Statement of Claire Sylvia
Phillips & Cohen LLP

Submitted to
the Subcommittee on Health Care, District of Columbia, Census and the National Archives and
the Subcommittee on Regulatory Affairs, Stimulus Oversight and Government Spending
of the House Committee on Oversight and Government Reform

Joint Hearing on
"Is Government Adequately Protecting Taxpayers from Medicaid Fraud?"

April 25, 2012

Chairmen and Members of the Subcommittees, thank you for the opportunity to appear before you today to address the critical role that private citizen whistleblowers play in combating fraud against Government programs, including Medicaid. My name is Claire Sylvia and I am a partner in the law firm of Phillips and Cohen LLP, which specializes in representing whistleblowers under the federal False Claims Act and state False Claims acts, as well as under the Dodd-Frank SEC whistleblower provisions and the IRS whistleblower provisions.

INTRODUCTION

The Government's most important tool in fighting fraud against the Government is the federal False Claims Act, with its "*qui tam*," or whistleblower provisions, which provide private citizens incentives to pursue lawsuits on behalf of the federal Government to redress fraud against the Government. The Act, first enacted in 1863, was substantially amended 25 years ago when Senator Charles Grassley and Representative Howard Berman led successful efforts to strengthen the False Claims Act and increase

the incentives for whistleblowers to bring information about fraud to the Government's attention. The changes Congress made in 1986, which provided whistleblowers the opportunity to play an ongoing role in cases they initiate and enhanced the resources of the federal Government in pursuing these cases, have proven phenomenally successful in attacking a notoriously difficult problem. The Department of Justice has reported that more than $30 billion has been recovered under the False Claims Act since the 1986 amendments.

THE FALSE CLAIMS ACT QUI TAM PROVISIONS

The False Claims Act *qui tam* provisions address two key problems inherent in the Government's efforts to combat fraud – lack of information and lack of adequate resources. Fraud against Government programs, including Medicaid, is difficult to detect and even when detected is difficult to prosecute. The False Claims Act *qui tam* provisions address the first problem by providing incentives to persons to report fraud to the Government. As Congress recognized when first enacting the False Claims Act, and again when amending the Act in 1986, it is very difficult to detect fraud without the cooperation of close observers of the activity. The False Claims Act provides incentives to persons with knowledge of the fraud to report that information to the Government. Those incentives include not only the possibility of a reward, but also the opportunity to have an ongoing role in pursuing the case, and protections against retaliation. Without those incentives, few individuals would be willing to risk the cost to their careers and personal lives that reporting fraud typically entails. While other oversight methods, such as data mining and audit programs can also serve important roles in detecting fraud, the ability to harness the information of insiders has proven especially effective. One study

prepared in 2006 for the Taxpayers Against Fraud Education Fund by Jack Meyer of the Economic and Social Research Institute, estimated that for every dollar spent to investigate and prosecute health care fraud in civil cases, $15 dollars is returned to the Treasury. And that study was prepared before the types of record-setting False Claims Act recoveries the Government has received in the last few years.

The False Claims Act *qui tam* provisions address the second problem – the Government's lack of adequate resources – by providing the opportunity for private citizens and their counsel to take an active role in pursuing these cases on behalf of the Government. As Congress recognized in 1986, large corporations that are the subject of fraud investigations are able to devote far more resources to these cases than the Government, which is often outmatched. The *qui tam* provisions of the False Claims Act enhance the Government's resources by leveraging the resources of whistleblowers and the private law firms that represent them. Cases under the False Claims Act can take years to develop and pursue and typically require a tremendous investment of legal resources. The combined efforts of the federal Government and private resources have been uniquely effective in pursuing large and complex fraudulent practices that might otherwise have gone unaddressed, even if detected.

Recent changes in federal law will further enhance the Federal Government's ability to combat Medicaid fraud. Congress amended the False Claims Act in 2009 in the Fraud Enforcement and Recovery Act to clarify a number of provisions of the Act and address court interpretations that were inconsistent with Congress's intent when it amended the Act in 1986. In the Affordable Care Act of 2010, Congress further strengthened provisions of the Act in several ways, including expressly providing that

violations of the healthcare Anti-Kickback Statute are violations of the False Claims Act and requiring that Medicare and Medicaid overpayments be reported and returned within 60 days. The Act also enhanced the Government's ability to prevent and deter fraud in other ways, including requiring more rigorous screening processes for providers before they are enrolled in the program, requiring States to withhold payments to Medicaid providers where there is a pending investigation of a credible allegation of fraud, and providing more resources to fight fraud and improve the coordination and sharing of information among agencies to combat fraud.

In addition to these changes to 2006 Congress provided incentives in the Deficit Reduction Act to encourage States to adopt their own Medicaid False Claims Act statutes and many have done so. The combined federal and state remedies and the coordination between the federal Government and the states provide an even more powerful means of redressing Medicaid fraud.

