Testimony of Robin Page West
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Subcommittee on Government Organization, Efficiency and Financial Management
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Thank you Chairman Platts, Chairman Gowdy, Ranking Member Towns, Ranking Member Davis and distinguished members of the Subcommittees for inviting me to discuss Medicaid fraud.

My name is Robin Page West. I am an attorney, and I represented Richard West (no relation) in the Medicaid fraud lawsuit that resulted in a settlement in September of this year in which Maxim Healthcare Services, Inc. agreed to pay $150 million to the federal government and 41 states' Medicaid programs. For the past 20 years, I have focused on bringing cases such as Mr. West's to recover money the government has lost to fraud. I am also the author of a book on this subject published by the American Bar Association, now in its second edition, entitled Advising the Qui Tam Whistleblower: From Identifying a Case to Filing Under the False Claims Act.

In examining ways to improve oversight and accountability of Medicaid, it is helpful to look at the process we followed in bringing Mr. West's Medicaid fraud lawsuit. As he testified, after Mr. West attempted to bring this matter to the government's attention by contacting the state, the Medicaid program, and his social worker, all to no avail, he turned to a private lawyer. We then brought a lawsuit under the False Claims Act ("FCA"), a statute enacted during the civil war to stop unscrupulous defense contractors. This law allows the government not only to to sue fraudsters and recover the amounts stolen, but also to collect civil penalties and treble damages.

What makes the law unusual, and so effective, though, is that an ordinary person can step into the shoes of the government and do it, too. If the case is successful, that person is entitled to a share of the recovery. The part of the law allowing this is called the qui tam provision, which stands for a Latin phrase *"Qui tam pro domino rege quam pro se ipso in hac parte sequitur,"* which translates as "He who sues on behalf of the King, as well as for himself." The person who sues on behalf of the government--the whistleblower-- is known as a "qui tam relator."

In 1986, the whistleblower rewards in the statute were strengthened by bipartisan amendment to create what sponsors Senator Charles Grassley and Representative Howard Berman called a "coordinated effort" between private citizens and the government to recover money lost through fraud. The reward to the whistleblower in a successful intervened case can range from 15 to 25% of the government's recovery.

To see just how effective the whistleblower reward provisions have been in driving recoveries under the False Claims Act, we can look at the numbers. According to Taxpayers Against Fraud, (TAF), a non-profit public interest organization that tracks these statistics, before the 1986 amendments, the Department of Justice recovered less than $100 million a year under the False Claims Act. In Fiscal Year 2010, over $3 billion was recovered under the False Claims Act—twice as much as was recovered in FY 2000. Of this amount, nearly 80% was recovered as a direct result of whistleblower lawsuits—a total of $2.39 billion.*

The whistleblower incentives have been so successful in recouping monies lost to fraud that over half the states plus New York City and the District of Columbia have passed their own versions of the federal False Claims Act in order to increase the amount of money coming back to them. As just one example, earlier this year, Quest Diagnostics Inc. agreed to pay $241 million to resolve a California state false claims act lawsuit brought by a competitor that alleged Quest

overbilled the state's Medicaid program.

Mr. West's first step in using the FCA as a tool to stop Medicaid fraud was to locate an attorney with experience using this statute. Many attorneys are not familiar with the unique requirements for filing a False Claims Act suit. The procedures for bringing an action under the FCA are quite different from any other type of lawsuit, and failure to follow these procedures can result in dismissal of the case. For example, unlike most litigation where discovery happens *after* the case is filed, in a qui tam case, substantially all of the evidence the relator has of the fraud must be provided to the government at the very beginning of the case. Also unique to qui tam litigation is a requirement that the case be filed under seal, so that not even the defendant knows about it.

A crucial part of the process is to present the evidence of the fraud, as well as an explanation of the fraud and of the regulatory framework, to the government clearly and concisely. These cases can be complex, but it is not up to the government to figure out how the fraud works—that is the job of the relator and his lawyer. The purpose of qui tam cases is to assist the government's enforcement efforts, not to slough work onto the government. So an experienced FCA lawyer will not merely throw down a bare bones lawsuit. Rather, she will develop the evidence and the theory of the case as much as possible before presenting it to the government. If it does not find the case appealing, the government may choose not to become involved. In fact, the government chooses not to intervene in almost 80% of the qui tam cases filed.* So the lawyer needs to understand what cases will be worthwhile to the government and how to convey their value clearly and concisely.

In Mr. West's case, we collected all the documentation he had that showed how many hours the nurses were in his home, and compared it to how many hours Medicaid was billed. The

documents we used consisted of the time sheets the nurses left with Mr. West after their visits, his day planner, and billing records obtained from Medicaid. We analyzed these records and presented them in a way that juxtaposed the number of hours of service against the number of hours billed to demonstrate how they did not match. In addition, Mr. West had learned, through conversations with various of his nurses, information that made him believe Maxim was doing this on purpose. We provided detailed information to the government about these conversations as well.

After we developed our case, assembled the evidence for the government, and filed the lawsuit under seal, members of the U. S. Attorney's office invited us to meet with them to discuss our submission. Subsequently, the government began its own investigation, which ultimately expanded beyond the Maxim office that was providing Mr. West's care to include all states in which Maxim did business.

