David J. Gibson, M.D.
Chief Executive Officer

September 7, 2014

Shantanu Agrawal, M.D.
Deputy Administrator & Director, Center for Program Integrity
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Via Regular Mail, (no E-mail address is available)

Subject: Addressing Medicare and Medicaid Fraud

Dear Dr. Agrawal:

Two articles that were recently published attracted my attention. They have prompted my sending you this letter. The first entitled "Pervasive Medicare Fraud Proves Hard to Stop" was published in the *New York Times* on 08-16-14; the second entitled "How Agents Hunt for Fraud in Trove of Medicare Data" was published in the *Wall Street Journal* two days earlier by Christopher Stewart. In a report on the Center for Program Integrity after its first year of operation, the CMS Office of Inspector General concluded that it is currently impossible to know whether there were *any* program savings generated.

Your frustration with this OIG finding of lack of progress was evident in your asking the public for ideas as to how to be effective in this critical task of protecting health care entitlement programs from criminal activity. This letter is responding to that request. Please pardon the letter's length. The scope and magnitude of the problem warrants a thoughtful and detailed response.

I am also sending a copy of this letter to Senator Orrin Hatch's office in that the *NYT* article referenced above indicated that he shared you frustration.

To start by stating the obvious, unless you get a handle on the fraud problem that is pervasive in both programs, the programs' costs will outstrip the taxpayer's confidence and their ability to support them and these programs will implode. Neither program is sustainable with their current structure.

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Malcolm Sparrow, the Professor of Public Management at the Kennedy School of Government has accurately described both of the programs as a runaway reward system for organized crime in this country. This criminal empowerment is also a national security issue. Fraud in health care, particularly as it relates to counterfeit pharmaceutical products, is a major source of funding for terrorist organizations around the world.

Both the Medicare and the Medicaid programs are poorly designed from a public policy perspective and incompetently managed – this is particularly the case with Medicaid. The administration of these programs is delegated to inexperienced crony vendors with influence peddling lobbyists on their pay roll. This crony capitalism problem was best exemplified by the failure to launch of the HealthCare.gov website whose implementation was awarded in no bid contracts to corporations with relationships to Washington politicians and their wives.

Beyond the above, the protection of both programs from criminal activity is delegated to individuals with health care backgrounds. They have no experience in law enforcement and predictably retreat to a claims examination focusing on a medical utilization / quality assurance review perspective. This approach has not and will not work going forward. To paraphrase Johnny Lee's ballad of my youth, you are "lookin' for criminal activity in all the wrong places". That is why your efforts are failing to protect these programs. Stated synoptically, your approach is anachronistic.

The Fraud Prevention Institute's (FPI) Background

I lead a California based not-for-profit organization that is dedicated to preventing the penetration of criminal activity into vital state and federal medical entitlement programs. We have a dedicated group of individuals who have worked tirelessly to deliver on our commitment to society. You can review our credentials on our website (http://fraudpreventioninstitute.org/). Our members are some of the most highly decorated former state and federal law enforcement officers. Each gained their expertise while working in the California Fraud Prevention Bureau (CFPB).

CFPB was FPI's antecedent initiative. It was a pilot joint state/federal antifraud taskforce. This task force produced an efficiency rate of $20 in savings per dollar spent over its four years of activity. The unit eliminated over $300 million in fraud schemes, which led to over 200 Federal convictions with a 100% felony conviction rate. The pilot returned a record $75 million in court-ordered restitution and asset forfeitures.

Despite this unequaled success record, it became apparent to all our law enforcement personnel that investigating nefarious individuals and obtaining convictions was not an effective way to protect the MediCal Program. A broader view of criminal enterprises was called for.

As a direct result of this realization, FPI concentrates its efforts in two areas. The first is to develop data mining technology that will identify likely fraudulent activity before a payment is made to a claimant. The second is to develop experienced based investigative techniques that not only prevent criminal activity but also, when taken to court, result in successful prosecutions of nefarious corporations and individuals.

FPI built its software and investigations around the anti-kickback statutes that are present at both the various state and federal levels. These statutes empowered FPI to deliver significant penalties and make available massive recoveries from fraudulent corporations doing business within health care.

FPI has applied its technology in various opportunities. For example, we have performed a data mining based analysis that spanned three-years of paid claims data for both the MediCal program in California and the Medicaid program in Texas. Our accuracy rate for prospectively finding actionable data indicating likely fraudulent activity, scored by independent, disinterested auditors, exceeds 90%.

