Berkley's district that has that sort of relationship with Mr. Urey?

[157] Code of Ethics for Government Service § 5 (1958).

Nevertheless, the ISC believes this sort of interaction is far from unusual on its own. Certainly, Members are on notice that they should not engage in favoritism when performing casework.[159] In this case the ISC finds, based on the totality of the evidence, that Representative Berkley and her staff saw their intercessions as a natural form of constituent service to an important and beneficial constituent within their district. It does not matter that she treated her husband as any other constituent. Relevant rules, Committee guidance and precedent require that Members refrain from acting in a manner which would benefit the Member's narrow financial interest, regardless as to whether the action is ordinary or extraordinary relative to the office's day-to-day activities.

Accordingly, just because Dr. Lehrner was treated similarly to other providers, it is not necessarily the case that Representative Berkley should have treated him similarly, given clause 2 of Section 5. A respondent violates clause 2 of Section 5 where (1) she accepts a benefit; and (2) reasonable people could construe the receipt of that benefit as influencing the performance of her duties.

Construing the term "benefit" in light of House Rule XXIII clause 2, the Committee has historically found "benefit" in the same cases involving "compensation." Representative Sikes, for example, was found to have benefited from his ownership in a company seeking to develop federal land.[160] Representative Waters had a financial benefit at stake when her Chief of Staff interceded on behalf of a bank in which she owned stock.[161] As noted above when discussing House Rule XXIII, clause 3, "compensation" is a broad term encompassing anything related to a narrow, personal financial interest. "Benefit" should be construed similarly.

With respect to the second element, the Committee has consistently prohibited acting on matters in which a Member has a financial interest precisely because the public would construe such action as self-dealing, whether the Member engaged in the action for that reason or not. This is a standard to which the American people hold fiduciaries in a variety of other professional capacities, including but not limited to the executive branch,[162] directors and officers of corporations,[163] attorneys,[164] and doctors.[165] It is not a difficult standard to recognize. For

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[158] ISC Interview of Dr. Lehrner.

[159] *Ethics Manual* at 300 ("a Member's obligations are to all constituents equally, and considerations such as political support, party affiliation, or one's status as a campaign contributor should not affect either the decision of a Member to provide assistance or the quality of help that is given to a constituent.").

[160] *Sikes* at 11.

[161] *Waters* at 14-15.

[162] 18 U.S.C. § 208 (making it a crime for an executive branch employee to participate in matters in which he has a financial interest).

[163] *Cede & Co. v. Technicolor, Inc.*, 634 A.2d 345, 361 (1993) ("Corporate officers and directors are not permitted to use their position of trust and confidence to further their private interests.... The Rule that requires an undivided and unselfish loyalty to the corporation demands that there be no conflict between duty and self-interest.").

[164] *See* Model Rules of Prof'l Conduct R. 1 (defining the lawyer-client relationship; contains restrictions on allocation of authority to lawyer, conflicts of interest, and safekeeping of client property).

example, in *Waters*, once the Member realized that her staff had contacted the Treasury Department in a manner that could be seen as benefitting a single bank in which she held stock, she immediately recused herself from further action on that bank's behalf, and ordered her staff to stop further work.[166] Representative Berkley intuitively recognized the public's standard in her own example, recoiling at the notion that a Member might intervene on behalf of a road project leading to her own business.

Unfortunately, there is no operative distinction between Representative Berkley's hypothetical and the actual facts in this case, when applied to the elements of clause 2 of Section 5. Representative Berkley did receive a benefit – her husband received funds for his business based on claims filed with and subject to the approval of government insurers. And while the ISC credits Representative Berkley's testimony that she was not motivated by a desire to see that benefit obtained, the ISC nevertheless finds that a reasonable person could construe that benefit as having influenced the performance of her duties. If Representative Berkley had simply and solely engaged in policymaking aimed at more efficient claims processing by the VA, even though it would have benefited her husband along with a number of other doctors, she would not have violated this rule. If she had assisted any other medical practice in her district with the issue, that also would have been proper. But she was barred from doing so for her husband, in part because reasonable people would construe the benefit she received as her motivation, whether it was or not.

C. Improper Supervision of Staff

A significant amount of the conduct described above involved actions of Representative Berkley's staff; necessarily this raises the question, often faced in these investigations, of the Member's responsibility to oversee and administer her staff. Members are responsible for the supervision of their staff. As stated in a recent report, "[l]ongstanding precedent of the Committee holds that each Member is responsible for assuring that the Member's employees do not violate this rule, and Members may be held responsible for any violations occurring in his or her office."[167] The investigative subcommittee in that case went on to say that "staff misconduct in a Member office can range on a spectrum between subordinates following orders despite their

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[165] Declaration of Geneva (1948) ("The health of my patient will be my first consideration…I will respect the secrets that are confided in me, even after the patient has died….").

[166] *Waters* at 11-12. Importantly, Representative Waters continued working on matters pertaining to minority and community banks generally, which is entirely appropriate, because again, the House has exempted actions on behalf of a large class from discipline in order to allow the Member to serve in her capacity as representative. *See Waters* at 7.

[167] Comm. on Ethics, *In the Matter of Allegations Relating to Representative Laura Richardson*, H. Rept. 112-642, 112th Cong. 2d Sess. 93 (2012) (hereinafter *Richardson*); *see also* Comm. on Standards of Official Conduct, *In the Matter of Representative E.G. "Bud" Shuster*, H. Rep. 106-979, 106th Cong. 2d Sess. 31 (2000) (Member held liable for violations of prohibition on campaign work by official staff arising from lack of uniform leave policy); *Statement Regarding Complaints against Representative Newt Gingrich*, 101st Cong. 2d Sess. 60, 165-66 (1990) (Member held responsible for violations arising out of presence of political consultant in his office); *In the Matter of Representative Austin J. Murphy*, H. Rept. 100-485, 100th Cong. 1st Sess. 4 (1987) ("a Member must be held responsible to the House for assuring that resources provided in support of his official duties are applied to the proper purposes").

wrongfulness, and 'rogue' agents acting outside the authority granted to them by the Member."[168] The ISC found no evidence of any such "rogue" staffers; rather, the conduct of staff in Representative Berkley's office often occurred at her direction or with her knowledge. Even in the cases where Representative Berkley did not deliver direct orders or was not part of a conversation in which Dr. Lehrner's interests were plainly at stake, much of the problematic conduct in her office can be traced to the lack of any discernible policy with respect to conflicts of interest, or a procedure for interactions with Dr. Lehrner.

Witnesses repeatedly said that Representative Berkley had never addressed the question of what sort of interaction staff might or should have with Dr. Lehrner. Most staff had not seen her financial disclosure statements. And, other than some correspondence years earlier regarding the sponsoring of legislation, Representative Berkley and her staff did not inquire with the Committee about any of these interactions. What followed was predictable – a staff eager to please their employing Member accommodated requests from her husband without ever stopping to question whether such action would create an impermissible conflict of interest.

In previous cases, the Committee has warned Members that the failure to establish policies that inculcate ethical behavior can result in discipline. In *the Matter of Representative E.G. "Bud" Shuster*, for example, the Member's staff had been performing campaign work during official hours.[169] While staff explained that they believed they were on leave during the times this work was performed, there was no uniform policy for taking such leave. Accordingly, the Committee held that Representative Shuster had violated the rules regarding improper use of official resources.

In much the same way, Representative Berkley acted at her peril when she failed to properly instruct her staff with respect to conflicts of interest. The ISC recognizes that the rules on conflicts of interest are not easily applied. The dual standard of constant disclosure and selective recusal, while necessary to enable the Member to perform her duties, is far more confusing than a single standard would be. However, when a Member chooses not to give her staff even the most basic direction or insight with respect to the constraints on activities related to her financial interests, she places her office at risk for violating those constraints. Members must use "added circumspection" to evaluate actions to avoid self-dealing – and, because personal office staff act at the behest of the Member, such circumspection might naturally include setting policies and providing oversight on this critical issue.

D. Potential Sanction

Very recently, the Committee issued a letter of reproval to a Chief of Staff for engaging in conduct that constituted a conflict of interest for his employing Member.[170] In that letter, the Committee noted that the Chief of Staff's "actions blurred an already difficult and close line of permissible conduct...." Here, similarly, Representative Berkley and her staff smudged the line between constituent service and self-dealing, through active attempts to assist her husband's

[168] *Richardson* at 97.

[169] *Shuster* at 31.

[170] *Waters* Appendix C (letter of reproval to Mikael Moore).

business, buttressed by a lack of appropriate policies to manage this risk. If the public believes that its elected servants are using their influence to enrich themselves (whether it be in conjunction with public goods or in spite of them), the esteem of the House will inevitably degrade.

E. Lobbying Disclosure Act

The ISC also investigated allegations that, in addition to contacting the office regarding his own practice, Dr. Lehrner had contacted the office based on concerns of third parties, from DaVita and the RPA to other physicians in the Las Vegas community. The ISC considered whether these contacts might violate House Rule XXV, clause 7, which bans "lobbying contacts" between a Member and her spouse if the spouse is a lobbyist under the Lobbying Disclosure Act of 1995. The ISC determined that the contacts did not violate the Rule.

The Lobbying Disclosure Act defines a lobbyist as "any individual who is employed or retained by a client for financial or other compensation for services that include more than one lobbying contact, other than an individual whose lobbying activities constitute less than 20 percent of the time engaged in services provided by such individual to that client over a 3-month period."[171] Dr. Lehrner simply does not meet this standard. He receives compensation from KSSN for his services as a full-time practicing nephrologist. He does not receive compensation for lobbying services from any individual. To the extent he contacted Representative Berkley's office on behalf of third parties, he did not fit the definition of a person doing so as a lobbyist under the relevant law. Accordingly, the ISC found no violation of House Rule XXV, clause 7, and finds that the conduct in question did not violate any other House Rule, law, regulation, or other standard of conduct.

VI. CONCLUSIONS AND RECOMMENDATIONS

The ISC wishes to close by noting again that it found Representative Berkley was under the mistaken impression that her actions on behalf of her husband's practice were appropriate and permitted as long as she treated him in the same manner by which she would treat any other constitutent and that the payments she sought from the federal government on his behalf were properly due. To be clear, the ISC found no evidence suggesting that Representative Berkley's husband should not have received the payments. This is not a case where parties conspired to engage in graft. Indeed, with respect to Representative Berkley's actions related to UMC's kidney transplant center, the ISC found quite credible Representative Berkley's statement that she was simply acting to save a program at her county hospital, without consideration for – or even detailed knowledge of – her financial interest in that program. Nevertheless, the ISC found that Representative Berkley should have been more mindful of the potential that interaction between her husband's business and her office would pose a conflict of interest. Representative Berkley should have directed her husband's practice to contact one of his Senators' offices, or directed his practice, which maintained offices in each of Nevada's congressional districts, to contact either of the other Nevada Representatives.

[171] 2 U.S.C. § 1602(10).

The favored ethical maxim in the Committee's history – and the root value for all ethical standards of conduct – is President Cleveland's motto, "a public office is a public trust."[172] In essence, most ethical obligations of Members and staff reduce to the fiduciary relationship they have with the American people. As in many other realms – law,[173] business,[174] and medicine[175] are three examples – the Member, acting as an agent for her constituents must act only as a vessel for the interests of their district. The rules, in this way, attempt to combat both corruption and the perception of corruption, by instilling in the public faith that their elected officials are conducting themselves based on the interests of the American people as opposed to their own.

Conflicts of interest may pose the greatest threat to that faith, because self-dealing is such a simple and well-understood breach of that public trust. The term "public servant" cannot survive if the servants serve themselves. Prohibitions on self-dealing are at the heart of every fiduciary relationship, and the Member-constituent relationship is no exception. While that prohibition in this context is complicated by the Member's role as representative, the ISC believes that the Committee should affirm again, as it did recently in *Waters*, that Members are prohibited from acting in a manner that affects their own narrow financial interest uniquely.

Representative Berkley violated this prohibition. She directed and permitted her staff to take action to ensure that her husband's medical practice received payment from government agencies. Whether other constituents were having the same problem is of no moment – Representative Berkley would have been free to assist those constituents, but should have recused herself from the specific case involving KSSN.

It appears from all of the evidence that the question of avoiding conflicts of interest rarely crossed Representative Berkley's mind, and the testimony of staff suggests that they did not consider the issue prior to acting. In many ways, this is precisely the most troubling point. Given the wide variety of issues undertaken in a congressional office, it is inevitable that staff will be faced with work that poses a conflict of interest without staff ever being aware of it, unless the Member takes proactive steps to ensure that such conflicts are avoided. This problem was heightened in this case by the lack of a policy for staff interaction with Dr. Lehrner. Employees will, if not instructed to the contrary, have a natural inclination to do everything they can to please their employer's spouse. This might include taking action to ensure that the spouse receives money, without it ever occurring to the employee that their employer would be barred

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[172] *See* Code of Ethics for Government Service ¶ 10, H. Con. Res. 175, 72 Stat., pt. 2, B12 (adopted July 11, 1958); *see also* Edmund Burke, *Reflections on the Revolution in France* (1790); Henry Clay, *Speech at Ashland, Kentucky*, (March 1829) ("Government is a trust, and the officers of the government are trustees; and both the trust and the trustees are created for the benefit of the people.").

[173] *See* Model Rules of Prof'l Conduct R. 1 (defining the lawyer-client relationship; contains restrictions on allocation of authority to lawyer, conflicts of interest, and safekeeping of client property).

[174] *Cede & Co. v. Technicolor, Inc.*, 634 A.2d 345, 361 (1993) ("Corporate officers and directors are not permitted to use their position of trust and confidence to further their private interests.... The Rule that requires an undivided and unselfish loyalty to the corporation demands that there be no conflict between duty and self-interest.").

[175] Declaration of Geneva (1948) ("The health of my patient will be my first consideration...I will respect the secrets that are confided in me, even after the patient has died....").

from taking that action directly. To avoid this issue, Members are protected from violations or even allegations when they clearly explain the limits on assistance to spouses, and more so when they set a clear policy on interacting with them.

Accordingly, the ISC recommends that the Committee issue this Report, and that this Report serve as a reproval of Representative Berkley for the violations described herein. The ISC was unable, however, to reach a consensus as to whether a formal letter of reproval should be issued to Representative Berkley. The ISC notes for the record that Representative Berkley was entirely cooperative with the investigation, and credits her testimony both in terms of candor, and in terms of her objective lack of scienter in violating the rules.

The ISC recommends to the Committee that it expound upon guidance it has issued to the House community about conflicts of interest. The ISC does not in any way intend to undercut a Member's responsibility to know the rules by which the Member is bound, and ensure that the Member's staff is acting in conformity to those rules. However, the ISC believes the House community will greatly benefit from the Committee providing additional guidance that will help it maneuver the sometimes murky waters of the rules pertaining to conflicts of interests.