The FCA provides 60 days for the government to determine whether to intervene in a case. It usually takes the government much longer to make this decision, so it must request the court to grant it additional time. It takes an average of thirteen months* for the government to make its decision whether to pursue a matter, although in my personal experience, the time has averaged closer to three years. If the government chooses not to intervene, the relator may continue on with the case, and if successful, receive a larger reward of up to 30% of the government's recovery.

In Mr. West's case, the government ultimately chose to intervene. Its investigation took seven years, and throughout that time, the judge, on behalf of the court system, and I, on behalf of Mr. West, kept in contact with the government prosecutors to make sure the investigation was moving forward. The comprehensive investigation resulted not only in a civil settlement but in

criminal indictments of eight employees, a deferred prosecution agreement, and a corporate integrity agreement requiring Maxim to report to an independent monitor, who will review Maxim's business operations and regularly report concerning the company's compliance with all federal and state health care laws, regulations, and programs. Details of the settlement are at http://www.homehealthcarefraudsettlement.com.

One reason the False Claims Act is so effective is the court oversight that comes about as soon as the 60 day clock starts running on the intervention decision. This is quite different from hotlines that are not accountable for responding to callers or taking any action on their complaints and tips. But even though the False Claims Act requires the government to investigate every case swiftly, it has built-in safeguards against frivolous lawsuits so court and government resources are not squandered:

- Because most False Claims Act lawyers work on a contingency basis, they only get paid if they win. This means that they are unlikely to invest time, money and energy building a case that they themselves do not feel will be productive.

- Under the False Claims Act, a relator can be required to pay the defendant's attorney's fees if the court finds that the claim was frivolous or brought primarily for purposes of harassment, so whistleblowers with unpure motives have a huge disincentive to file a case.

- The FCA is rarely used to correct minor billing mistakes and errors that are not systematic because they do not amount to large sums of money, and such cases will not be chosen for intervention.

There is no doubt that the cases whistleblowers are bringing to the government are of high quality. According to TAF, more than 80 percent of the False Claims Act cases now being pursued by the U.S. Department of Justice were initiated by whistleblowers.*

Many oversight programs and contractors exist to identify improper payments and fraud. These programs and contractors cost the government money, sometimes more than they recover. For example, CMS' Senior Medicare Patrol (SMP) program, which was launched in 1997,

teaches seniors, caregivers and beneficiary family members how to review Medicare notices and Medicaid claims for signs of fraudulent activity and what to do about it. According to its website, http://www.aoa.gov/AoA_programs/Elder_Rights/SMP/index.aspx#data, from 1997 through December 2010, "About $106 million in savings, including Medicare and Medicaid funds recovered, beneficiary savings and other savings have been attributed to the project as a result of documented complaints." This $106 million saved over 14 years, in light of a current annual budget for the program of $9.3 million, leads to the question whether this program, and others like it, are even saving what they cost.

One of the reasons the False Claims Act avoids this problem is that it uses very attractive incentives to mobilize private individuals and their attorneys to do the work at no cost to the government, completely independently of whatever government oversight may or may not be in place, without the need for funds for training or execution of the program. The FCA model is more effective in this regard than even the Medicare Recovery Audit Contractor (RAC) program, which, although it pays contractors a percentage of the improper payments they recoup from providers, still dips into the recouped funds to pay those contingent fees. This is not the case with FCA recoveries. Not one dime comes from taxpayers to pay for these recoveries, because the statute allows for recovery of triple damages *from the fraudster* so that the government can be made whole, not only for the cost of whistleblower awards, but also for the cost of investigations, prosecutions, and lost interest. A TAF study conducted in 2005 found that "For every dollar spent to investigate and prosecute health care fraud in civil cases, the federal government receives nearly thirteen dollars back in return." Moreover,the study found, "[t]he benefit/cost ratio of nearly thirteen to one is likely to be an underestimate of the real return that the taxpayers are receiving on outlays for civil health care fraud enforcement. The indirect

benefits associated with deterrent effects... undoubtedly add substantially to the public's benefit." http://www.taf.org/MedicareFraud040805.pdf A 2012 report by the HHS OIG reports an even higher ratio--$16.7 to $1 expected return on investment. http://oig.hhs.gov/publications/docs/budget/FY2012_HHSOIG_Online_Performance_Appendix.pdf

In closing, one aspect of Mr. West's case that I would like to highlight is that the waiver program that provided his benefits was capped at a monthly amount that, if exceeded, triggered his suspension from the program and temporary denial of further Medicaid benefits. So when Mr. West went to the dentist, he was informed he could not get treatment because he had supposedly exceeded his cap by virtue of nursing services he knew he had not received. In most Medicare, Medicaid, FEHB, TRICARE or other federal and state health programs, that would not happen because there is no cap like this that triggers exclusion. So typically when Medicaid beneficiaries notice suspicious billings on their explanation of benefit forms, they have no incentive to expend time questioning them, because their future Medicaid benefits and healthcare services are not at stake. This is one reason I believe we have not seen more healthcare fraud cases initiated by Medicare and Medicaid beneficiaries.

Thank you again for inviting me to testify. I look forward to answering your questions.

* The Department of Justice's statistics are available at http://www.taf.org/statistics.htm, http://www.taf.org/FCA-stats-2010.pdf and http://www.taf.org/DOJ-HHS-joint-letter-to-Grassley.pdf