Perhaps the most discouraging finding resulting from our various analyses is that the incidence of payment for fraudulent claims is, at a minimum, twice the published rate of 10%. We found 20 to 30% of submitted claims to be likely fraudulent and that if our technology were in place during the study period, more than 90% of fraudulent claims would not have been paid and the current "pay-an-chase" pattern that bleeds the program of limited resources could have been prevented.

The following ten recommendations respond to your request for assistance. They are each based on what FPI has learned from its operational experience in the past.

Recommendations for protecting Medicare and Medicaid

1. *End pay-and-chase*

Unless this issue is definitively resolved, there is no hope of protecting Medicare and Medicaid from fraud. Fraud is perpetrated by sophisticated criminal enterprises that launder money and move it off shore at the close of business every day. These enterprises have no tangible assets (real estate, computers, automobiles, etc.). Everything is leased. Thus, even if malfeasants are identified, investigated and successfully prosecuted, there is no reasonable likelihood that any taxpayer money will be recovered.

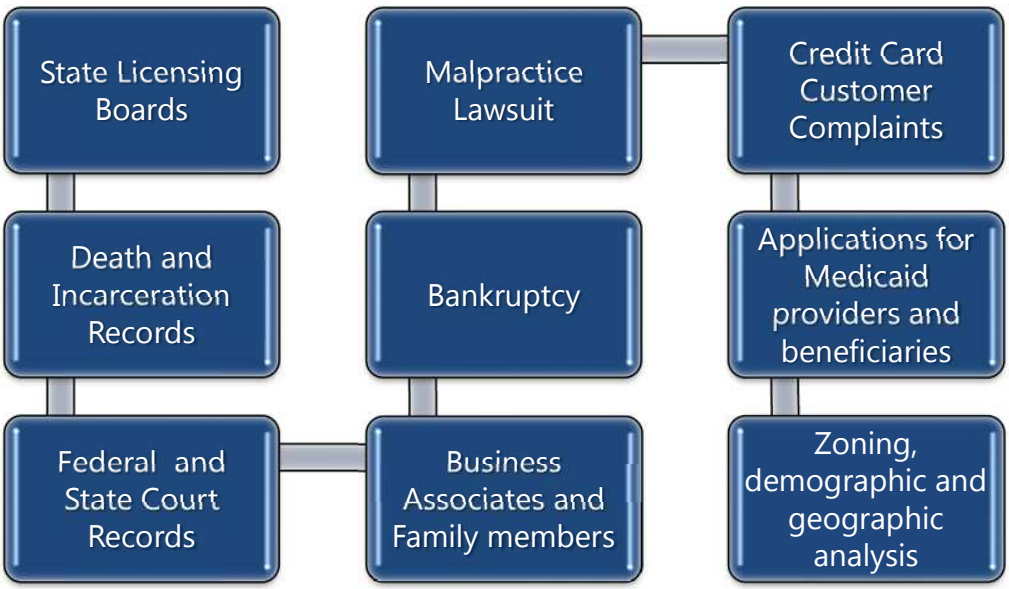
Addressing this issue calls for proactive screening of every claim and a re-credentialing of the submitting business with payment pended before any funds are distributed. By definition, this requires state-of-the-art data mining technology with access to multiple databases and incorporating filters that are developed based upon prior and evolving schemes.

Specifically, our technology is based upon a neural network architecture that concentrates on non-linear functions and has in-place designed filters that recognize anomalies in patterns within cross-mapped databases. This type of artificial intelligence is now commonly used in the aerospace, automotive, banking, defense, electronics, entertainment, financial, insurance, manufacturing, oil and gas, robotics, telecommunications, and transportation industries.

So, rather than looking for "smoking guns" in just the claims database, our technology scans multiple databases looking for anomalous and consistent patterns that have been found in the past to be consistent with miscreant behavior. A simple example would be a contractor consistently charging for services for individuals that were deceased or were incarcerated at the time of the invoiced service.

Miscreants exhibit predictable characteristics. They declare bankruptcy repeatedly. They accumulate complaints within state licensing boards, credit card companies and business rating bureaus. They are frequently sued for malpractice. They have family members and business associates with criminal records. They have business addresses in locations not zoned for commercial use.

FPI has developed this technology. It is based upon the experience referenced above by the California Fraud Prevention Bureau. In addition, our claims review system looks far beyond medical claims submitted to include cross mapping multiple databases that are analyzed in real time and continuously. The following diagram depicts some of the databases FPI's technology continuously monitors, mostly at the state level, in addition to the medical claims submitted.