The ISC believes that this case, and the recent *Waters* case brings to the forefront the need for much clearer guidance to be provided to the House community on conflicts of interest rules. The ISC believes the rules lack clarity, and this lack of clarity highlights the need for a complete and thorough review of the rules. The ISC recommends that the rules be committed to a task force to review the rules and that the task force issue clear, thorough, and comprehensive rules pertaining to conflicts of interest that the House community can readily understand and abide by.

Exhibit 1

From: Urey, Richard
Sent: Tuesday, April 1, 2008 5:28 PM
To: Flarman, Carrie <[redacted]@mail.house.gov>
Subject: RE: VA minutes 033108.doc

Roger....

From: Flarman, Carrie
Sent: Tuesday, April 01, 2008 4:58 PM
To: Urey, Richard; Coffron, Matthew
Subject: RE: VA minutes 033108.doc

I also contacted the VA at the Congresswoman's request on why this is the system, etc

Carrie Flarman
Legislative Assistant
Office of Congresswoman Shelley Berkley
(202) 225-[redacted] (phone)
(202) 225-[redacted] (fax)
[redacted]@mail.house.gov

From: Urey, Richard
Sent: Tuesday, April 01, 2008 4:57 PM
To: Flarman, Carrie; Coffron, Matthew
Subject: FW: VA minutes 033108.doc

Just fyi...I already resonded to dr l.

From: Lawrence Lehrner [mailto[redacted]@ksosn.com]
Sent: Tuesday, April 01, 2008 3:53 PM
To: Bette Schnur
Cc: Urey, Richard
Subject: RE: VA minutes 033108.doc

Thanks.

Could a more complex system be devised if they tried?

Larry

-----Original Message-----
From: Bette Schnur
Sent: Tuesday, April 01, 2008 6:58 AM
To: Lawrence Lehrner; Lori LeBlanc
Cc: [redacted]@mail.house.gov'
Subject: VA minutes 033108.doc

March 31, 2008

Minutes from meeting with Erasimo from VA

On Thursday 3/27/08 Erasimo picked up 558 claims for $115,622.00
He had processed all the claims by today.

EXHIBIT 1

He took 14 claims with him because they should be pd. It has been over 90 days since the pt was dcd from the hospital, the hospital bill still hasn't been rcvd, but our claims are authorized to pay, so he will submit them for payment.
There are 17 claims that are authorized to pay, but the hospital bill hasn't been received yet & it hasn't been 90 days since the pt was dc'd from the hospital. So we will hold those & call the VA to ask them to follow up on the hospital bill.
There are 9 claims that are ok'd to be paid & he will submit those for payment today.
There are 5 claims he states have already been pd, 4 are from 07 & 1 from Jan 08. After research, we have found that no payment has been received for these claims. I will have him research payment info in his end.
96 claims were put in for payment & a check should be received within 30 days. The allowable amount to be pd is $20,004.29

A majority of the claims were denied for no auth.
No auth was explained to me to mean that the services we provided were not payable by the VA because the VA hadn't sent the patient to the facility & since the services provided weren't considered to be an emergency basis the patient could have been seen at a VA facility.

He asked that I copy the claims that were denied for no auth and he will again pick up the original HCFAs. He stated that there is a possibility that they may pay the claims sometime in the future because they may be considered for payment after medical review.

He informed me that I can bill any other insurance the patient may have. We will have to review each case to see what other ins the patient may have.
He stated that the VA is a payer of last resort, meaning that if the patient has any other insurance the claim should be billed to that other payer.

The only incident where VA is definitely going to pay is if the VA sent the patient to the facility (as is the case with our office visits & dialysis patients) or if the patient is sent directly from the VA to another facility (hospital).

He stated that if a patient presents themselves as a veteran & does not indicate any other insurance than we can bill the VA, but we should simultaneously bill the patient because the bill is the patient's responsibility. He stated that the patient is always aware that the bill is their responsibility.

The patient should provide us with other insurance information. If the patient doesn't have any other insurance then the patient should make payments & payment arrangements otherwise the patient's account can go to collections. It is no guarantee that the VA will pay.

He suggested we bill the patient with the statement: We are billing you for these services because the VA hasn't come to a decision as to whether or not they will pay for these claims. We suggest you contact the VA to discuss your claim. You also need to contact us regarding making payment for these services.

He stated the squeaky wheel gets the grease, meaning if we bill the patient & the patient goes to tl stating why a claim should be paid, then they may process that patient's file & approve the claim Once again no guarantee.

If a claim is MilBill (Millenium Bill), then the VA will not pay for the claim.

Some of our claims are authorized to be paid, however they are waiting for the hospital bill.
The reason why our hospital claim has not been paid is because they have not received the hospit
Two reasons why a hospital bill may not have been received, is one, the bill simply hasn't been r yet, or two, the hospital billed a different insurance and never billed the VA.

If the hospital bill is not received within 90 days from the date of discharge then their hospital ser automatically be denied.
If our services were received within 90 days from the date of discharge, and the services were aut then he suggested we call the VA within 60 days to ask the VA if the hospital bill has been receiv will hopefully prompt the clerk to call the hospital and inquire as to where the hospital bill is. It is guarantee they will follow up on the hospital bill though.
Our claims have the possibility to be paid if they are authorized & no hospital bill has been receiv they have to "back the claims into the system".

Even if services are authorized, the claim still goes to the nursing staff for medical review (of whi one person). So the medical review for claims is extremely backed up.

Claims for Centennial Hospital are on hold because Valley Health Systems has not provided the V the necessary Medicare ID info. No idea when that will be rectified. As of now those claims are r processed.

When a face sheet only indicates VA insurance, we may call the VA with 72 hours of the patient' admission to give them a head's up that the patient is in the hospital. However, the VA won't con with us whether the services are authorized. They may contact the hospital.

He is to provide me with a list of clerks I can contact at the VA to notify when a patient is in the hospital.

He will fax or email me a list of individuals I can contact at the hospital and ask them if the VA h authorized the services or if the VA has denied the services or if the hospital is going to bill a diff insurance.

I inquired as to why we can never get any individual to take responsibility for a claim. He told me I was dealing with government employees. I was left to derive my own meaning. He told me the system is the way it is because that is the way Congress has written the law. If the system needs to be changed then Congress needs to rewrite the law.

Our procedure will now be:

Contact the individual at the hospital to see if they have a VA auth or other insurance

information.

If the hospital contact only has VA & no auth, we will contact the VA to notify them so hopefully case management will now follow up on the patient.

If any other insurance information is provided we will bill that insurance

If only VA insurance is provided we will bill the VA, but the patient will be responsible for payment.

We will bill the patient stating why we do not expect payment from the VA

If we know services are authorized and the patient has been discharged from a hospital for 60 days we will call the VA to inquire whether the hospital bill has been received or not.

None of the efforts on our part will in any way guarantee payment from the VA. The bill will always be the patient's responsibility & we will strongly encourage the patient to contact the VA.

Exhibit 2

From: Fiarman, Carrie
Sent: Tuesday, April 1, 2008 3:33 PM
To: Holley, James <[redacted]@va.gov>
Subject: VA question

Hey James,

I am not sure who I should contact over at VA now that Ray is gone, so I figured I would send this your way and maybe you can help me get some answers.

Since August 2007, 558 claims were submitted by the Kidney Specialists of Southern Nevada to the VA. As of 3/31/08, none of them have been paid. These 558 claims total over $116,000. Of those 558, about 60% have been initially denied for various reasons. Of the other approx. $40,000 worth in claims, $20,000 in claims were approved and to be paid immediately. According to the VA, another $20,000 in claims are waiting for approval from the hospital in order to be paid by the VA. The other approx. $60,000 may or may not be paid in the future. The doctors have to go back and see if the patients have a primary insurance.

The clinic is being told to bill the patient and the VA.

Why are the payments being held?
Is this the correct way to bill? Should we really be billing the patient and the VA? How can we resolve this? How can we make sure this doesn't happen again in the future? How can we make sure that this clinic and other clinics are paid in a timely manner for services provided to veterans?

Thanks for your help as always!

Carrie

Carrie Fiarman
Legislative Assistant
Office of Congresswoman Shelley Berkley
(202) 225[redacted] (phone)
(202) 225[redacted] (fax)
[redacted]@mail.house.gov

EXHIBIT 2

Exhibit 3

From: Bright, John B <[redacted]@va.gov>
Sent: Thursday, April 3, 2008 11:32 AM
To: Flarman, Carrie <[redacted]@mail.house.gov>
Subject: Re: clinics and reimbursement issues

Can I call you Friday? I'm travelling all day today

----- Original Message -----
From: Flarman, Carrie <[redacted]@mail.house.gov>
To: Bright, John B
Sent: Thu Apr 03 10:12:47 2008
Subject: clinics and reimbursement issues

Hey there,

How is your new position treating you?? Busy I am sure! I do have a question for you and I wasn t really sure who else to contact.

I have heard from some dialysis clinics that there are reimbursement issues with the VA. Clinics are not getting reimbursed for a number of reasons. They are also being told that they should bill both the VA and the patient because the VA is not always the primary insurance and other reasons. We ve also been told there is no way of knowing prior to billing the VA if the patient is eligible for coverage. Has this always been the practice of the VA or is this a new policy? Also, is this an isolated incident or is this happening to other clinics as well?

I know you are probably very busy with your new position, so if this is not something you are aware of could you redirect me to someone that can help me? J There is a strong likelihood that the boss will be meeting with Mansfield pretty soon on this issue so we are looking for some insight on this as soon as we can get it.

Thank you for your help and expertise as always!!!

-Carrie

Carrie Flarman
Legislative Assistant
Office of Congresswoman Shelley Berkley
(202) 225-[redacted] (phone)
(202) 225-[redacted] (fax)
[redacted]@mail.house.gov <mailto:[redacted]@mail.house.gov>

EXHIBIT 3

Exhibit 4

From: Flarman, Carrie
Sent: Tuesday, April 8, 2008 5:52 PM
To: Coffron, Matthew <[redacted]@mail.house.gov>; George, Bryan <[redacted]@mail.house.gov>; Urey, Richard <[redacted]@mail.house.gov>; Cherry, David <[redacted]@mail.house.gov>
Subject: FW: Kidney Specialist of So Nevada - VA Payments
Attach: Issue Brief Kidney Specialist of So Nevada update 4-7-08 (2).doc

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Just an fyi...this is a great summary of what the final outcome of the situation is after VA (national) looked into it

Carrie Flarman
Legislative Assistant
Office of Congresswoman Shelley Berkley
(202) 225-[redacted] (phone)
(202) 225[redacted] (fax)
[redacted]@mail.house.gov

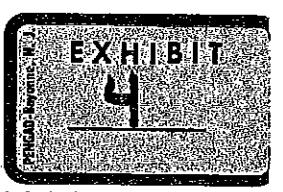
-----Original Message-----
From: Vasquez, Stacy [mailto[redacted]@va.gov]
Sent: Tuesday, April 08, 2008 1:58 PM
To: Flarman, Carrie
Cc: Ballenger, David; Holley, James
Subject: Kidney Specialist of So Nevada - VA Payments

Hello Carrie:

David is preparing for a budget hearing so I am follow up with you about your vendor payment question. I have attached a detailed explanation. Please let me know if you have any questions.

Best,

Stacy J. Vasquez
Congressional Relations Officer
Office of Congressional and Legislative Affairs
Department of Veterans Affairs
[redacted]
Washington, DC 20420
(202) 461-[redacted]
[redacted]@va.gov



VHA ISSUE BRIEF

Issue Title: Outstanding VA payments to Kidney Specialists of Southern Nevada for care provided to VA patients in Las Vegas.

Date of Report: 4/8/08

Brief Statement of Issue and Status:
The Director, VA Southern Nevada Healthcare System (VASNHS) was notified on Thursday, 3/27/08 that Kidney Specialists of Southern Nevada allegedly had more than 500 outstanding, unpaid, invoices for veteran care. Following the initial notification, Carrie Flarman, Legislative Assistant, Office of Congresswoman Shelley Berkley contacted VACO officials with a similar complaint.

Actions, Progress, and Resolution Date:
At the direction of the Medical Center Director, the Acting Fee Basis Supervisor immediately contacted the Kidney Specialist of Southern Nevada to investigate the status of all outstanding bills to the VASNHS. He contacted their Business Manager, Betty Shnur, and arranged to personally pick up copies of the outstanding claims before noon that day. All claims were reviewed on Friday, 3/28/08, and Saturday, 3/29/08. On Monday, 3/31/08 the Acting Fee Supervisor went to the Kidney Specialist of Southern Nevada and personally spoke with Ms. Shnur, discussing the information provided below and explaining the process for unauthorized claims.

Status of claims:

On 3/29/08, 196 claims were approved and processed for payment in the amount of $20,004.29. Payment processing normally takes between 30-45 days, however, VASNHS will request expedited payments.

Of the remaining invoices, they found the following:

14 invoices were duplicate claims which had been previously paid. Ms. Shnur will close these claims.

5 invoices were for services which were provided outside of the period authorized. Each authorization is for a specific period of time. Any services provided outside that period of time must be re-authorized. Ms. Shnur has been advised of this and will contact VASNHS officials requesting approval for a service extension. Once approval is received, claims may be resubmitted for payment.

1 invoice is for a patient who is not enrolled in the VA Healthcare System.

31 invoices are associated with approved, non-VA hospital claims for which VASNHS have not received the hospital bill. The hospitalizations were in February and March so they anticipate receipt of those bills within 30-60 days. Once we are in receipt of the hospitalization bill, we will review for appropriate payment.

258 invoices are associated with unauthorized claims. These claims are pending review by Utilization Review Clinicians. The value of these claims is $52,756. The review is expected to be complete within 15 business days (4/23/08) and appropriate payments made at that time.

76 invoices were for services which had been denied. The denial letters were reprinted and provided to Ms. Shnur.

In an effort to avoid such delay in the future, VASNHS has begun a systems improvement project to improve the fee payment process.

Contact for Further Information: Barbara Fallen, Network COO or Joseph Triplett, HHS at 562-826-[redacted]

Addendum 4/7/08
The origin of this situation involve the Kidney Specialists of Southern Nevada not understanding the nuances of the VA authorization process and the VASNHS failure to clearly communicate the complex laws and regulations governing the payment for community care. There has been turn over in staff at both organizations which most probably exacerbated the confusion and delay in resolution of particular claims. This highlights the need for VASNHS to regularly remind community providers of the need to ensure that the non-emergent care they provide has been authorized by the VA prior to treatment and to clearly identify what type of documentation must be included when submitting claims for payment.

