TESTIMONY

of

Dennis E. Burke, President & CEO
Good Shepherd Health Care System
Hermiston, Oregon

before the

House Judiciary Subcommittee on the Constitution and Civil Justice

on

OVERSIGHT OF THE FALSE CLAIMS ACT

April 28, 2016

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Good afternoon. Mr. Chairman and Members of the Constitution and Civil Justice Subcommittee, my name is Dennis Burke. I am the President and CEO of Good Shepherd Health Care System in Hermiston, Oregon, where I have had the pleasure of serving for the past 27 years. I appreciate this opportunity to share our experience with the False Claims Act. It is my hope that – in some small way – our experience will shed light on some of the consequences of the FCA, that I am sure were never intended by Members of Congress.

First, I would like to make it clear that my Board of Directors and I strongly support anti-fraud statutes, active government programs that seek to identify and eliminate fraudulent activity and whistleblowers who have legitimate allegations. Fraud harms all of us and reduces limited resources for **bona fide** healthcare purposes. I will be brief today but it is my hope that you will find an opportunity to read the more detailed, written account of our experience, as outlined in the letter attached to my statement, addressed to Senator Wyden, dated August 23, 2006.

Let me say from the outset that it was our intent to comply with the law and we felt we were in full compliance. We were not and we are not perfect BUT we were not intentionally violating any law. We were the victim of a disgruntled former employee who turned relator. Having said that, we could just as easily have been the victim of a rogue employee who intentionally violated our policies and procedures. The ensuing

process would have been the same. Sadly, the FCA makes no distinction between organizations that are victims of false allegations and those that have proper anti-fraud measures in place but fall victim to rogue employees, just as it makes no distinction between organizations that are doing everything they can and should do to prevent fraud and those organizations that take minimum precautions.

What happened to us is what I will call an overreaction…an overreaction that cost us dearly in terms of both reputation and dollars and cents. In the end, it was determined that **we had not defrauded the government** and the DOJ dropped its investigation. This is what happened….

In 2003, agents from the FBI and the Oregon Medicaid Fraud Unit visited our hospital, asking questions about our billing practices. A few weeks later, we were raided by a team of agents who came to the hospital at night. They combed through our records, taking boxes of billings, financial documents, contracts, medical records and other information. Our hospital counsel was ultimately able to ascertain that a *qui tam* case had been filed against us. But it was "sealed", so we were unaware of the nature of the investigation.

The federal court in Portland, Oregon made the FBI affidavit for the raid public. Our local newspaper and *The Oregonian* (a Portland, Oregon newspaper) featured all of the allegations in the complaint. These stories were extremely damaging to our hospital's reputation. We even had a visiting physician clinic threaten to discontinue its relationship with our hospital.

The *qui tam* relator's allegations included every fraud "hot button" at that time. This included:

- lab unbundling
- physician kick-backs
- three-day window billing violations
- upcoding
- billing for services not rendered
- misrepresentation of physician credentials
- cost report irregularities, etc.

Due to the nature and scope of the allegations, the investigation was heightened from a civil to a criminal investigation. At the time of the raid, I was told by an agent that "if even a part of these allegations are true, someone is going to jail".

During the course of the investigation, the government began discovering significant differences between the allegations and actual hospital practices. In a matter of weeks, the government scaled the investigation back to a civil investigation.

Over the course of two-and-a-half years the majority of the allegations were dismissed outright. However, the investigation did reveal that we had some irregularities associated with our Emergency Room billings. We had installed a new computer system and the department manager had – inadvertently – programmed the billing system such that the Emergency Room medical director's name appeared on all of our billing forms as the treating physician and the treating physician's name appeared as the consulting physician. Because of this error, the Department of Justice requested that we perform an extensive

audit (at our expense) through an independent third party reviewer recommended by the Department of Justice.

The results of the audit showed that all services were provided by qualified physicians and that services were appropriately coded. In fact, the audit revealed that Medicare and Medicaid were actually slightly under-billed vis-a-vis the level of coding that could be supported by the documentation. Following the results of this audit, the State Medicaid Fraud Unit and the Department of Justice dropped their investigation.

In its entirety, we were subject to a humiliating raid and an investigation by the federal government due to a disgruntled former employee. The relator took advantage of the law's protections to, in essence, "throw everything on the wall to see if anything might stick." We experienced a three-year investigation, which consumed hundreds of internal man-hours and well over $1 million in attorney fees, consultation fees and undeserved settlement costs, not to mention the significant harm to our reputation.

Having experienced what we consider to be a frivolous complaint of false allegations and an expensive investigation, we would like to share our concerns and perceptions of the law as it currently exists – hopefully to protect our hospital and others against future unintended consequences of a well-meaning law:

- Relators should be required to demonstrate that they have brought their concerns to the attention of the target organization (or hospital) before they bring the matter to the government.
- Without being required to make specific allegations, is not fair that targeted organizations like ours, are subject to over $1 million in expenses and in the end, the accuser is able to just walk away and say "oops, I guess we were (I was) wrong."

- The penalty provisions in the False Claims Act are astronomical. As such, the financial risks posed by the laws, in most cases, cause hospitals like ours to avoid the uncertainty of a trial and instead choose the safer, more predictable route of settlement. DOJ offered us a $750,000 "rough justice" settlement which was very tempting to my board. But we knew the claims were unjustified and decided to take a stand – unfortunately not everyone is in the position to take the same leap of faith due to the risks they face for doing so.

That is our experience in an abridged telling. I urge you to read the full account in the letter attached to my statement. We hope our experience will not continue to be acceptable under the law. I greatly appreciate this opportunity and look forward to any questions you might have. Thank you.