In addition to the above database monitoring, FPI monitors the defendant list of high-end law firms that have a record of representing corporations accused of program fraud, identity theft and money laundering. The corporations that defraud medical entitlement programs frequently use the same network of expensive law firms for their representation. These firms also generally use the same network of retired local law enforcement, FBI, IRS and HHS personal in their client representation efforts.

FPI's cross mapping of seemingly desperate databases gives our data mining technology the ability to triangulate on fraud generating companies and prevent payment before it is released and is thereafter unrecoverable.

We have further found that many of the criminal syndicates that prey upon immigrant communities, particularly within Medicaid, have tribal cultures that merely mascaraed as corporate. They commonly still have intact relationships with members of their tribe or family that remain in the Middle East or in Southeast Asia and actively manage money transferred offshore. When these interconnected structures are found, prosecutorial pursuit needs to go after the entire domestic and international infrastructure.

2. *You need to reorganize the Center for Program Integrity so that it is a law enforcement rather than a health care utilization management unit.*

The reality is you are dealing with some of the most sophisticated malfeasants that are either domestically or internationally based. Many are career criminals who have learned how to defraud these programs while serving time in state and federal penitentiaries. They are moderately bright, technically sophisticated, and proficient at identity theft. They are able to obtain and trade stolen identities in multiple domestic and international markets.

Staffing and directing the Center for Program Integrity unit with health care professionals (medical directors, utilization management nurses, medical quality assurance nurses, even forensic nurses, etc.) makes as much sense as asking street cops to perform brain surgery. You have the wrong team roster looking in the wrong places for fraud. We are not primarily dealing here with rogue doctors up-coding for their services or performing inappropriate testing and interventional procedures – though this does occur. Rather, the primary problem is sophisticated and hardened criminal syndicates that are preying upon these programs. Health care professionals are not equipped to deal with the scope or the sophistication of these enterprises.

3. *You need to leverage the Anti-Kickback Statutes at both the state and federal levels with the punitive goal of putting criminal syndicates and corporations out of business or significantly reduce their ability to*

defraud in the future. These corporate malfeasants tend to concentrate in the pharmaceutical, medical durable goods and implantable device supply industries though medical care deliverers, including hospitals, SNFs, various rehabilitative facilities and medical clinics, have been involved in the past.

The government's ability to impose significant penalties and obtain massive recoveries in the health care industry, using these anti-kickback statutes, has been well documented. Specifically, the health care civil treble damage penalties are derived from Title 18 USC section 287 & 1001. The recent $2.2 billion settlement with Johnson & Johnson illustrates the power of this law enforcement tool. In essence, this is health care's Racketeer Influenced and Corrupt Organizations Act, (RICO).

The key here is to maximally exploit the increase in the potential criminal penalties under most state and federal guidelines for sentencing. It is FPI's position that the criminal act occurs at the point of filing a claim not at the point of payment. Furthermore, FPI contends that the filing of the "billed" rate, not the actual payment rate, should constitute the calculation for penalties. Data generated in prior FPI studies establishes a ratio of 3.53 (billed vs. paid).

Thus, FPI contends that just the submission of a proactively identified fraudulent claim for goods and services represents the criminal act. Thus imposing the penalties under the anti-kickback statutes can be imposed without payment of the claim and loss of taxpayer funding.

This recommendation goes back to the previous point concerning the central focus of activity for the unit. Utilization review investigations are not relevant to these statutes. These statutes apply to criminal syndicates and corporations that do not practice medicine but bill for goods and services that are generally not delivered.

An additional point that should be of concern relates to the Affordable Care Act. HHS Secretary Kathleen Sebelius' announced in an October 30, 2013 letter to Representative Jim McDermott (D-Wash.), that insurance offered through the ACA's new public health insurance exchanges do not constitute "Federal health care programs" and thus are not within the scope of the federal anti-kickback statute. Thus, going forward, law enforcement has lost its major weapon for fighting fraud within the heavily subsidized public exchanges within the ACA.

4. *You need to incorporate the "broken window" approach to policing these entitlement programs.*

The broken windows theory is a criminological theory of the norm-setting and signaling effect of urban disorder and vandalism on additional crime and anti-

social behavior. The theory, first introduced in a 1982 article by social scientists James Q. Wilson and George L. Kelling, states that maintaining and monitoring urban environments in a well-ordered condition will stop further vandalism and escalation into more serious crime.