Exhibit 5

From: Bright, John B <[redacted]@va.gov>
Sent: Thursday, April 10, 2008 12:01 PM
To: Flarman, Carrie <[redacted]@mail.house.gov>
Subject: Re: more follow-up

I'm told she asked a question at a hearing about payments to mental health providers. Was this question anecdotal to this issue or related to a specific issue. I'll get you some answers.

----- Original Message -----
From: Flarman, Carrie <[redacted]@mail.house.gov>
To: Bright, John B
Sent: Thu Apr 10 10:45:58 2008
Subject: more follow-up

It seems the Congresswoman still has some more questions

1) Have you heard specific complaints from any other clinics or facilities that non-payment is an issue?

2) How can we prevent wide-spread fraud of people claiming they have VA insurance if there is no identifier/ insurance card? It seems that the burden of proof relies on the clinics and they are left with no recourse when the patient turns out to be a non-veteran. What can the clinics do to be sure the patient is a veteran? She is looking at wanting to meet with Mansfield on this issue so I am trying to clear it up for her.

You almost got away without follow up on this one! Haha. Hope your trip is going well!

-Carrie

Carrie Flarman
Legislative Assistant
Office of Congresswoman Shelley Berkley
(202) 225-[redacted] (phone)
(202) 225-[redacted] (fax)
[redacted]@mail.house.gov <mailto:[redacted]@mail.house.gov>

Exhibit 6

From: George, Bryan
Sent: Tuesday, April 15, 2008 10:41 AM
To: Fiarman, Carrie <[redacted]@mail.house.gov>
Subject: RE: Dr larry reference

---

swell

-----Original Message-----
From: Fiarman, Carrie
Sent: Tuesday, April 15, 2008 10:33 AM
To: George, Bryan; Urey, Richard
Subject: Dr larry reference

She just mentioned the situation and her husband by name saying they haven't been paid over a year.

Sent using BlackBerry

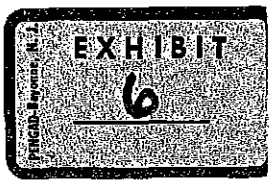


Exhibit 7

From: Fiarman, Carrie
Sent: Tuesday, April 15, 2008 4:27 PM
To: Urey, Richard <[redacted]@mail.house.gov>
Subject: FW: Kidney Specialist of So Nevada - VA Payments

Problem...

Everyone will now be quite aware of the fact that her husband is the one who needs to get paid.

Also she has now brought ridiculous amounts of attention to something that needs to be handled locally first. I personally feel that John Bright is doing everything he can to curb this before it gets out of hand.

Not sure what to do...

Carrie Fiarman
Legislative Assistant
Office of Congresswoman Shelley Berkley
(202) 225-[redacted]phone)
(202) 225-[redacted](fax)
[redacted]@mail.house.gov

-----Original Message-----
From: Bright, John B [mailto[redacted]@va.gov]
Sent: Tuesday, April 15, 2008 4:19 PM
To: Fiarman, Carrie
Subject: RE: Kidney Specialist of So Nevada - VA Payments

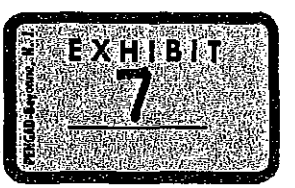
Ms. Berkley brought this up at the HVAC meeting this morning with Dr. Cross. There will be a flurry of activity now. I'll keep you posted.

-----Original Message-----
From: Fiarman, Carrie [mailto[redacted]@mail.house.gov]
Sent: Tuesday, April 15, 2008 10:46 AM
To: Bright, John B
Subject: FW: Kidney Specialist of So Nevada - VA Payments

This is what I got.

Carrie Fiarman
Legislative Assistant
Office of Congresswoman Shelley Berkley
(202) 225-[redacted]phone)
(202) 225-[redacted](fax)
[redacted]@mail.house.gov

-----Original Message-----
From: Vasquez, Stacy [mailto[redacted]@va.gov]
Sent: Tuesday, April 08, 2008 1:58 PM
To: Fiarman, Carrie
Cc: Ballenger, David; Holley, James



Subject: Kidney Specialist of So Nevada - VA Payments

Hello Carrie:

David is preparing for a budget hearing so I am follow up with you about your vendor payment question. I have attached a detailed explanation. Please let me know if you have any questions.

Best,

Stacy J. Vasquez
Congressional Relations Officer
Office of Congressional and Legislative Affairs
Department of Veterans Affairs
810 Vermont Ave NW, Suite 515L
Washington, DC 20420
(202) 461[redacted]
[redacted]@va.gov

Exhibit 8

From: Fiarman, Carrie
Sent: Tuesday, June 3, 2008 1:04 PM
To: Coffron, Matthew <[redacted]@mail.house.gov>
Subject: FW: Kidney Specialist of So. Nevada
Attach: Issue Brief Kidney Specialist of So Nevada (4).doc

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fyi

Carrie Fiarman
Legislative Assistant
Office of Congresswoman Shelley Berkley
(202) 225-[redacted] (phone)
(202) 225-[redacted] (fax)
[redacted]@mail.house.gov

From: Bright, John B [mailto:[redacted]@va.gov]
Sent: Tuesday, June 03, 2008 1:01 PM
To: Fiarman, Carrie
Subject: FW: Kidney Specialist of So. Nevada

Here is another update. Not a lot of progress but we are continuing to work with them. I'm leaving on vacation to Mexico Thursday night and will be gone until June 23. This is the first 2-week vacation of my career.

We continue to play with the OIG on the colonoscopy issue. Of course, they haven't found anything but continue to interview staff and are a nuisance. This is there second week and hopefully their last.

Hope all is well with you. Thanks

JOHN B. BRIGHT
Director
VA Southern Nevada Healthcare System
702-636-[redacted]

From: Feistman, Ann Marie
Sent: Tuesday, June 03, 2008 9:47 AM
To: Bright, John B
Cc: Domenicone, Janet M.
Subject: FW: Kidney Specialist of So. Nevada

Here is the status report as of 6/3/08 of the original issue brief regarding the Kidney Specialists of Southern Nevada.

Ann Marie Feistman, FACHE
Associate Director
VA Southern Nevada Healthcare System
Phone: 702-636-[redacted]
FAX: 702-636-[redacted]

EXHIBIT 8

VHA ISSUE BRIEF

Issue Title: Outstanding VA payments to Kidney Specialists of Southern Nevada for care provided to VA patients.

Date of Report: 5/28/08

Brief Statement of Issue and Status:
John Bright, Director of VA Southern Nevada Healthcare System was notified on Thursday, 3/27/08 that Kidney Specialists of Southern Nevada had more than 500 outstanding, unpaid, invoices for veteran care. The Kidney Specialists of Southern Nevada did not understand the nuances of the VA authorization process and the VASNHS failed to clearly communicate the complex laws and regulations governing the payment for community care. There has been turn over in staff at both organizations which most probably exacerbated the confusion and delay in resolution of particular claims. This highlights the need for VASNHS to regularly remind community providers of the need to ensure the non-emergent care they provide has been authorized by the VA prior to treatment and to clearly identify what type of documentation must be included when submitting claims for payment.

Actions, Progress, and Resolution Date:
Mr. Bright immediately notified Ann Marie Feistman, Associate Director at the VA Southern Nevada Healthcare System of the issue. Ms. Feistman instructed the Acting Fee Basis Supervisor to contact the Kidney Specialist of Southern Nevada to investigate the status of all outstanding bills to the VASNHS. He contacted their Business Manager, Betty Shnur, and arranged to personally pick up copies of the outstanding claims before noon that day. All claims were reviewed on Friday, 3/28/08, and Saturday, 3/29/08. On Monday, 3/31/08 the Acting Fee Supervisor went to the Kidney Specialist of Southern Nevada and personally spoke with Ms. Shnur, discussing the information provided below and explaining the process for unauthorized claims.

Status of claims on 4/4/08:

On 3/29/08 196 claims were approved and processed for payment in the amount of $20,004.29. Payment processing normally takes between 30-45 days, however, VASNHS will request expedited payments.

Of the remaining invoices, we found the following:

14 invoices were duplicate claims which had been previously paid. Ms. Shnur will close these claims.

5 invoices were for services which were provided outside of the period authorized. Each authorization is for a specific period of time. Any services provided outside that period of time must be re-authorized. Ms. Shnur has been advised of this and will contact Dr. Mary Douglas at VASNHS requesting approval for a service extension. Once approval is received, claims may be resubmitted for payment.

1 invoice is for a patient who is not enrolled in the VA Healthcare System.

31 invoices are associated with approved, non-VA hospital claims for which we have not received the hospital bill. The hospitalizations were in February and March so we anticipate

receipt of those bills within 30-60 days. Once we are in receipt of the hospitalization bill, we will review for appropriate payment.

258 invoices are associated with unauthorized claims. These claims are pending review by our Utilization Review Clinicians. The value of these claims is $52,756. Review is expected to be complete within 15 business days (4/23/08) and appropriate payments made at that time.

76 invoices were for services which had been denied. The denial letters were reprinted and provided to Ms. Shnur.

In an effort to avoid such delay in the future, VASNHS has begun a systems improvement project to improve the fee payment process.

Status as of 4/24/08

Kidney Specialist of Southern Nevada submitted 261 claims for review for potential payment from the VASNHS. The value of these claims was $50,662.81.

Of the 261 claims, 60 have been reviewed, found to be valid, and processed for payment in the amount of $12,210.81. Payments will be received during the month of May, 2008. VASNHS currently has 30 claims in the review process for a total of $4,530.

Upon evaluation, it was found that 32 claims in the amount of $5,758 for payment for unauthorized care were ineligible for VA payment under the "Mill Bill" criteria. The "Mill Bill" stipulates that the VA is a "payer of last resort", if a veteran has private health insurance or Medicare, the VA is barred from paying. The veterans provided care by the Kidney Specialist of Southern Nevada on these 32 claims had other insurance resulting in denial of payment by the VASNHS. The Kidney Specialist of Southern Nevada will be notified via denial letters.

Four claims in the amount of $884 were for incarcerated veterans. The VA is barred from providing or paying for care for incarcerated veterans as medical care is the responsibility of the prison system. The Kidney Specialist of Southern Nevada will be notified via denial letters.

Unauthorized inpatient medical care must be supported with copies of the hospitalization records. There are 135 bills which are tied to seven inpatients stays for a total of $27,280. The records have been requested and will be reviewed for appropriateness upon receipt. At that time, a determination will be made regarding payment.

Status as of 6/3/08

Unauthorized inpatient medical care must be supported with copies of the hospitalization records. There were 135 bills which were tied to seven inpatient stays for a total of $27,280.

We received records for one patient and payment for 16 claims in the amount of $1,300 will be received during the month of June 2008. Three (3) claims were denied as they are associated with a motor vehicle accident and the veteran is pursuing a tort claim. There are 116 claims for which we have not received a copy of the records. We had previously contacted the vendor to provide the needed information and will now contact the veterans.

Contact for Further Information:
Jan Domenicone, Administrative Officer to the Associate Director at 702-636[redacted]

Exhibit 9

Matt Griffin

From: Coffron, Matthew <[redacted]@mail.house.gov>
Sent: Wednesday, August 06, 2008 7:28 AM
To: Larry Lehrner
Subject: RE: Palmetto Medicare

Thanks,

I was wondering when I would hear something about the switch from Noridian. As for the delay in payments received from Medicare, I am sure that has more to do with the hold that was placed on payments when we couldn't get the SGR fix passed in a timely manner. I am surprised that they still haven't been received though, that seems excessive. I'll wait to hear from the Congresswoman and I'll try to make some calls around to see what's up.

-Matt

Matthew Coffron
Legislative Assistant
Office of Congresswoman Shelley Berkley
405 Cannon House Office Building
202-225[redacted]

From: Larry Lehrner [mailto[redacted]@nande.org]
Sent: Wednesday, August 06, 2008 9:46 AM
To: Coffron, Matthew
Subject: FW: Palmetto Medicare

Matt-

Shelley asked me to send this to you. She will discuss it with you today.

In advance thanks for your help.

Larry

From: Lori M. LeBlanc [mailto[redacted]@nevadakidney.com]
Sent: Tuesday, August 05, 2008 3:13 PM
To: [redacted]@mail.house.gov'
Cc: 'Lawrence Lehrner'
Subject: FW: Palmetto Medicare

Richard,

Dr. Lehrner asked me to clearly outline the issues Nevada providers are experiencing with the crossover from Noridian to Palmetto that occurred 8/4:

1. Palmetto is not indicating to physicians whether their EDI Submitter Status is accepted/approved: the status is "open".
2. Palmetto has given providers a date of this Thursday to find out a more definitive status. They also instructed us to hold claims from last Wednesday (July 30) until this Thursday (Aug 7).

EXHIBIT 9

3. The EDI Submitter "plug-in's" for the software were not mailed out timely. Several providers are waiting for their software update.
4. Palmetto's automated system does not state "# of pended claims OR # of approved claims". Noridian's system stated the total # so we could judge if they were receiving all our claims. Palmetto will only allow you to call about specific claims.
5. Several providers have not received payment from Medicare since July 2, 2008 dates of service. We typically receive payments within 14 days of submission. Noridian's website states that we should expect payment turnover to increase; however, we have not.

Thanks. Lori

Regards,
Lori M. LeBlanc, MBA, CPC
CEO
DoctorsXL
Kidney Specialists of Southern Nevada
Sierra Nevada Nephrology Consultants
775.287[redacted]cell
775.784[redacted]direct
775.322.[redacted]fax

From: Lawrence Lehrner [mailto:[redacted]@ksosn.com]
Sent: Tuesday, August 05, 2008 2:05 PM
To: Lori M. LeBlanc
Subject: RE: Palmetto Medicare

If you can write down all the issues and e-mail them to Richard Urey that would be helpful.

Send me a copy so I can forward to him in case your e-mail is blocked as not being from Shelley's district

Larry

> -----Original Message-----
> **From:** Lori M. LeBlanc [mailto:[redacted]@nevadakidney.com]
> **Sent:** Tuesday, August 05, 2008 12:59 PM
> **To:** Lawrence Lehrner
> **Subject:** RE: Palmetto Medicare
>
> Larry -- an additional "beef"
> Palmetto's automated system does not state "# of pended claims OR # of approved claims". Noridian's system stated the total # so we could judge if they were receiving all our claims. Palmetto will only allow you to call about specific claims. Lori

---

> **From:** Lawrence Lehrner [mailto:[redacted]@ksosn.com]
> **Sent:** Tuesday, August 05, 2008 1:58 PM
> **To:** Urey, Richard
> **Cc:** Lehrner, Mrs.; Lori M. LeBlanc
> **Subject:** Palmetto Medicare
>
> Richard-

The transition from Noridian to Palmetto as the Medicare claims processor for the state of Nevada is not going well. Palmetto will not provide information to allow transmission of claims. For details of the problem please call my administrator- Lori LeBlanc- 775 287[redacted] and than any fire you can light under Palmetto would be greatly appreciated.