THE FALSE CLAIMS ACT AND MEDICAID FRAUD

The success of the *qui tam* provisions in helping the federal Government combat Medicaid fraud is undeniable. According to the Department of Justice, in the fiscal year ending in September 2011, recoveries under the False Claims Act reached a record $3 billion in settlements and judgments. That was the second year in a row that recoveries under the False Claims Act exceeded $3 billion. Of those total recoveries in fiscal year 2011, a record $2.8 billion in recoveries was attributable to claims brought under the whistleblower provisions of the False Claims Act, and $2.4 billion of that amount involved fraud committed against federal health care programs, and most of these recoveries are attributable to the Medicare and Medicaid programs.

Medicaid fraud takes a variety of forms from simple overcharging by a doctor for services not rendered to complex pricing and marketing schemes that affect multiple federal healthcare programs including Medicaid. While typical fraud schemes, such as billing for services never rendered, providing unnecessary services and paying illegal kickbacks have a long history, new ways of defrauding federal programs emerge, and often require insiders to explain them.

Some of the most significant recoveries in recent years have come from pharmaceutical and health care companies. The Government recovered nearly $2.2 billion in civil claims against the pharmaceutical industry in fiscal year 2011 alone, including $1.76 billion in federal recoveries and $421 million in state Medicaid recoveries. These recoveries included:

- $900 million from eight drug manufacturers to resolve allegations that they had engaged in unlawful pricing to increase their profits

- $750 million paid by GlaxoSmithKline to resolve criminal and civil allegations related to the submission of claims for payment to government health care programs for adulterated drugs and for drugs that failed to conform to the strength, purity or quality specified by the Food and Drug Administration

- $130 million paid by Maxim Healthcare Services, Inc. to resolve allegations that Maxim submitted false claims to Medicaid programs and the Department of Veterans Affairs for services not rendered, services that were not documented properly, and services performed by unlicensed offices

Since the end of the Government's fiscal year 2011, whistleblowers have helped achieve additional substantial recoveries for a variety of unlawful practices that have defrauded the Medicaid program. Those recoveries have included:

- $950 million from Merck to settle criminal charges and civil claims related to unlawful marketing of Vioxx and misleading statements about the safety of the drug

- $137.5 million from WellCare Health Plans, which provides managed health care services for Medicare and Medicaid beneficiaries, to settle whistleblower allegations that, among other things, it falsely inflated amounts it claimed to be spending on medical care to avoid returning Medicaid overpayments and engaged in certain marketing abuses, including cherry picking healthy patients to avoid future costs

- $11 million from Dava Pharmaceuticals Inc. to resolve allegations that it lowered the drug rebate amount owed to Medicaid by incorrectly classifying certain drugs

- $6.85 million from a residential youth treatment facility for Medicaid recipients in Virginia for providing substandard adolescent psychiatric services and falsifying records

All of these types of practices divert funds from the Medicaid program and its core mission.

Not to be lost in this discussion of actual dollars returned to the Treasury as a result of the efforts of private citizen whistleblowers is the deterrent effect that the False Claims Act has had, which although more difficult to quantify is undoubtedly substantial. Twenty-five years ago, there was not widespread awareness of the False Claims Act. Now, the Act is well known and an important part of internal healthcare compliance programs. While fraud in Government programs has been by no means eliminated, there is far more awareness of the consequences of defrauding federal health care programs and more awareness among potential observers of wrongful conduct that there is a way to ensure that fraud is stopped and addressed.

CLAIRE MARIE SYLVIA

PROFESSIONAL EXPERIENCE

Partner, Phillips & Cohen LLP	2007 to present
Of-Counsel, Phillips & Cohen LLP	2006-07
Deputy City Attorney, Ethics Unit, Office of the San Francisco City Attorney	1995 to 2006
Assistant Senate Legal Counsel, Office of the United States Senate Legal Counsel	1989-95
Center for Law in the Public Interest, Los Angeles, California	1988-89
Law Clerk, the Honorable Mariana R. Pfaelzer United States District Court, Central District of California	1987-88

EDUCATION

Harvard Law School, *Juris Doctor*, 1987
Editor, *Harvard Law Review*; Ames Moot Court Competition Finals, Best Brief (team);
Teaching Assistant, Politics of the Legal System, Brown University

Brown University, Bachelor of Arts, *Magna Cum Laude*, 1984
Major: Law and Society, Honors

PUBLICATIONS:

The False Claims Act: Fraud Against the Government (West 2d ed. 2010)

OTHER

California Bar (1988); District of Columbia Bar (1990)

Committee on Oversight and Government Reform
Witness Disclosure Requirement – "Truth in Testimony"
Required by House Rule XI, Clause 2(g)(5)

Name: Claire Sylvia

1. Please list any federal grants or contracts (including subgrants or subcontracts) you have received since October 1, 2009. Include the source and amount of each grant or contract.

n/a

2. Please list any entity you are testifying on behalf of and briefly describe your relationship with these entities.

Phillips & Cohen LLP; partner

3. Please list any federal grants or contracts (including subgrants or subcontracts) received since October 1, 2008, by the entity(ies) you listed above. Include the source and amount of each grant or contract.

n/a

I certify that the above information is true and correct.
Signature:

Date: 4/23/12