FPI takes this approach to policing. Unfortunately, many identified instances of fraudulent activity are not prosecuted because the amount of money involved does not reach prosecutorial actionable thresholds. This is a mistake on two levels. It demoralizes law enforcement and it encourages fraudsters to continue and increase their nefarious activities.

FPI offered to institute the broken window approach to policing in its various proposals to states.

5. *You need to reduce the amount of money the Center for Program Integrity and all other CMS anti-fraud units are spending and significantly reduce the staffing you currently have in these units. In addition, you need to terminate all the no-bid contracts you have signed with inexperienced vendors such as the zone program integrity contractors, known as the ZPICs (pronounced ZEE-pix),that know little to nothing about protecting these programs.*

As the OMB audit has demonstrated, over staffing and over spending, does not deliver results. This problem is now ubiquitous within government at all levels. Recent reports of crossed jurisdictional lines of responsibility between the FBI, ATF and Homeland Security illustrate this problem.

Well-designed, experience-based data mining technology will do most of the targeting without significant personnel support. It has been our experience that field investigations, including the generation of avadavats, are best performed by local law enforcement that are supported by training from the various CMS anti-fraud units. Furthermore, if the prosecution conducted in state courts, local district attorneys rather than federal prosecutors are called for going forward. This use of already in place local and state resources negates the need for redundant federal staffing.

By way of reference, FPI offered to address the fraud issue in the Medicaid program for both the states of Texas and California at *no cost* to either program. FPI would not only data mine all of the claims submitted over the previous year but proactively evaluate claim going forward. FPI would also develop a network of experienced retired former law enforcement officials from both the state and federal level with decades of experience in investigating corporate crime.

We asked for two things in return for our efforts. The first, we would take a negotiated percentage of the prevented pay-and-chase funding for our income

and the state would indemnify our investigative efforts in that we could not afford the insurance premiums that would be required. Neither state accepted our proposal but rather chose to do as CMS has done – hire more staff and use connected crony vendors for information system support. This has produced the same bloated spending that produced HealthCare.gov in advance of the enactment of the Affordable Care Act.

To give this point significance, FPI will make the same proposal to the federal government that we have made to the states of California and Texas. Specifically, FPI will clean up the fraud issue for both the Medicare and the Medicaid program within 24-months or less and remain in place to prevent the fraud problem's return. FPI will raise the required development and operation funding from a combination of government and private grants as well as the private investor market to fund the data mining technology infrastructure and develop the integration of data bases described above at both the federal and state levels. FPI will also develop and staff the investigative infrastructure described above that will function under the direction of local, state and federal law enforcement agencies to address the likely malfeasants identified from FPI's database monitoring program.

All of this will be accomplished at *no cost* to the federal or state governments. In return, we will fund our efforts on taxpayer savings that are now being lost to uncollectable pay-and-chase spending. We will also require the various government entities to fully indemnify our investigative work.

Beyond resolving the issue of fraud, this will allow you to reallocate your current government employees back to the private sector where they will enjoy a sense of accomplishment while they regain a productive work environment. In addition, you will strike a major accomplishment for good government by ending your relationship with the crony contracting vendors within the current bureaucracy. This would be a win for both the taxpayers and good government advocates.

6. *You need to go back to Congress and fix the design of the Medicaid Program.*

Medicaid is designed to reward fraudsters. The program is dual funded by the federal and the various state governments. Furthermore, administration of the program is delegated to the state. This design is reasonable to that point. However, here is where the program runs off the track. If fraud is identified, the state administrating the program is obligated to refund any overpayment of the federal funds paid out by the administrator whether any recovery of funding ever occurs. This design flaw killed the CFPB unit referenced above. The unit's success

resulted in federal penalties against the State of California that the state could not afford.

Thus, actually identifying fraud-diverted overpayments represents a penalty for the state. Predictably, no one looks seriously for fraud in Medicaid. They occasionally identify a particularly odious malfeasant, preferably a doctor, and a well-choreographed kabuki follows. The government generates reams of press releases, but in reality, no real attempt is made to protect the program.

If you want to protect the Medicaid program, start by fixing its fundamental design flaw.

7. *You need to understand the different types of criminal enterprises that target Medicare and Medicaid.*

Organized criminal activity is structured based upon the culture and the socioeconomic status of the people they victimize. Addressing fraud detection and prevention requires an understanding of the quite different criminal architectures that infests the various medical entitlement programs.