Thanks

Larry

Exhibit 10

From:	Larry Lehrner <[redacted]@prodigy.net>
Sent:	Thursday, August 7, 2008 9:57 AM
To:	Coffron, Matthew [redacted]@mail.house.gov>
Subject:	thanks

Matt-

Thanks for your quick response to our problems with Palmetto. A senior VP called us and promised to fix all the issues by today.

Larry

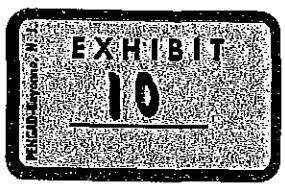


Exhibit 11

From: Urey, Richard <[redacted]@mail.house.gov>
Sent: Saturday, November 8, 2008 2:06 PM
To: [redacted]@ksosn.com'
Subject: Re: Medicare Issues

Thanx larry. Will review.

Sent from my BlackBerry Wireless Handheld

----- Original Message -----
From: Lawrence Lehrner <[redacted]@ksosn.com>
To: Lehrner, Mrs.; Urey, Richard
Sent: Fri Nov 07 14:11:12 2008
Subject: FW: Medicare Issues

Shelley and Richard-

A summary of the problems we are having with Palmetto (the Medicare MAC for NV). Any help is greatly appreciated. In case you cannot open a Microsoft Word file I have inserted a copy of the letter in the body of this e-mail.

Thanks

Your favorite constituent

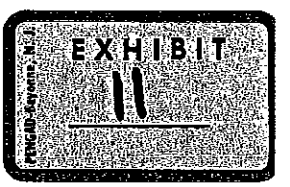
Larry

November 7, 2008

Palmetto Medicare Issues

Wait on hold 30-45 min to ask customer service 3 questions & 3 questions only. Customer service can rarely answer questions on claims. Even though they can't answer the question, it still counts as a question. They state they can't see the claim in it's entirety since the claim was submitted electronically. They are unable to determine what information is missing or what is wrong with claim when calling on the status or a denial. If asked for more information than they can provide they state they need to transfer you to a level 2 claims department.

When transferred to a level 2 claims department, we've never spoken to a person only heard the message "reached the voicemail box & it is full", then it hangs up the call, not even an option to return to customer service. So then you wait on hold 30-45 min to tell customer service you want to speak with a supervisor or someone who can answer your questions now & not to be transferred to level 2. Customer services states they have to write up a request to have a supervisor call back, the time frame is 24-48 hrs. Yet no return calls, no other recourse.



Problems with refunds. When we find that Medicare has overpaid a claim, we process & submit the refund in a very timely manner with their specific paperwork for sending in a refund. Medicare cashes the check, and then still offsets the money on a future eob. We call to discuss & recoup the funds, customer service can't assist, has to go to level 2 for assistance. We never actually get to reach anyone or leave a message for level 2.

When call on claim status or denial, one rep will state can't see info or determine what the problem is, if you call back, another may help you & tell you what is wrong or that the claim is being processed; so getting told different answers by two different reps, which is correct?. We also get a lot of "the claim is in process" response. When asked what it is "in process" for, payment or denial, they are not able to retrieve that information.

On claims that where Medicare is secondary and they tell us the primary information did not come through on the claim, they want us to get a EDI Fax Cover Form and fax the primary eob to them. Then on loop 23 they want us to enter the word FAX and rebill electronically. One rep told me that this was because of problems with fraud. Other reps have told me to write these up for redetermination. We have done the redetermination write ups and no result. It is not feasible to put FAX on loop 23, it is not indicated in the Medicare manual on how to complete a HCFA that fax is to be indicated, thus claims will be denied. Also, loop 23 would require reprogramming since it is not a universal value for claims submission. Also had a rep tell us to submit the claim on paper & maybe the claim will be processed. We stated we aren't allowed to submit on paper, we have to file all claims electronically, we have 14 providers.

I had a claim that I received a denial co 18 (which is duplicate) when I called to find out why they denied originally, she told me she did not have a claim for the date of service I called on . I told her I have an eob from Palmetto and gave her the ICN number. She still said she had no claim for that dos. How is that possible when we have a denial? They simply state there is no claim on file. No recourse.

Have a denial for a CO 50 (not medically necessary) that I called on and told the rep that another rep had told me this was an internal problem and they were supposed to be reprocessing those claims. This rep did not know what I was talking about and said she would research this and call me back. Her name was Tara. I have not heard back yet. Other reps have said to rebill. We have resent those claims, no other recourse.

Called Medicare spoke to Amber who said that we are using the wrong Modifier (the EC modifier) She said the rules are different with Palmetto than with Noridian. I told her I think she is wrong and she told me to look on the website under modifier. I looked it up and we are doing it right. I called Medicare back and spoke to Tom who did not know anything about the modifier being wrong and told me the claims I had called Amber on were just paid on 10/31/08.

31-60 day = $406,867.88
61-90 days = $14,147.40
91-120days = $9,230.11
121+days = $13,475.27

Total=$443,720.66

<<Medicare Issues 110608.doc>>

Exhibit 12

From:	Urey, Richard <[redacted]@mail.house.gov>
Sent:	Sunday, November 16, 2008 11:18 PM
To:	Coffron, Matthew <[redacted]@mail.house.gov>
Subject:	FW: Medicare Update
Attach:	Los Angeles Times_ Tardy Medicare reimbursements are hurting doctors in California, Nevada and Hawaii.pdf; ATT00001.htm

One I neglected to forward to u from Dr. L.

From: Lawrence Lehrner [mailto:[redacted]@ksosn.com]
Sent: Tuesday, November 11, 2008 1:32 PM
To: Urey, Richard
Cc: Lehrner, Mrs.
Subject: FW: Medicare Update

Not just my practice. Shelley can further cement her reputation as the doctor's friend by getting CMS to move on this issue.

Thanks

Larry
-----Original Message-----
From: Lori M. LeBlanc [mailto:[redacted]@nevadakidney.com]
Sent: Tuesday, November 11, 2008 9:50 AM
To: Lawrence Lehrner; Bette Schnur; Kay Howes
Subject: FW: Medicare Update

fyi

Regards,
Lori M. LeBlanc, MBA, CPC
CEO
DoctorsXL
Kidney Specialists of Southern Nevada
Sierra Nevada Nephrology Consultants
775.287[redacted]ell
775.784[redacted]irect
775.322[redacted]Fax

From: Michael N. Murphy, M.D. [mailto:[redacted]@sbcglobal.net]
Sent: Tuesday, November 11, 2008 9:50 AM
To: Lori M. LeBlanc
Subject: FW: Medicare Update

Are you already in the loop on this?

Michael N. Murphy, M.D., F.A.C.P., F.A.S.N.
Interventional Nephrologist
Sierra Nevada Nephrology
[redacted]
Carson City, NV 89703
775-883-[redacted]

EXHIBIT 12

--- On Tue, 11/11/08, Faiella, Shirley <[redacted]@ctrh.org> wrote:
From: Faiella, Shirley <[redacted]@ctrh.org>
Subject: FW: Medicare Update
To: [redacted]

[redacted]

[redacted]

Date: Tuesday, November 11, 2008, 7:10 AM

Shirley Faiella
Manager, Medical Staff and Physician Recruitment Services
Carson Tahoe Regional Medical Center
1600 Medical Parkway
P.O. Box 2168
Carson City, NV 89701
775-445-[redacted] - office
775-721-[redacted] - Cell

From: Lawrence Mathels [mailto[redacted]@nsmadocs.org]
Sent: Monday, November 10, 2008 11:13 AM
To: [redacted]

Subject: Medicare Update

To: NSMA Council
NSMA Commission on Governmental Affairs
NSMA Commission on Public Health
NSMA Commission on Internal Affairs
CCMS BoT
WCMS BoT

cc: Assemblywoman Heidi Gansert

Assemblyman Joe Hardy, M.D.
Beverly Neyland, M.D., President-Nevada Academy of Pediatrics
Mark Berry, MD, Nevada Academy of Pediatrics
Fred Redfern, MD, President, Nevada Orthopedic Association
Rudy Manthei, DO, Chair, KODIN

From: Larry Matheis

We've spent a lot of time during the past several weeks responding to the growing Medicare claims processing problems resulting mostly from the August 4th transition to Palmetto GBA from Noridian. The contract (part of the CMS commitment to contracting out as many functions as possible) actually combined administration of Medicare Parts A and B. New regions for these new contracts were created on a population basis and Nevada was made part of the new J-1 Region with California, Hawaii and the various Pacific Islands. In 2006, when the proposal was published, NSMA opposed the new region contending that California would consume whatever time and resources a new contractor might have. CMS made a number of concessions to NSMA, but would not move Nevada back into a intermountain region.

Not surprisingly, the biggest part of the problem results from the incredible underestimate of the impact on that transition of the California Medicare market. California has the largest number of Medicare beneficiaries in the country and over 10% of the entire Medicare population. I have been reporting since September (when the California transition occurred) the growing number of complaints from physicians that we've received. While these have been passed on to the J-1 Medical Director Arthur Lurvey, MD, progress has been quite slow because of the communications problems at Palmetto. The EDI and Enrollment phone lines are still slow and Palmetto acknowledges that their phone staff were undertrained and gave out incorrect information frequently.

The principal breakdowns have been in the Electronic Data Interchange (EDI) part of claims processing. As first reported a week ago Saturday by Palmetto's Vice President for Medicare Operations Mike Barlow to the NSMA Council, the biggest problem with EDI resulted from another CMS contract-the one to implement the HIPAA requirement that every physicians/health care provider have a unique National Provider Identifier (NPI). He said this was a national problem but that the carrier contractors were unaware that the NPI files, which had been using crossover software to link an NPI to previously used identifiers, were directed by CMS to drop using the crossovers in July. That meant that all of the practices which used the "early boarding" test system to make sure that the claims could be processed weren't rally testing for key parts of the data sets. It's good that the problem was finally understood, but it was 3 months after Nevada had entered the new region. Most of the large volume claims problems result from this corrupted NPI database, which requires the practice to go into the NPI files nationally at: (https://nppes.cms.hhs.gov/NPPES/Welcome.do).

As was demonstrated last week, when the Plametto team were available in the NSMA offices on Wednesday and Thursday, there are a lot of individual claims problems that Palmetto is having to fix code by code. As they do, they post the answers on the "Alerts" section of their provider web page (http://www.palmettogba.com/J1B). It seems that most of the problems identified last week have been fixed.

If your practice continues to have any problems, please let me know. If necessary, we will have the Palmetto staff back in Nevada to work through them one at a time. It was announced that a Nevada staff person has been hired and is being trained. The person should be available in State within a couple of weeks. Special consideration for Nevada cases is being given when identified on the phone inquiries. If you have any specific problems with a Palmetto staff person, let me know and I'll pass that along to Mr. Barlow at his request.

We are a long way from seeing the system work smoothly, but it is clear that they understand that Nevadans are having problems. The attached article from the Los Angeles Times discusses these problems.

Exhibit 13

From: Urey, Richard <[redacted]@mail.house.gov>
Sent: Monday, December 6, 2010 7:50 PM
To: [redacted]@ksosn.com'; Lehrner, Mrs. <[redacted]@mail.house.gov>; Fiarman, Carrie <[redacted]@mail.house.gov>
Cc: George, Bryan <[redacted]@mail.house.gov>; Story, Tod <[redacted]@mail.house.gov>; Churchill, Jan <[redacted]@mail.house.gov>
Subject: Re: Medicare Provider Hotline #'s

Good question. Sorry to hear about this. Staff will find out. Carrie.

Sent from my BlackBerry Wireless Handheld

From: Larry Lehrner <[redacted]@ksosn.com>
To: Urey, Richard; Lehrner, Mrs.
Sent: Mon Dec 06 19:36:49 2010
Subject: FW: Medicare Provider Hotline #'s

For the past 6 months or so Medicare (at least our provider- Palmetto) was taking less than 60 days to approve our new doctors. We are now told that it will be 90 days before they can approve our new doctors. Our latest new doctor does interventional procedures and we calculate that we are owed over 100,000 (Medicare Allowable) for his services. We cannot bill until we get his Medicare number and then it will take at least another 14 days to be paid. Did Congress mandate a time limit on how long the Medicare Carriers can take to approve doctors for their Medicare number?

Thanks

Larry

From: Sheila Poco [mailto:[redacted]@nevadakidney.com]
Sent: Monday, December 06, 2010 3:54 PM
To: Lawrence Lehrner ([redacted]@ksosn.com)
Cc: Lori M. LeBlanc
Subject: Medicare Provider Hotline #'s

From: Bree Mosley
Sent: Monday, December 06, 2010 2:02 PM
To: Sheila Poco
Subject: RE: RQ Medicare Update

There are 2 numbers:

Provider Contact Center: (866) 931-[redacted]

- For general information on enrollments and status of applications less than 30 days old
- Generally you can get through within 15-20 minutes

Complex Inquiries Only Telephone: (866) 895-[redacted]

- For complex issues regarding enrollment including status of applications greater than 30 days old.
- This line is VERY difficult to get through to. If you can get through, the hold time is generally 30-45 minutes

I usually call the Provider Contact Center for a brief update if I'm not satisfied with the online information. When I

EXHIBIT 13

finally got through to the Complex Inquiries line, it was to find out why there was such a delay, to make sure that web was as current as possible, and to make sure we hadn□t missed any requests for info from them.

Thank you,

Bree Mosley
Credentialing Specialist
DoctorsXL
[redacted]@doctorsxl.com
775.674.[redacted] Direct Phone
775.322.[redacted] Fax

From: Sheila Poco
Sent: Monday, December 06, 2010 1:40 PM
To: Bree Mosley
Subject: RE: RQ Medicare Update

What is the provider hotline # that you call?

Exhibit 14

From: Larry Lehrner <[redacted]@prodigy.net>
Sent: Thursday, December 9, 2010 1:00 PM
To: Fiarman, Carrie <[redacted]@mail.house.gov>
Subject: RE: Medicare Enrollment

Who is monitoring the carrier compliance with these very lax (in my opinion) standards?

Larry

From: Fiarman, Carrie [mailto[redacted]@mail.house.gov]
Sent: Thursday, December 09, 2010 9:34 AM
To: 'Larry Lehrner'
Subject: RE: Medicare Enrollment

Hey Dr. Lehrner,

I reached out to my contact and Congressional affairs and below is exactly what he told me. I am still waiting to see if CMS developed these standards or if it was Congress. Does this help at all?

