HARRY L. BETHEL
1314 Flagler Avenue
Key West, FL 33040
305-294-8170 (H)
305-304-2700 (C)
kwconchbubba@bellsouth.net

HARRY L. BETHEL
6744 Woodlake Circle
Young Harris, GA 30582
706-379-1513 (H)
kwconchbubba@bellsouth.net

July 22, 2016

Mayor and City Commissioners,

I apologize for not being able to attend the City Commission work shop on August 11th. As some of you know, I am currently at our home in Young Harris, Ga. recovering from back surgery.

The reason that I was moved to be a founding member of the CTROH is the fact that I have always valued my community. Recently, I have become passionately troubled by stories of disregard in the manner with which our fellow constituents have been treated at our community hospital. I believe that the situation has declined to a level which demands our involvement and requires our action.

Since I am not able to personally attend this meeting, I would like to share with you that I have received well over 200 emails, telephone calls, face book messages and other forms of outreach in which our fellow island residents have expressed grave trepidation over how they were treated, disrespected and (in many situations) majorly over-billed for medical service. Think about the courage it has taken these individuals to come forward to share their painful stories in order to try to help save our hospital.

I preface the following by saying that this is our community hospital and that it is imperative we get involved to preserve our medical center.

With that, I would like to outline my positions.

- **The Lease** - Where within this document is the assurance that the tenant (HMA or CHS or whoever) act as a medical steward for our community. That is their primary function yet there does not seem to be any indication that the tenant makes a commitment to communicate with or respect our fellow residents and most importantly our physicians.
- **Medical Privileges** - A wise resident recently told me to consider our hospital as an entity similar to our County Courthouse. An entity in which a professional (lawyer, nurse, technician or physician) who possesses current and credible licenses will be respected and allowed to practice at that entity.
- **Primary Care Physicians** - An individual's primary care physician should ALWAYS be contacted when a person needs medical treatment at our hospital.
- **Emergency Room Care** - Residents expect to be treated in a expedient manner when they go to our hospital. They expect to be treated with respect and to be made as comfortable as possible while they are being diagnosed.
- **Patient Respect** - Patients and their family members expect to be treated with dignity and open communication when they or their family members are treated at our hospital.

- **Employment** - The medical professionals, of all levels, expect to be treated as valued employees; recognized for the talent and dedication with which they care for our community. This means equitable salaries, a guarantee of working hours, respectful working conditions, etc. To cut a nurse, technician or a housekeeper to less than 30 hours a week allows our hospital to not give that employee any benefits and does not allow that employee to provide for their families.
- **Conditions** - The residents want assurance that our hospital will be maintained in a clean, comfortable and well equipped facility.
- **Billing Accountability** - Our residents want and deserve accountability in the hospital bills which they receive. Residents feel they have been over-billed, threatened, intimidated and forced to enter into unmanageable repayment agreements for charges resulting from care at our hospital. Sadly, some of our constituents who have the best insurance plans are telling the most frightening stories and have encountered insurmountable obstacles to get itemized invoices.

I do not want to give the impression that I think having an independent, private hospital is the objective. I well understand that Key West is far removed from the mainland and that there are probably many medical services which cannot be financially maintained in our community. But I am extremely worried by the number of travelling doctors, travelling nurses and travelling medical technicians which this hospital touts as "employees". These travelling services may include extremely qualified professionals but such services devalue our community and the tremendous talents within our community,

HMA or CHS has to improve on their image and the principles they portray in our community. They seem to have evolved into an organization which has fostered distrust by our residents and by our physicians. This image has to change to assure that our hospital can best serve our community.

I hope you notice how many times I have used the term "our" in referring to the hospital, the medical staff and the community. This is "our" hospital and we must do everything within our power to assure it is operated to best serve our community.

Please call me at my Georgia residence or on my cellphone as needed to talk more about our mission.

Sincerely,

Harry Bucher

Cc: "CTROH" Committee To Rescue Our Hospital

Remember; ALWAYS be FAIR and you will ALWAYS be RIGHT

FOR IMMEDIATE RELEASE
Monday, August 4, 2014

Community Health Systems Inc. to Pay $98.15 Million to Resolve False Claims Act Allegations

The Justice Department announced today that Community Health Systems Inc. (CHS), the nation's largest operator of acute care hospitals, has agreed to pay $98.15 million to resolve multiple lawsuits alleging that the company knowingly billed government health care programs for inpatient services that should have been billed as outpatient or observation services. The settlement also resolves allegations that one of the company's affiliated hospitals, Laredo Medical Center (LMC), improperly billed the Medicare program for certain inpatient procedures and for services rendered to patients referred in violation of the Physician Self-Referral Law, commonly known as the Stark Law. CHS is based in Franklin, Tennessee, and has 206 affiliated hospitals in 29 states.

"Charging the government for higher cost inpatient services that patients do not need wastes the country's health care resources," said Assistant Attorney General Stuart F. Delery for the Justice Department's Civil Division. "In addition, providing physicians with financial incentives to refer patients compromises medical judgment and risks depriving patients of the most appropriate health

care available. This department will continue its work to stop this type of abuse of the nation's health care resources and to ensure patients receive the most appropriate care."

The United States alleged that from 2005 through 2010, CHS engaged in a deliberate corporate-driven scheme to increase inpatient admissions of Medicare, Medicaid and the Department of Defense's (DOD) TRICARE program beneficiaries over the age of 65 who originally presented to the emergency departments at 119 CHS hospitals. The government further alleged that the inpatient admission of these beneficiaries was not medically necessary, and that the care needed by, and provided to, these beneficiaries should have been provided in a less costly outpatient or observation setting. CHS agreed to pay $89.15 million to resolve these allegations. The settlement does not include hospitals that CHS acquired from Health Management Associates (HMA) in January 2014.