"Below is a link to our Medicare Program Integrity Manual, specifically Chapter 15: Medicare Enrollment. If you look under Section 6 Timeliness and Accuracy Standards you will see how long the contractors have to process the CMS-855 applications. For example, Section 6.1.1.1 talks about CMS-855A applications, and it says the contractor shall process 80 percent of CMS-855A initial applications within 60 calendar days of receipt, process 90 percent of CMS-855A initial applications within 120 calendar days of receipt, and process 99 percent of CMS-855A initial applications within 180 calendar days of receipt.
http://www.cms.gov/manuals/downloads/pim83c15.pdf
The contractor is still well within their range for processing these enrollment applications, and keeping with our manual instructions, when they say it will take them 90 days to process."

Carrie Fiarman
Legislative Assistant
Office of Congresswoman Shelley Berkley
(202) 225[redacted](phone)
(202) 225[redacted]fax)
[redacted]@mail.house.gov
Please visit our website at http://berkley.house.gov/ and sign up for our email newsletter!

From: Larry Lehrner [mailto[redacted]@prodigy.net]
Sent: Thursday, December 09, 2010 12:25 PM
To: Fiarman, Carrie
Subject: Medicare Enrollment

Carrie-

Have you been able to get any information on the rules regarding Medicare Enrollment and how long the carrier can take to process an application?

Thanks

Larry

EXHIBIT 14

Exhibit 15

DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
WESTERN CONSORTIUM
DIVISION OF SURVEY AND CERTIFICATION

CMS-DSC-BQJ

May 28, 2008

Hospital Certification Number: 29-0007
Transplant Center Identification Number: Pending

Ms. Karen Watnem
University Medical Center of Southern Nevada
Transplantation Services
1800 W. Charleston Boulevard
Las Vegas, NV 89102

Dear Ms. Watnem:

On March 12, 2008, Healthcare Management Solutions (HMS) conducted an initial Medicare approval survey of the organ transplant program at the University Medical Center of Southern Nevada (UMC-Southern Nevada). The initial survey involved the Adult Kidney Transplant Program.

Based on the survey results, the Centers for Medicare and Medicaid Services (CMS) has determined that UMC-Southern Nevada does not meet the requirements for participation in the Medicare Organ Transplant Program for the Adult Kidney Transplant Program and is out of compliance with the Conditions of Participation listed below. Regulations at 42 CFR § 488.3 require that a provider must be in compliance with the applicable Conditions of Participation.

42 CFR § 482.80 Data Submission, Clinical Experience, and Outcome Requirement

42 CFR § 482.90 Patient and Living Donor Selection

42 CFR § 482.92 Organ Recovery and Receipt

42 CFR § 482.96 Quality Assessment and Performance Improvement

Enclosed is form CMS-2567, Statement of Deficiencies documenting both the Condition-level and Standard-level deficiencies found during the survey. All deficiencies cited on the CMS-2567 require a Plan of Correction (PoC). You are required to respond within 10 days of receipt of this notice. Please indicate your corrective actions on the right side of the form CMS-2567 in the column labeled "Provider Plan of Correction" corresponding to the deficiencies on the left. Additionally, indicate your anticipated completion dates in the column labeled "Completion Date."

An acceptable plan of correction must contain the following elements:

- The plan for correcting each specific deficiency cited;
- Efforts to address improving the processes that led to the deficiency cited;
- The procedure(s) for implementing the acceptable plan of correction for each deficiency cited;
- The completion date for correction of each deficiency cited;
- A description demonstrating how the hospital has incorporated systemic improvement actions into its Quality Assessment and Performance Improvement (QAPI) program in order to prevent the likelihood of the deficient practice from reoccurring;
- The procedures for monitoring and tracking to ensure that the plan of correction is effective and that specific deficiencies cited remain corrected and/or in compliance with the regulatory requirements; and
- The title of the person responsible for implementing the acceptable plan of correction.

Please submit your Plan of Correction by June 11, 2008 to:

Ed Q Japitana
Nurse Consultant
Division of Survey and Certification
Centers for Medicare and Medicaid Services
San Francisco Regional Office
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

You (or an authorized program representative) must also sign and date the bottom of the first page of the CMS-2567.

The correction dates on the Plan of Correction must be no later than 45 days for Standard-level deficiencies and for the Condition-level deficiencies cited under 42 CFR § 482.90 Patient and Living Donor Selection; 42 CFR § 482.92 Organ Recovery and Receipt; and 42 CFR § 482.96 Quality Assessment and Performance Improvement.

For the Condition-level deficiency cited under 42 CFR § 482.80 Data Submission, Clinical Experience, and Outcome Requirements, the correction date on the Plan of Correction must be no later than 180 days. Although the latest correction date may be 180 days, a plan of correction will not be considered acceptable unless it outlines the steps that the transplant program will take immediately to develop and implement a comprehensive plan of correction.

You should also be aware that copies of the Form CMS-2567 and subsequent plans of correction are releasable to the public upon request in accordance with the provisions at 42 CFR § 401.133.

Deficiencies which resulted in non-compliance with the Conditions of Participation must be corrected in order for payment for covered transplant services to continue. CMS will terminate your participation in Medicare as an approved transplant program for the Adult Kidney Transplant Program if you do not achieve compliance with the Conditions of Participation by **July 14, 2008** for Condition-level deficiencies cited under **42 CFR § 482.90; 42 CFR § 482.92; and 42 CFR § 482.96**; or by **October 13, 2008** for Condition-level deficiencies cited under **42 CFR § 482.80**. You will receive a notice from CMS advising you of the termination process and your appeal rights. CMS will review the next Scientific Registry of Transplant Recipients (SRTR) Center-Specific Report that will be released in July 2008 to assess whether or not compliance with the Medicare Condition of Participation at 42 CFR § 482.80 has been achieved.

The requirement that UMC-Southern Nevada Adult Kidney Transplant Program must submit a plan to correct its Medicare deficiencies before it is granted approval of the above listed transplant programs does not affect the current status of UMC-Southern Nevada as a participating provider of hospital services in the Medicare Program.

If you have any questions regarding the content of this letter, please contact Ed Q. Japitana at 415-744-[redacted] or by email at [redacted]@cms.hhs.gov.

Sincerely,

FOR

Deborah Romero
Operations Manager
CMS Western Consortium

Exhibit 16

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations/Survey and Certification Group

August 6, 2008

Ms. Karen Watnem
University Medical Center Transplantation
1800 W. Charleston Boulevard
Las Vegas, NV 89102

Dear Ms. Watnem:

This letter outlines the options we discussed during our conference call on August 5, 2008, regarding Medicare participation for the adult kidney transplant program at University Medical Center. As we discussed, based on the survey findings from March 2008, the adult kidney transplant program did not meet Medicare's outcome requirements based on the January 2008 report from the Scientific Registry of Transplant Recipients (SRTR). As a result, the program was given a prospective termination date of October 13, 2008, if the July 2008 SRTR report did not show that the program's outcomes were back in compliance. Based on the July 2008 SRTR report, the adult kidney transplant program continues to be out of compliance with the Medicare Conditions of Participation for patient survival, 1-year post-transplant.

As outlined in the conference call, University Medical Center has three options:

1) *Voluntary Withdrawal* – Within 7 calendar days of the conference call (August 12, 2008) the transplant program has the option of contacting the Centers for Medicare & Medicaid Services (CMS) and voluntarily withdrawing from the Medicare program. The transplant program may reapply for Medicare at any later time period.

2) *Request Approval Based on Mitigating Factors* – Within 10 calendar days of the conference call (August 15, 2008) the transplant program may notify CMS that it intends to apply for approval based on mitigating factors. Within 30 calendar days (September 4, 2008), the program should submit any additional information that it would like CMS to consider. You should have received a document outlining the items you must include in your application for CMS consideration of mitigating factors and clearly detail the specific factors which you feel represent mitigating factors.

3) *Involuntary Termination* – The transplant program also has the option of not taking any action which would allow the termination from Medicare to proceed as planned. If termination were to occur, the transplant program would still have appeal rights under 42 CFR §498.

EXHIBIT 16

For your reference, we have also attached a table of the program's recent 1-year patient and graft survival rates. If you have any questions about any of the information contained in this letter, please feel free to contact Sherry Clark [redacted]@cms.hhs.gov, (410) 786-[redacted].

Sincerely,

Thomas E. Hamilton
Director

cc: CMS Regional Office

Exhibit 17

September 11, 2008

Sherry Clark
Survey and Certification Group, CMSO
Centers for Medicare and Medicaid Services
7500 Security Blvd, Mailstop S2-12-25
Baltimore, MD 21244

Dear Ms. Clark:

This letter supplements our Request for Approval Based on Mitigating Factors dated August 11, 2008. To reiterate, our request is for the following:

Name:
University Medical Center of Southern Nevada ("UMC")

Program:
Kidney Transplant Service

Contact:
Karen Watnem, RN
Transplant Administrator
702-671-[redacted] office
[redacted] cell
[redacted]@umcsn.com

Conditions of Participation for which UMC is requesting CMS review for mitigating factors are:

42 CFR 482.80 – Data submission, clinical experience and outcome requirements for initial approval of transplant centers.
42 CFR 482.82 – Data submission, clinical experience and outcome requirements for re-approval of transplant centers.

EXHIBIT 17

INTRODUCTION

UMC is requesting approval based on mitigating factors for all of the reasons set forth in Appendix One of the Process for Requesting Consideration of Mitigating Factors in CMS' Determination of Medicare Approval of Organ Transplant Centers ("Process for Requesting Consideration").

First, UMC is barely out of compliance with the Final Rule's standard for one-year patient survival, and would actually be in compliance with the applicable standard but for the suicide death of one patient for reasons wholly unrelated to the patient's (successful) kidney transplant.

Second, decertification of UMC would cause a catastrophic loss of access to care for the patients on UMC's wait list and for the large and growing population of Southern Nevada. Indeed, Nevada's only other kidney transplant program closed just two months ago on July 1, 2008, and that program's wait-listed patients are still in the process of being merged into UMC's wait list. The closest existing kidney transplant centers (in Phoenix, Arizona; Salt Lake City, Utah; Southern California; and Northern California) are all at least four to six hours' drive from UMC.

Third, factors beyond the control of UMC have had a negative effect on the program's outcomes, including the untimely illness and death of Dr. Joseph Snyder, the program's primary nephrologist, and the current serious illness of the program's primary surgeon.

Fourth, UMC's kidney transplant program has successfully implemented major quality assessment and performance improvement measures in the past six months and additionally enjoys unprecedented support—both financial and otherwise—from UMC's new executive leadership team.

IMPORTANT NOTE

In addition to the factors summarized above, please note that on September 9, 2008, UMC informed the OPTN of its decision to initiate immediately a period of "functional inactivation" as described in the OPTN Bylaws, Appendix E, Section H, Part C, and as further described in the Final Rule at 42 CFR 488.61(e). UMC took this step, out of an abundance of caution, after learning on September 8, 2008, of a serious illness requiring the hospitalization (in an intensive care unit) of the kidney program's primary (and sole fulltime) surgeon.[1] As previously described in UMC's corrective action plan submitted to the OPTN (see Exhibit A-5) and described during CMS' validation survey on August 5, 2008, UMC has been actively recruiting additional surgical staff to the program. At this time, UMC is finalizing a contract pursuant to which the University of Utah will supply four experienced surgeons from its highly successful kidney transplant program to UMC's program on a rotating, fulltime basis until such time as UMC successfully recruits permanent additional surgical staff. In light of the current serious illness of UMC's primary surgeon, UMC decided to initiate its period of functional inactivation until such time as the contract with the University of Utah is executed and the Utah physicians are licensed to practice in Nevada by the appropriate Nevada authorities. UMC will not reactivate its program

[1] The UNOS peer review survey team noted in February 2008 that the primary surgeon is "well trained, skilled, and dedicated to the kidney transplant program" (see Exhibit A-4).

with the OPTN until the Utah team is in place and ready to perform transplants or until UMC has successfully recruited additional fulltime, experienced kidney transplant surgical staff.

A. PATIENT SURVIVAL OUTCOMES

CMS' letter to UMC dated August 6, 2008, correctly notes that UMC's program does not satisfy the Final Rule's one-year patient survival condition of participation. For the SRTR cohort of July 1, 2004 – December 31, 2006, the "expected" number of deaths was 1.81. For the SRTR cohort of January 1, 2005 – June 30, 2007, the "expected" number of deaths was 1.75. Thus, for each of those SRTR reporting periods, UMC would be in compliance with the outcomes requirement if the actual number of deaths had been four (i.e., 4.00<1.81 + 3.00; and 4.00 < 1.75 + 3.00). In each reporting period, a fifth death would place UMC just outside of the compliance standard (by .19 for the first SRTR cohort and by .25 for the second SRTR cohort).

In each reporting period, UMC's program had five actual deaths, thus barely missing the compliance standard. However, in each of the SRTR cohorts, one of the five deaths resulted from a patient's suicide for reasons wholly unrelated to the success of the patient's transplant. This patient was transplanted on March 25, 2005. The transplant was successful and on May 6, 2005, the patient's creatinine was 1.1 and her BUN was 12. The patient committed suicide on May 8, 2005. At the time of listing, the patient had a history of mental illness. She was deemed to satisfy selection criteria based upon regular psychiatric care, a successful compliance history, high cognitive functioning and a supportive husband of 14 years. In the program's judgment, this patient's death was not due to inadequate transplant care. But for this patient's continued inclusion in the SRTR cohorts, UMC would be in compliance with the Final Rule's outcomes standard. Ironically, this patient will "drop off" the next SRTR reporting cohort for the period July 1, 2005 through December 31, 2007. As can be seen in the three-year table below (requested by CMS to be set forth in this submission), UMC will report a total of four deaths in the next SRTR reporting period; consequently, UMC's program will be in compliance with the Final Rule's outcomes standard when the SRTR issues its next report in January, 2009.[2]

As can also be seen in the table below, UMC's trendline has been improving, particularly in the final year of the three-year table (i.e., calendar year 2007). In that year, with 39 total transplants, this were no one-month deaths, one one-month graft failure, one one-year death and one one-year graft failure.

[2] Two of the other four deaths that occurred during the SRTR's two most recent reporting periods were patients who were listed pursuant to looser selection criteria than now exists at the program. One patient, age 74, with hypertension and diabetes (but with no cardiac symptoms and a satisfactory pre-transplant cardiac evaluation) died of myocardial infarction shortly after transplant in February 2006. Another patient, age 62, with hypertension, diabetes and a history of coronary artery disease, died of cardiac arrest shortly after transplant in March 2006. Neither of these patients would have satisfied the program's revised selection criteria that was published in March 2008 (see the program's OPTN corrective action plan, Exhibit A-5). Of the remaining two deaths in the reported SRTR cohorts, one patient's death was reported by the coroner as caused by chronic renal failure even though the patient's last creatinine result (three weeks prior to death) was 0.9. This patient was repeatedly non-compliant post-operatively and self-reported post-operative drug abuse (pre-transplant evaluation revealed no psychiatric concerns and no evidence of substance abuse). The patient refused advice to report to the ER and was found dead at home. The program suspects that drug abuse was likely the proximate cause of death.

TABLE: UMC'S THREE-YEAR OUTCOMES AT SIX-MONTH INTERVALS

	Kidney Transplants	1 Month Deaths	1 Year Deaths	Total Grafts	1 Month Graft Failures	1 Year Graft Failures
1/1/05-6/30/05	22	0	2	22	1	0
7/1/05-12/31/05	13	0	0	13	0	1
1/1/06-6/30/06	20	2	0	20	2	1
7/1/06-12/31/06	19	0	1	19	0	2
1/1/07-6/30/07	13	0	0	13	0	0
7/1/07-12/31/07	26	0	1	26	1	1

B. ACCESS-TO-CARE ISSUES

1). Evidence of Access:

Closure of UMC's kidney transplant program would have a devastating effect on the patient population in the State of Nevada, southwest Utah, and northern Arizona. The July 1, 2008 closure of the kidney transplant program at Sunrise Hospital and Medical Center ("Sunrise")—the only other transplant hospital in the area—means that the UMC wait list, already large, is growing rapidly as former Sunrise patients are merged onto UMC's list. Prior to the closure of Sunrise, UMC had 137 total patients on its wait list, 73 of whom were status 1. Currently, UMC lists 159 total patients, 85 of whom are status 1. Of a total 162 patients who were referred to UMC from Sunrise, 20 have been listed so far, and 139 patients are still being evaluated. In other words, UMC's wait list could shortly more than double as a result of Sunrise's closure.

In addition to the rapidly growing wait list at UMC, closure of UMC's transplant program would severely impact the patient population because the nearest transplant hospitals are several hundred miles from Las Vegas. Patients would have a much more difficult time accessing transplants with that kind of distance barrier and almost surely many patients would de-list.

2) Population Considerations:

The patient population served by UMC includes a large transient contingent attracted by cultural and other factors unique to Las Vegas. This population has a demonstrably high incidence of diabetes, drug and alcohol abuse, and prostitution, all of which make the wait list population high risk compared with other wait list populations.

3) Organ-Type Considerations:

Las Vegas is a large city with a rapidly growing population, and as such is necessarily the source of a large number of cadaveric organs. If UMC closes, many of those organs will be lost because of the great distances to the nearest transplant centers.

C. FACTORS BEYOND THE CONTROL OF THE HOSPITAL

The UMC program nephrologist, Dr. Joseph Snyder, who at the time was being shared with the then-existing transplant center at Sunrise, was diagnosed with a life-threatening disease in 2006 and became increasingly unavailable to the program until his untimely death on December 17, 2007. Dr. Snyder's illness and subsequent unavailability caused strains on the program that might well have indirectly affected UMC's outcomes for parts of 2006 and 2007. Furthermore, while not related to the cohort period of 1/1/2005-6/30/2007, UMC's primary transplant surgeon is also now ill with a serious illness which prompted the program to inactivate as of September 9, 2008. The program will not be reactivated until new surgical personnel have been hired.

D. QUALITY IMPROVEMENT AND MANAGEMENT INTERVENTIONS

1) Analysis:

UMC has engaged in a comprehensive, thorough, and far-reaching root cause analysis, leading to the extensive Corrective Action Plan submitted to CMS (see Exhibit B). Furthermore, UMC submitted a final Corrective Action Plan to the OPTN within the last two weeks, and in a September 5, 2008 telephone call, OPTN staff confirmed that the plan is satisfactory (see Exhibit A-5).

2) QAPI:

UMC meets all three of the QAPI criteria set forth in the Process for Requesting Consideration: significant improvements in its QAPI Program, implementation of improvements, and insufficient time for improvements to manifest in SRTR data. UMC has instituted a major revision of its policies and procedures to conform to OPTN and CMS guidelines (see Exhibits A-5 and B). In March 2008, UMC established a Transplant QAPI Committee, which has been meeting monthly for the purpose of developing transplant-specific policies. Specific policy changes include the following: On March 19, 2008, UMC revised its policies in the management of recipient and living donors to encompass all of the program's multidisciplinary team. Multidisciplinary rounds were re-instituted on March 19, 2008, and a multidisciplinary documentation tool was adopted and is completed on every inpatient affiliated with the transplant program. The transplant social worker was dedicated to the transplant department on a fulltime basis on May 27, 2008. On March 19, 2008, UMC also implemented revised

procedures for consent for the potential recipient and living donor. All potential recipients and donors are required to sign informed consents for evaluation and surgery prior to proceeding with work-up. Consent forms have been revised to incorporate components that must be contained in the consent process as required by the Final Rule and the OPTN, and the forms are given to each patient in the initial patient packet.

In March 2008, a revision of clinic charts was begun to provide a more structured and streamlined process for correlating patient medical records. The new charting process is now complete. On March 19, 2008, UMC implemented revised procedures for ABO verification, and the new process was approved by the Medical Executive Committee on March 25, 2008. An in-service training was provided to all operating room nurses on utilization of the revised ABO forms on June 5, 2008. On March 31, 2008, a new clinic process was implemented, including a new evaluation process for living donors. At that time a living donor coordinator was also established.

In April 2008, several transplant policies were revised in collaboration with the transplant surgeon, nephrologists, transplant administrator, and coordinators, including the pre-transplant process, post-transplant process, and the living donor process from entrance into the program through post-donation. In April a policy was also implemented to ensure collaboration and communication between the transplant center and dialysis centers. With all of these policy changes, UMC has moved from a "surgeon-driven" program (as characterized by the UNOS peer review survey team in February 2008) to a comprehensive multidisciplinary approach.

A sufficient amount of time has not yet passed to allow for these improvements to be reflected in the SRTR data, but as stated in response to Patient Outcomes, section A above, when the next SRTR report is published for the period 7/1/2005-12/31/2007, two deaths will fall out of the cohort, and UMC will be in compliance with the Final Rule's outcomes standard. Further improvement is expected as the QAPI takes deeper root within the program.

3) Governing Body and Management:

UMC's new executive leadership team has demonstrated an unprecedented financial and philosophical commitment to supporting UMC's kidney transplant program. The three criteria of improvements in management, implementation of those improvements; and insufficient time for the improvements to manifest in the SRTR data, as set forth in the Process for Requesting Consideration, have all been met. UMC has achieved impressive changes in executive leadership and administration according to the corrective action plan recently submitted to the OPTN (see Exhibit A-5), including the following:

1) Appointment of Kathy Silver as the permanent Chief Executive Officer as of April 15, 2008.

2) Appointment of Karen Watnem as a fulltime, dedicated Transplant Administrator on March 14, 2008.

3) Appointment of Mario Paquette, LPN, as Data Coordinator for Transplant Service on May 27, 2008.

4) Appointment of two additional Clinical Transplant Coordinators; one of whom began work on July 14, 2008, the other of whom began work on August 4, 2008. One of these new coordinators is dedicated to the crucial task of wait list management.

A critical management change that UMC has instituted, as noted in the OPTN Corrective Action Plan, is that for the first time the dedicated Transplant Administrator, Karen Watnem, reports directly to the Chief Executive Officer, so the fragmented reporting noted by the UNOS peer review survey team in February 2008 is no longer in existence.

CONCLUSION

As acknowledged in its Corrective Action Plans to both CMS and the OPTN, UMC has previously suffered from systemic deficiencies that may have adversely affected its patient outcomes. Over the past six months, a concerted effort has been put forth to analyze and correct these deficiencies. A comprehensive corrective action plan has been successfully implemented. New executive leadership has demonstrated unprecedented support for the program. Critical policies, including patient selection criteria, have been revamped, updated and improved. A model QAPI program is in place. Lines of communication are clear and, for the first time, a fulltime, dedicated transplant administrator reports directly to the CEO.

The program has for some time been aggressively recruiting for additional permanent surgical staff. Out of an abundance of caution, when the program's sole fulltime surgeon fell seriously ill last week, the program decided that it was in the best interests of its patients to initiate a period of functional inactivation to ensure that all of the systemic improvements that have been implemented are matched by a first-class surgical team with appropriate levels of breadth and depth. As noted above, UMC will not re-activate its program until such a surgical staff is fully in place. The program knows of no better way of demonstrating its commitment to outstanding patient outcomes than by calling this "timeout" to allow for the retention of a robust surgical team.

We request that CMS seriously consider these mitigating factors when making its certification decision. We believe that UMC has already satisfied the Final Rule's outcomes standard once the non-transplant-related patient death is taken into account. Even so, UMC has already demonstrated its commitment to improve its outcomes by implementing the measures noted above. Finally, closing the program would mean great hardship for the patients on its wait list, given the recent closure of the program at Sunrise and the migration of Sunrise's patients to UMC's wait list, and the fact that UMC is the only kidney transplant program within several hundred miles of Las Vegas. We ask that CMS grant approval to UMC based on these mitigating circumstances.

If there are any questions concerning this request please feel free to contact Karen Watnem or me.

Sincerely,

Kathleen Silver
Chief Executive Officer
University Medical Center of Southern Nevada

Exhibit 18

Timeline: University Medical Center of Southern Nevada
Kidney Transplant Program
Survey, Correspondence and Enforcement Action

March 2008	
10-12	Initial Onsite Survey
May 2008	
28	CMS Regional Office sent letter to UMC with survey findings. Condition-level findings for: Outcomes, Patient and Living Donor Selection, ABO Verification, and Quality Assessment and Performance Improvement (Original termination dates July 14, 2008, and October 13, 2008- both later extended)
June 2008	
11	Plan of Correction for 2567 due from UMC
July 2008	
14	Original termination date for Condition-level deficiencies other than outcomes.
August 2008	
4	CMS RO sent letter to UMC extending termination date for deficiencies not related to patient survival outcomes
5	Conference call with UMC to outline that the program did not meet the July 2008 SRTR outcomes and describe program's options 1) voluntary withdrawal; 2) request approval based on mitigating factors; 3) allow termination to proceed.
5-7	Surveyors conduct onsite revisit at UMC to review correction of earlier cited deficiencies. Three deficiencies still outstanding including: 1) patient survival outcomes; and 2) ABO verification during organ recovery
6	Send follow-up letter to UMC confirming August 5, 2008 conference call findings.
11	UMC submits letter to CMS outlining intent to apply for approval based on mitigating factors
September 2008	

EXHIBIT 18

5	CMS RO sent letter to UMC with findings from re-visit and requesting plan of correction
11	UMC submits full request for approval based on mitigating factors
15	Discussion by CMS Mitigating Factors Panel
23	Discussion by CMS management and decision to deny approval based on mitigating factors, de-certification timetable proceeds.
29	Conference call with UMC to relay that the termination will continue (i.e., the request for approval based on mitigating factors was not successful)

October 2008

13	Original termination date for Condition-level deficiencies related to outcomes
16	Letter to UMC from CMS Regional Office, Medicare de-certification set at November 20, 2008 unless the program chooses to withdraw by October 24, 2008
21	Received call from attorney representing UMC. The facility does not have sufficient time to provide beneficiaries with 30 day notice and there was an error in the type of outcomes not met. CMS agreed to re-send the letter with later termination date to allow sufficient time for beneficiary notice and to correct the notice.
23	Re-send Letter to UMC from CMS Regional Office, extension of Medicare-de-certification date to December 3, 2008, unless the program chooses to voluntarily withdraw by November 6, 2008

Exhibit 19

DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
WESTERN CONSORTIUM
DIVISION OF SURVEY AND CERTIFICATION

October 23, 2008

Ms. Karen Watnem
University Medical Center—Southern Nevada
Transplant Program
1800 W. Charleston Boulevard
Las Vegas, NV 89102

Re: Adult Kidney Transplant program

Dear Ms. Watnem:

As we informed you in August 2008, the Centers for Medicare and Medicaid Services (CMS) has determined that the Adult Kidney-Only transplant center at the University Medical Center does not satisfy federal requirements for participation as a Medicare-approved transplant program. Specifically, we found that the transplant center does not meet the patient survival outcome requirements contained in 42 C.F.R. §482.80. As you also aware, CMS subsequently denied your request for approval based on mitigating factors under 42 C.F.R. § 488.61(a)(4). Accordingly, Medicare approval for the transplant center will be revoked effective December 3, 2008. No Medicare payment will be made for transplant services furnished by the center on or after that date. This action does not affect the Medicare hospital provider agreement for University Medical Center.

We will publish a public notice of the revocation in the Las Vegas Sun. You will be advised of the actual publication date for the notice, which will be no later than November 20, 2008.

In lieu of CMS revocation of your certification, the program may voluntarily withdraw from Medicare. If the program elects this option, you must notify Ed Q Japitana at 415-744-[redacted] or via electronic mail at [redacted]@cms.hhs.gov no later than November 6, 2008.

No later than November 3, 2008 you must inform Medicare beneficiaries on the waiting list that Medicare will not pay for transplants performed by the transplant center after December 2, 2008, 42 C.F.R. § 482.102(2)(ii). You must also assist waiting list patients who choose to transfer to another Medicare-approved transplantation center without loss of time accrued on the waiting list. 42 C.F.R. § 482.102(2)(ii).

The transplant center may seek re-entry into the Medicare program at any time by following the initial approval procedures described in 42 C.F.R. §.488.61(a)(4) More specific information on the application and approval process may be found at: http://www.cms.hhs.gov/CertificationandComplianc/20_TransplantLaw.

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge with the Civil Remedies Division of the Departmental Appeals Board for the Department of Health and Human Services, in accordance with

EXHIBIT 19

regulations contained in 42 C.F.R. Part 498. A written request for a hearing must be filed no later than 60 days from the date you receive this notice. Such a request (accompanied by a copy of this notice) should be directed to:

Departmental Appeals Board
Civil Remedies Division
Attention: Oliver Potts, Chief
Cohen Building, Room G-644
330 Independence Avenue, SW
Washington DC 20201

Please send a copy of the request to my attention at the following address:

Centers for Medicare & Medicaid Services (CMS)
Division of Survey and Certification, Non-LTC Branch
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

A request for hearing must contain the information specified in 42 CFR 498.40(b) and must identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. Completion of the administrative review process is a prerequisite to obtaining judicial review.

Please be advised that pursuing the administrative review process will neither delay the effective date of the revocation nor extend the date of eligibility for Medicare payment for services furnished by the transplant center. Revocation and cessation of payment will still take effect on December 3, 2008.[1]

If the program elects to voluntarily withdraw from Medicare, such withdrawal waives your right to appeal CMS' decision to terminate the provider agreement.

If you have any questions concerning this letter, please contact Ed Q Japitana at 415-744-[redacted] or by email at [redacted]@cms.hhs.gov.