In addition, the government alleged that from 2005 through 2010, one of CHS's affiliated hospitals, LMC in Laredo, Texas, presented false claims to the Medicare program for certain cardiac and hemodialysis procedures performed on a higher cost inpatient basis that should have been performed on a lower cost outpatient basis. The government also alleged that from 2007 through 2012, LMC improperly billed Medicare for services referred to LMC by a physician who was offered a medical directorship at LMC, in violation of the Stark Law. The Stark Law prohibits a hospital from submitting claims for patient referrals made by a physician with whom the hospital has an improper financial relationship, and is intended to ensure that a physician's medical judgment is not compromised by improper financial incentives, and is instead based on the best interests of the patient. CHS agreed to pay $9 million to resolve the allegations involving LMC.

"This is the largest False Claims Act settlement in this district and it reaffirms this office's commitment to investigate and pursue health care fraud that compromises the integrity of our health care system," said U.S. Attorney David Rivera for the Middle District of Tennessee. "This office is committed to ensuring that all companies billing government healthcare programs are responsible corporate citizens and that hospital providers do not engage in schemes to increase medically unnecessary in-patient admissions of government healthcare program beneficiaries in order to increase profits."

"This settlement demonstrates our commitment to working with our law enforcement partners and with the Department of Justice to protect the integrity of our nation's health care system," said U.S. Attorney Kenneth Magidson of the Southern District of Texas. "Put simply, these types of fraudulent practices will not be tolerated and the investigation and resolution of such claims will continue to be a high priority of this office."

"Health care providers should make treatment decisions based on patients' medical needs, not profit margins," said U.S. Attorney Anne M. Tompkins for the Western District of North Carolina. "We will not allow this type of misconduct to compromise the integrity of our health care system."

As part of today's agreement, CHS entered into a Corporate Integrity Agreement with the U.S. Department of Health and Human Services - Office of Inspector General (HHS-OIG), requiring the company to engage in significant compliance efforts over the next five years. Under the agreement, CHS is required to retain independent review organizations to review the accuracy of the company's claims for inpatient services furnished to federal health care program beneficiaries.

"In an effort to ensure the company's fraudulent past is not its future, CHS agreed to a rigorous multi-year Corporate Integrity Agreement requiring that the company commit to compliance with the law," said Inspector General Daniel R. Levinson, of the U.S. Department of Health and Human Services. "The dedicated work of OIG's investigators, auditors, and attorneys, in concert with our law enforcement partners, has again resulted in the recovery of taxpayer dollars and better protection against fraud in the future."

The settlement resolves lawsuits filed by several whistleblowers under the *qui tam* provisions of the False Claims Act, which permit private parties to file suit on behalf of the government and obtain a portion of the government's recovery. Those relators are Kathleen Bryant, former Director of Health Information Management at CHS's Heritage Medical Center in Shelbyville, Tennessee; Rachel Bryant, former nurse at CHS's Dyersburg Hospital in Dyersburg, Tennessee; Bryan Carnithan, former Emergency Medical Services Coordinator at CHS' Heartland Hospital in Marion, Illinois; Amy Cook-Reska, former coder for CHS' LMC in Laredo; Sheree Cook, former nurse at CHS's Heritage Medical Center in Shelbyville; James Doghramji, former internal medicine and emergency room physician at CHS's Chestnut Hill Hospital in Philadelphia; Thomas Mason, former emergency room physician at Lake Norman Regional Medical Center in Mooresville, North Carolina; Scott Plantz, former emergency room physician at CHS's Longview Regional Medical Center in Longview, Texas; and Nancy Reuille, former nurse and Supervisor of Case Management at CHS's Lutheran Hospital in Fort Wayne, Indiana. The relators' share of the settlement has not yet been determined.

This settlement illustrates the government's emphasis on combating health care fraud and marks another achievement for the Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative, which was announced in May 2009 by Attorney General Eric Holder and the Secretary of Health and Human Services. The partnership between the two departments has focused efforts to reduce and prevent Medicare and Medicaid financial fraud through enhanced cooperation. One of the most powerful tools in this effort is the False Claims Act. Since January 2009, the Justice Department has recovered a total of more than $20.2 billion through False Claims Act cases, with more than $14 billion of that amount recovered in cases involving fraud against federal health care programs.

This settlement was the result of a coordinated effort by the U.S. Attorney's Offices for the Middle District of Tennessee, Southern District of Texas, Northern and Southern Districts of Illinois, Northern District of Indiana and Western District of North Carolina; the Civil Division's Commercial Litigation Branch; HHS-OIG; DOD's Defense Health Agency - Program Integrity Office and the FBI.

The lawsuits are captioned *United States ex rel. Bryant v. Community Health Systems, Inc., et al.*, Case No. 10-2695 (S.D. Tex.); *United States ex rel. Carnithan v. Community Health Systems, Inc., et al.*, Case No. 11-cv-312 (S.D. Ill.); *United States ex rel. Cook-Reska v. Community Health Systems, Inc., et al.*, Case No. 4:09-cv01565 (S.D. Tex.); *United States ex rel. James Doghramji; Sheree Cook; and Rachel Bryant v. Community Health Systems Inc., et al.*, Case No. 3-11-cv-00442 (M.D. Tenn.); *United States ex rel. Mason v. Community Health Systems, Inc., et al.,* Case No. 3:12-cv-817 (W.D.N.C.); *United States ex rel. Plantz v. Community Health Systems, Inc., et al.*, Case No. 10C-0959 (N.D. Ill.); *United States ex rel. Reuille v. Community Health Systems Professional Services Corporation, et al.,* Case No. 1:09-cv-007RL (N.D. Ind.). The claims resolved by this agreement are allegations only and there has been no determination of liability.