Sincerely,

Deborah Romero

Deborah Romero
Operations Manager
CMS Western Consortium

[1] We emphasize this point in view of language in the preamble to the publication of the final rules for approval and re-approval of organ transplant centers which indicates erroneously -- and contrary to regulation and long-standing CMS policy -- that Medicare payment may continue pending the exhaustion of appeals under 42 C.F.R. Part 498, 72 Fed. Reg. 15198, 15247-15248 (March 30, 2007).

Exhibit 20

DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Consortium – Division of Survey & Certification

Refer to: WCDSC-

October 31, 2008

Ms. Kathy Silver
Chief Executive Office
University Medical Center – Southern Nevada (UMC)
1800 W. Charleston Boulevard
Las Vegas, NV 89102

Re: Adult Kidney Transplant Program

Dear Ms. Silver:

As communicated in the October 23, 2008 letter, the Centers for Medicare & Medicaid Services (CMS) determined that the Adult Kidney Only transplant center at the University Medical Center does not meet federal requirements for participation as a Medicare-approved transplant program.

After examining the unique circumstances of the UMC, the imminent efforts to effectuate improvements, and most importantly our shared desire to minimize disruption to the health care of potential organ recipients, we will extend the termination date until January 8, 2009. Accordingly, no Medicare payment will be made for transplant services furnished by the center on or after that date. This action does not affect the Medicare hospital provider agreement for UMC itself.

All other due process rights and contact information from the October 23 letter remain unchanged. Furthermore, you continue to have available to you the option to voluntarily withdraw prior to the termination effective date. The associated publication of public notice in the Las Vegas Sun, will therefore occur no later than December 8, 2008, unless a binding, mutual agreement is achieved between the parties (with performance milestones), and the agreement is executed prior to December 8, 2008. We reaffirm the basis for taking the termination action and reserve the right to pursue termination based on those original survey findings previously conveyed to you and the history of unacceptable outcomes (as indicated in the July 2008 risk-adjusted outcomes report from the Scientific Registry of Transplant Recipients Report).

Further, we are extending the scheduled termination date to January 8, 2009 based on the understanding that the interim milestones in the Attachment to this letter (enclosed) are met. This extension will permit the hospital additional time to explain recent actions taken by hospital to come into compliance with federal requirements for patient safety and quality of care, reduce mortality rates, and implement additional improvements that the hospital proposed to CMS on October 29, 2008.

In November 2008 CMS will review details of the hospital's improvement strategy. Should CMS determine that the improvement actions are not likely to enable fulfillment of the Medicare

Conditions of Participation, CMS will provide a written explanation of the determination prior to December 8, 2008 and the scheduled January 8th termination of Medicare participation will proceed.

If CMS and the hospital do execute a mutually-binding agreement prior to December 8, 2008, however, CMS may permit a further extension of the prospective termination date beyond January 8, 2009; CMS would then schedule an onsite survey in 2009 to verify that the improvements are effective in meeting all federal requirements. Should this later survey verify that the transplant program meets all CMS requirements for patient safety and quality of care, CMS may rescind the termination. However, if the re-survey finds that the hospital does not meet all federal Conditions of Participation, CMS would continue proceedings for the termination of the adult kidney transplant center's Medicare participation.

We look forward to further discussions and actions within the coming weeks to meet our common objective of high quality health care for transplant recipients in UMC's adult kidney transplant program. If you have any questions concerning this letter, please contact Ed Q Japitana at 415-744-[redacted] by email at [redacted]@cms.hhs.gov.

Sincerely,

Deborah Romero

Deborah Romero
Operations Manager
CMS Western Consortium

Enclosure

CC: Ms. Karen Watnem, Administrator, UMC Transplant Services
Mr. Glenn Krinsky, Attorney
Nevada State Department of Health
Commander Steve Chickering, Associate Regional Administrator, Survey & Certification
Thomas Hamilton, Director, Survey & Certification Group, CMS
Angela Brice-smith, Deputy Director, Survey & Certification Group, CMS
Karen Tritz, Technical Director, Transplant Program Survey & Certification, CMS
CMS Fiscal Intermediary/Medicare Administrative Contractor

CMS' one-month extension of the termination date will permit UMC to provide additional information to CMS to demonstrate present readiness to provide safe transplantation services of high quality. CMS will engage with UMC in the next 2-3 weeks to consider recent actions by the hospital to improve quality of care, reduce mortality rates, and implement additional improvements that the hospital proposed to CMS on October 29, 2008.

In November CMS will review details of the hospital's improvement strategy. Should CMS determine that the improvement actions are not likely to enable fulfillment of the Medicare Conditions of Participation, then the scheduled termination of Medicare participation will proceed. If CMS and the hospital agree, however, CMS may permit a further extension of the prospective termination date beyond January 8, 2009 and would then schedule an onsite survey in 2009 to verify that the improvements are effective in meeting all federal requirements. Should this later survey verify that the transplant program meets all CMS requirements for patient safety and quality of care, CMS may rescind the termination.

While the outcome of these additional deliberations is not pre-determined, we are encouraged by the hospital's indicated willingness to make necessary improvements.

Below are certain actions and informational resources that we will need to begin the additional review.

Actions and Information	To be met by
A. Surgical Capabilities ▪ We understand that UMC will execute contractual agreement(s) with qualified surgeons to maintain a fully operational surgical team that provides local surgical coverage 24 hours per day/ 7 days per week. If the agreements provide for rotational coverage, there must be significant protections and processes in the agreement to ensure that the rotational coverage does not result in fragmented care for patients during the post-transplant period. Please describe such arrangements and the status for the surgical team to be licensed by the State of Nevada and to be credentialed by UMC. ▪ Provide CMS a copy of the written agreement(s) with such surgeons. ▪ Describe the specific nature and breadth of coverage by the surgical team during the transplant period to ensure continuity of care.	Nov. 10, 2008
B. Maintenance of an Effective Internal Quality Assessment and Performance Improvement (QAPI) program. UMC will sent to CMS: ▪ A copy of the written Quality Assessment and Performance Improvement program operational protocols, including protocols for: 1. Regular review of all outcomes (patient and graft survival rates); 2. Timely review of all 30-day readmission and complication events; 3. Chart review to verify compliance with the blood type verification policies. ▪ A list of the members of the Quality Assessment and Performance Improvement team and their titles or description of primary responsibilities at the hospital; ▪ A list of all of the objective performance measures currently tracked by the QAPI	Nov. 10, 2008

program. ▪ Documentation that a full analysis was conducted of the adverse event that occurred in Spring 2008 in which a living donor's native kidney failed subsequent to the donation; a copy of the recommendations for policy or procedural changes to prevent a recurrence, and a description of the actions implemented to prevent a recurrence and to promote compliance with the hospital's own policies for donor selection and follow-up.	
C. Administrative and Surgical Leadership: ▪ Provide a written plan that fully describes the implemented and planned changes to transform the key administrative and surgical leadership of the program. The plan must identify previous leadership, and current and future leadership which would include both interim steps (during the period of the agreement with the University of Utah) as well as long-range plans. ▪ Describe specific commitments the hospital has made to support the development and proper administration and oversight of the program.	Nov. 10, 2008

Provide individual name(s) and any additional description of changes that UMC will be making or has made in the administrative or surgical leadership to transform the program and ensure that these efforts are sustained.

Position	Time Period			Description of other changes to these positions
	January - September 2008	*Interim, During Agreement with Univ. of Utah*	*Long-range plans, following Univ. of Utah agreement*	
Chief Executive Officer				
Chief Operating Officer				
Director of the Transplant Program				
Transplant Administrator				
Primary Transplant Surgeon				
Other Transplant Surgeons				
Primary Transplant Physician				
Other Transplant Physician				

Please respond to the following question by November 12, 2008

D. Questions Regarding the Agreement between the University Medical Center and surgeons from the University of Utah

1. What is the duration of the agreement between the surgeons from the University of Utah and the surgeons from the University Medical Center? What are the specific actions the hospital is taking to enlist and maintain a complete, local surgical team full-time beyond the interim rotational assignments?
2. Who are the four surgeons (and their qualifications) who will be serving in a rotating function? Are their primary responsibilities at the University of Utah to perform kidney transplants (i.e., they are part of the kidney transplant program at the University of Utah)?
3. Will these four surgeons also be recovering organs with the Organ Procurement Organization?

E. Pre-Transplant

1. Who are the primary transplant surgeon and primary transplant physician designated to the OPTN for UMC? Have they been approved by the OPTN?
2. Who are the members of the multidisciplinary team for living donors and candidates? What are their roles?
3. Will a transplant surgeon see all potential candidates being evaluated for transplantation?
4. Who are the nephrologists(s) evaluating the patient? Are those individuals specifically trained in transplantation?
5. What was the average days/weeks needed for a patient to complete an evaluation prior to going inactive? Does the program expect that this will change?
6. If surgeons are coming in on a rotating basis, how will they evaluate the patients? For example, if the patient comes one week and requires more testing, will the patient have to wait until that surgeon who initially saw him or her rotates in again to review his/her follow up? What will be the arrangements to ensure continuity of care for the patients? What arrangements are in place or are being made to prevent delays in listing of the patients?
7. Will the transplant surgeon who evaluates the patient be the individual who participates in determining whether the program's selection criteria are met?
8. What is the process the program will use to decide when the patient is listed (meeting, discussion, paper review by the team)?

F. Transplant

1. We understand that there will be 2 Utah surgeons available onsite at University Medical Center at all times. Is this accurate or is another arrangement contemplated?

G. Post-Transplant

1. How will patient follow-up be maintained if the surgeons are serving on a rotating basis? What will be the arrangements to ensure continuity of care for the patients' follow up care?
2. Who is the transplant nephrologists(s) who will be following up with the patient immediately post-transplant and post-discharge? What will be the arrangements to ensure continuity of care for the patients? Will the nephrologist call the surgeon in Utah if he/she has a question with regard to a patient whose surgeon is off rotation and not available at the Nevada transplant hospital?
3. Will the surgeon from Utah have any access to patient medical records when they are not in Nevada?

Exhibit 21

From: Kathy Silver
Sent: Wednesday, October 22, 2008 1:21 PM
To: rory reid [redacted]@lionelsawyer.com>
Subject: Kidney Transplant program

Sorry to bother you about this, but did you have a chance to mention to Senator Reid about our needing his help regarding the problems we are having with CMS and the Transplant program? I heard from Shelley Berkeley this morning and we have a call with her staff this afternoon. I have also asked a close friend, who is related by marriage to John Ensign to try to get some assist from him as well. At this point I feel that we must reach out to our Federal folks if we are to stay an action by CMS. Thanks for your help.

Kathleen Silver
Chief Executive Officer
University Medical Center of Southern Nevada
(702) 383[redacted]

EXHIBIT 21

Exhibit 22

From:	Luband, Charles A. [redacted]@ropesgray.com>
Sent:	Thursday, October 23, 2008 2:05 PM
To:	Coffron, Matthew [redacted]@mail.house.gov>
Cc:	Luband, Charles A. [redacted]@ropesgray.com>
Subject:	RE: UMC Conference Call

Thank you so much.

We're still working through the offices, but here's a quick status report:

I think Sen. Ensign's office is also inclined to help, but Michelle wanted to look through the materials and discuss with the Senator.

We spoke this morning with Sen. Reid's office (Kate Leone and Janice Miller in Las Vegas) and they very much want to help, although the staff needs to reach the Senator to coordinate.

I just spoke with Alanna Porter in Rep. Porter's office. They would very much like to do a delegation letter. I also encouraged her to call the two numbers I'm providing you below and she also offered to have the Congressman call Kerry Weems and Herb Kuhn.

I will reach out shortly to Leanne Walker in Dean Heller's office.

If you want to call someone at CMS the person to call at the Regional Office is Deborah Romero at 415-744[redacted] or Karen Tritz at 410-786[redacted] The message at this point is to not issue a new letter terminating UMC's approval. You should know that yesterday we received an email fourth hand where Ms. Romero indicated that they intend to resend the letter very shortly.

Charles A. Luband
ROPES & GRAY LLP
T 202-508-[redacted] M 202-607-[redacted] F 202-383-[redacted]
One Metro Center, 700 12th Street, NW, Suite 900
Washington, DC 20005-3948
[redacted]@ropesgray.com
www.ropesgray.com

-----Original Message-----
From: Coffron, Matthew [mailto[redacted]@mail.house.gov]
Sent: Thursday, October 23, 2008 1:29 PM
To: Luband, Charles A.
Subject: RE: UMC Conference Call

Hello Charlie,

I spoke with the Congresswoman this morning. She confirmed that she is

EXHIBIT 22

happy to send a letter (which I am currently drafting) and would be open to doing something as a delegation in the future. She also mentioned having spoken with Senator Reid on this issue.

I also tried to call Ed Japitana at CMS to get some clarification on their position, but learned that he is out this week.

Please keep me posted on the response you get from other offices if you can.

Thanks,

-Matt

Matthew Coffron
Legislative Assistant
Office of Congresswoman Shelley Berkley
405 Cannon House Office Building
202-225[redacted]

-----Original Message-----
From: Luband, Charles A. [mailto[redacted]@ropesgray.com]
Sent: Wednesday, October 22, 2008 10:07 PM
To: Coffron, Matthew
Cc: Luband, Charles A.
Subject: RE: UMC Conference Call

Matt --

I just wanted to send an email following on our call this afternoon. We very much appreciate the Congresswoman's help in this matter. Please feel free to contact me if you have any questions or need anything.

We spoke with Michelle Spence in Ensign's office after we spoke with you, and are hoping to speak with Kate Leone tomorrow.

Charles A. Luband
ROPES & GRAY LLP
T 202-508[redacted] M 202-607[redacted] F 202-383[redacted]
One Metro Center, 700 12th Street, NW, Suite 900
Washington, DC 20005-3948
[redacted]@ropesgray.com
www.ropesgray.com

written to be used, and cannot be used, for the purpose of avoiding U.S. tax-related penalties or promoting, marketing or recommending to another party any tax-related matters addressed herein.

This message (including attachments) is privileged and confidential. If you are not the intended recipient, please delete it without further distribution and reply to the sender that you have received the message in error.

From: George, Sandra Caron
Sent: Wednesday, October 22, 2008 3:46 PM
To: [redacted]@mail.house.gov
Cc: George, Bryan; Luband, Charles A.
Subject: UMC Conference Call

Hi Matt,

I understand that you will be speaking with University Medical Center and several of my colleagues at Ropes & Gray (including Charlie Luband, who I have copied above) regarding UMC's kidney transplant program. As you know, this is a very urgent matter - CMS has indicated that it plans to take steps as soon as November to terminate the program's Medicare eligibility status, which would result in closure of the program.

I have attached a background paper that explains the issue and sets forth UMC's request for the Congresswoman's and your assistance. Relevant correspondence between UMC and CMS is also attached.

We very much appreciate your taking the time to discuss the issue (particularly on a sunny recess day) and hope that we can count on the Congresswoman's assistance to prevent the elimination of Nevada's only kidney transplant center.

Thanks, again.

Best regards,
Sandra

Sandra Caron George
ROPES & GRAY LLP
T 202-508-[redacted] | F 202-383-[redacted]
One Metro Center, 700 12th Street, NW, Suite 900
Washington, DC 20005-3948
[redacted]@ropesgray.com
www.ropesgray.com
Not admitted in the District of Columbia. Supervised by Ropes & Gray LLP Partners who are members of the District of Columbia Bar.

Exhibit 23

From:	Porter, Alanna [redacted]@mail.house.gov>
Sent:	Thursday, October 23, 2008 1:54 PM
To:	Coffron, Matthew [redacted]@mail.house.gov>; Walker, Leeann [redacted]@mail.house.gov>
Subject:	FW: UMC Kidney Transplant Program
Attach:	CMS-UMC Correspondence.pdf; Wash_7337137_3_UMC TPs for Hill.DOC

Hey - you guys want to do a joint letter?

-----Original Message-----
From: Luband, Charles A. [mailto:[redacted]@ropesgray.com]
Sent: Wednesday, October 22, 2008 10:28 PM
To: Porter, Alanna
Cc: Luband, Charles A.
Subject: UMC Kidney Transplant Program

Alanna --

I am an attorney in Washington with Ropes & Gray. We represent UMC of Southern Nevada, which has a rather desperate issue regarding the Medicare status of UMC's kidney transplant program. This is a very urgent matter - CMS has indicated that it plans to take steps as soon as November to terminate the program's Medicare eligibility status, which would result in closure of the program and the loss of a transplant center that currently has over 250 people on its waitlist.

I have attached a background paper that explains the issue and sets forth UMC's request for Congressman Porter's and your assistance.

Relevant correspondence between UMC and CMS is also attached.

Charles A. Luband
ROPES & GRAY LLP
T 202-508-[redacted] | M 202-607-[redacted] | F 202-383-[redacted]
One Metro Center, 700 12th Street, NW, Suite 900
Washington, DC 20005-3948
[redacted]@ropesgray.com
www.ropesgray.com

Exhibit 24

From: Porter, Alanna <[redacted]@mail.house.gov>
Sent: Thursday, October 23, 2008 4:10 PM
To: Coffron, Matthew <[redacted]@mail.house.gov>
Subject: Re: Draft Letter to CMS

Awesome. Thanks.

From: Coffron, Matthew
To: Porter, Alanna
Sent: Thu Oct 23 16:09:10 2008
Subject: RE: Draft Letter to CMS

I just spoke with her on the phone. She is going to take a look at it now.

Matthew Coffron
Legislative Assistant
Office of Congresswoman Shelley Berkley
405 Cannon House Office Building
202-225[redacted]

From: Porter, Alanna
Sent: Thursday, October 23, 2008 4:08 PM
To: Coffron, Matthew
Subject: Re: Draft Letter to CMS

I think its great. Leeann has still not gotten back to me.

From: Coffron, Matthew
To: Porter, Alanna
Sent: Thu Oct 23 16:04:31 2008
Subject: Draft Letter to CMS

October 23, 2008

Dear Acting Administrator Weems,

We are writing to express our strong disagreement with a recent CMS decision to revoke Medicare approval of Nevada's only kidney transplant program at the University Medical Center (UMC) in Las Vegas. We are concerned that this decision could have strong negative consequences for our constituents.

It has been brought to our attention that the kidney transplant program at UMC will have its Medicare approval revoked effective November 20, 2008. We are troubled that this revocation is proceeding despite the fact that UMC has implemented measures to improve quality and taken substantial steps to address the shortcomings cited. This decision also ignores significant mitigating factors and circumstances out of the center's control.

Since originally notified of the deficiencies in the transplant program, UMC has submitted a Corrective Action Plan to CMS and taken significant steps to improve quality of care and improve both management

procedures and patient outcomes.

The one remaining unresolved deficiency cited in the August 4, 2008 letter sent to UMC by CMS is the one-year patient survival condition of participation. For two separate but overlapping Scientific Registry of Transplant Recipient (SRTR) cohort reporting periods, UMC did not meet the compliance standard because of a single patient death. However, UMC exceeded the one-year survival condition of both reporting periods due to the suicide of a single patient transplanted in March of 2005, which fell in the overlapping segment of the two reporting periods (July 1, 2004 to December 31, 2006 and January 1, 2005 to June 30, 2007).

This suicide of an otherwise successful transplant patient is lamentable, but beyond the control of UMC. Additionally, data for the latest cohort reporting period from July 1, 2005 to December 31, 2007 set to be released in January will show that UMC has come back into compliance with this final requirement.

Revoking Medicare approval for the UMC kidney transplant program is uncalled for and will jeopardize the health of hundreds of our constituents while placing a severe burden on transplant centers in surrounding states. We ask that you reconsider this decision, and would be happy to discuss this situation with you further if necessary. Thank you for your consideration and look forward to your response.

Sincerely,

SHELLEY BERKLEY	JON PORTER	DEAN HELLER
Member of Congress	Member of Congress	Member of Congress

Matthew Coffron
Legislative Assistant
Office of Congresswoman Shelley Berkley
405 Cannon House Office Building
202-225-[redacted]

Exhibit 25

Congress of the United States
Washington, DC 20515

October 24, 2008

Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, Maryland 21244-1849

Dear Acting Administrator Weems,

We are writing to express our strong disagreement with the apparent CMS decision to revoke Medicare approval of Nevada's only kidney transplant program at the University Medical Center (UMC) in Las Vegas. We are concerned that this decision does not protect Medicare beneficiaries, and could have strong negative consequences for our constituents.

It has been brought to our attention that the kidney transplant program at UMC will have its Medicare approval revoked effective December 3, 2008. We are troubled that this revocation is proceeding despite the fact that UMC has implemented measures to improve quality and taken substantial steps to address the shortcomings cited. This decision also ignores significant mitigating factors and circumstances out of the center's control.

Since originally notified of the deficiencies in the transplant program, UMC has submitted a Corrective Action Plan to CMS and taken significant steps to improve quality of care and improve both management procedures and patient outcomes.

The one remaining unresolved deficiency cited in the August 4, 2008 letter sent to UMC by CMS is the one-year patient survival condition of participation. For two separate but overlapping Scientific Registry of Transplant Recipient (SRTR) cohort reporting periods, UMC did not meet the compliance standard because of the inclusion of a death that resulted from a patient's suicide in May, 2005. This death from over three and a half years ago still falls in the overlapping segment of the two reporting periods (July 1, 2004 to December 31, 2006 and January 1, 2005 to June 30, 2007).

This suicide of an otherwise successful transplant patient is lamentable, but beyond the control of UMC. Additionally, data for the latest cohort reporting period from July 1, 2005 to December 31, 2007 set to be released in January will show that UMC has come back into compliance with this final requirement.

Revoking Medicare approval for the UMC kidney transplant program is uncalled for and will jeopardize the health of hundreds of our constituents while placing a severe burden on transplant centers in surrounding states. We ask that you reconsider this decision, and would be happy to discuss this situation with you further if necessary. Thank you for your consideration and look forward to your response.

Sincerely,

SHELLEY BERKLEY
Member of Congress

JON PORTER
Member of Congress

DEAN HELLER
Member of Congress

EXHIBIT 25

Exhibit 26

Lawmakers intervene in bid to retain transplant services

BY ANNETTE WELLS
REVIEW-JOURNAL

Posted: Oct. 30, 2008 | 10:00 p.m.

Nevada's only kidney transplant program might have a lifeline.

Rep. Jon Porter, R-Nev., said Wednesday he has had productive conversations twice in two days with Centers for Medicare and Medicaid Services, the agency that informed University Medical Center that certification for its transplant center is being revoked effective Dec. 3.

Porter said in one of his conversations with CMS, he received assurance that the investigation of UMC's transplant program would be re-examined.

"The acting director has committed to me that CMS will review the whole investigation to ensure it was handled appropriately," Porter said. "I have made it clear to CMS that this is a critical program for Nevadans."

Porter, along with Reps. Shelley Berkley, D-Nev., and Dean Heller, R-Nev., sent a letter to CMS urging the federal health agency to reconsider its decision to decertify the transplant program.

Porter met with Kerry Weems, CMS' acting administrator, on Tuesday in Las Vegas. He spoke with CMS officials again Wednesday while back in Washington.

David Cherry, a spokesman for Berkley, said the congresswoman is scheduled to meet with CMS officials sometime today. It was unclear whether Heller would be speaking with CMS.

Porter said "key areas" that concern CMS about the state's transplant program were discussed. Those concerns center around the federal agency's belief that UMC is not meeting minimum required patient survival outcomes.

According to health surveys in March and August, the transplant center's death rate for kidney transplant recipients was significantly higher than its expected

death rate, based on federal standards.

According to CMS officials, when the March survey was conducted, it was noted that five patients had died within a year of their kidney transplants. The same statistic was noted again in the hospital's August survey.

The expected death rate for that time period, taking a number of factors into account such as the patient volume and age of patients, would be 1.81, according to CMS.

Kathy Silver, the hospital's chief executive officer, says her understanding is that UMC's expected death rate should be 4.8.

Using that calculation, Silver said UMC would be well within the federal guidelines.

"It doesn't work that way," Silver said referring to the calculations CMS used to come up with the expected death rate.

Thomas Hamilton, director of CMS' Survey and Certification Group, says UMC is referring to a calculation method that is used for transplant centers that are new. This higher threshold, he said, helps new programs with a low volume of transplant patients get easier entry into the Medicare transplant program. Nevada's transplant center isn't one of the new programs, he said.

"You can't just pluck a number out of a data set that you don't like. ...That's manipulating the data. The real issue here is whether or not the transplant center has an effectively functional program that provides acceptable levels of quality of care," Hamilton said. "To that end, we've offered them an opportunity to voluntarily withdraw and request reinstatement as soon as they have an effectively functioning program. ... We look forward to that day."

Unless lawmakers can dissuade CMS from decertifying the transplant program, UMC plans to voluntarily withdraw its transplant program out of Medicare. Since Medicare pays for nearly 100 percent of the costs of transplants at the hospital, the program will be lost.

If the hospital chooses to re-open the program, it would have to undergo recertification, which could take years. Either way, the move leaves more than 200 people awaiting kidney transplants in Nevada in limbo. Their option would be to travel at least 300 miles to an out-of-state facility.

Silver, who said there will be a conference call today between UMC and CMS officials, praised the state's congressional delegation for its help.

"We're cautiously optimistic," she said about UMC's transplant program staying operational. "We have at least go them (CMS) to take a step back and take a look at maybe something was overlooked. That's all we're asking for."

Contact reporter Annette Wells at [redacted]@reviewjournal.com or 702-383-[redacted]

Find this article at:
http://www.lvrj.com/news/33564414.html

☐ Check the box to include the list of links referenced in the article.

Exhibit 27

Elhawary, Katherine M. (Perkins Coie)

From: Cherry, David
Sent: Thursday, October 30, 2008 7:10 PM
To: Coffron, Matthew
Subject: RE: Cell and personal e-mail

She spoke to CMS admin personally. She was OK'd to say they are close to deal.

From: Coffron, Matthew
Sent: Thursday, October 30, 2008 1:03 PM
To: Cherry, David
Subject: Cell and personal e-mail

For while I am out of the office.

Cell: 202 215 [redacted]

e-mail I check most often: [redacted]@yahoo.com

Matthew Coffron
Legislative Assistant
Office of Congresswoman Shelley Berkley
405 Cannon House Office Building
202-225 [redacted]

EXHIBIT 27

Exhibit 28

Response to

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA

REQUEST FOR PROPOSAL

2010-18

Nephrology Services

From

Kidney Specialists of Southern Nevada

Our Mission

To preserve kidney function

To minimize the complications of kidney dysfunction

To provide kidney replacement therapies- dialysis and kidney transplantation to patients with kidney failure

B. Healthcare Experience

1. Document your organization's credentials, experience, and involvement with nephrology services.

Kidney Specialists of Southern Nevada has provided contract Nephrology services to the following organizations:

UMC
Since August 2000 we have been providing contract Nephrology services to UMC. Both Dr. Bernstein and Dr. Khanna have demonstrated exemplary Nephrology care to the patients at UMC while guiding the hospital with process based on KDOQI (Kidney Disease Outcomes Quality Initiative) and best demonstrated practice to improve the overall quality of patient encounters and disease management. Dr. Bernstein has been instrumental in lowering cost associated with the admission of undocumented dialysis patients to UMC. In cooperation with UMC Administration and the Emergency Department through policy development and implementation, Dr. Bernstein fronted the effort to help solve this costly issue for the hospital. As a direct result of Dr. Bernstein's streamlined protocols, acute admissions of the unfunded dialysis population have been substantially decreased saving the hospital large sums of money each year while continuing to provide necessary life saving treatment to patients presenting to the emergency room. Kidney Specialists of Southern Nevada have gone above and beyond the usual call of duty with this unfortunate situation, even hiring a full time Nurse Practitioner to streamline assessment of these patients as well as facilitate timely discharge avoiding acute admissions whenever possible.

UMC Transplant Program
For 10 years Kidney Specialists of Southern Nevada have provided a Transplant Nephrologist, currently Ayoola Adekile, MD, for the UMC Transplant program. Dr. Adekile works closely with the surgeons and the entire transplant team to provide optimal care and outcomes for patients receiving a transplant or donating a kidney at UMC. He serves on the transplant selection committee that is involved with evaluating patients for renal transplantation. He has actively assisted with the interviewing process in the search for a new transplant surgeon at UMC. Now, with the addition of Dr. Syed Shah to Kidney Specialists of Southern Nevada, we believe that we are the only nephrology group in Las Vegas with 2 UNOS certified transplant nephrologists, giving us the ability to provide the required coverage for the UMC Transplant Program within one group of physicians.

When UNOS threatened to decertify the UMC transplant program, Dr. Lehrner contacted the Nevada Congressional delegation, including Senator Harry Reid. The Nevada Congressional delegation was instrumental in the CMS decision to allow the program to continue. In addition, Dr. Bernstein went to great lengths to keep the transplant program running, including obtaining his UNOS Certification, working for UMC as the Interim Transplant Nephrologist, and attending numerous meetings as an advocate for the program. Kidney Specialist of Southern Nevada have demonstrated continuous strong support for and commitment to the Transplant Program and will continue to do so in the years to come.

Kindred Hospitals
Since July 2004 we have provided Nephrology and anemia management services to the Kindred Hospitals in Las Vegas.