The major medical entitlement programs fall into three categories: Medicare, Medicaid and the dual eligible program. Each of these programs serves different beneficiary populations, though the population distinction has been blurred a bit by the growth of the dual eligible population. These distinct populations give rise to the unique criminal culture that preys upon each program. The following briefly describes these structures for each of the programs.

Medicare

Fraud in Medicare is mostly a "white collar" criminal activity.

Medicare is a program that is funded by employed individuals. They have paid a lifetime of contributions to the program and generally have a proprietary orientation to this program upon which they depend. Beneficiaries in this program are rarely participants in the various fraud schemes that prey upon the program. Rather, they are generally victims of identity theft. Their identities are stolen through various means whose description would exceed my ability to describe in this letter. Once stolen, these identities are traded on a national and an international market that usually does not cross over into garden-variety consumer identity theft.

Most of the white-collar criminal activity in Medicare is at the cyber level. Syndicates and corporations are involved and the methodology for using stolen identities, money laundering and money management into offshore accounts is highly sophisticated. It demands a law enforcement confrontation that is similar to experienced RICO investigative units. This level of sophistication far exceeds

the health care professional led efforts by CMS with units like the Center for Program Integrity, which you now lead.

Unless you bring the above-described level of sophistication to the law enforcement efforts to address Medicare fraud, protecting the Medicare program is not even remotely feasible.

Medicaid

Fraud in Medicaid is primarily "blue collar" criminal based. It thrives in a culture where the beneficiaries within Medicaid are distinctly different from those in Medicare. The beneficiaries come from a chronically dependent population that has contributed little, if anything, to the programs funding. These beneficiaries generally have no proprietary interest in the program and are frequently active participants in the fraud schemes that infest the program.

It works like this. "Cappers" collect identities used for billing expensive, often non-delivered and non-indicated medical diagnostic and therapeutic procedures. Cappers are identity brokers who collect Medicaid numbers, generally from beneficiaries willing to sell those numbers for a minimal payment. The capper then delivers the beneficiary and their numbers to fraudulent program vendors.

These agents collect Medicaid recipients from impoverished neighborhoods on a daily basis and deliver them on a percapita fee basis to unscrupulous Medicaid mill clinics, laboratories and hospitals for testing and therapy. Once in the system, their identities are purchased in a secondary market by multiple criminal enterprises for billing the Medicaid program indefinitely, even post mortem or during incarceration, for the beneficiary. FPI found a high percentage of fraudulent paid claims in its analysis to have been submitted for individuals with a decease date before the medical claims were submitted. Due to still enforceable confidentiality agreement, I cannot be more specific as to the percentage numbers. This secondary market is heavily oriented toward pharmacies, durable goods, medical transportation and paraprofessional practices.

Addressing Medicaid fraud requires a politically incorrect and unpalatable approach. Once the identity of a Medicaid beneficiary is identified as being on the Medicaid fraud market, that identities use within the system needs to be flagged and payment criteria for service must be enhanced. Thus, the beneficiary number is flagged within the claims processing system for individual claim review and likely pending of payment.

The identified beneficiary's Medicaid number needs to be changed every three months and new identity cards need to be delivered every quarter. These replacement cards should have a different color so that providers billing for

goods and services will know that any claims they submit for these identified beneficiaries will face rigorous scrutiny before any payment is made.

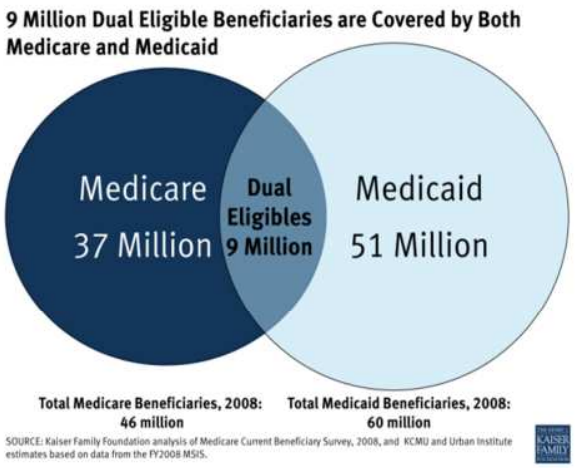
Admittedly, the politics here are terrible. Advocates will claim that individuals requiring health care will be inhibited from receiving needed services. It is similar to the voter registration argument that is now part of the political cacophony we hear every day. However, here is a reality check - you cannot protect the Medicaid program from its 20%+ rate of fraud without this management tool.

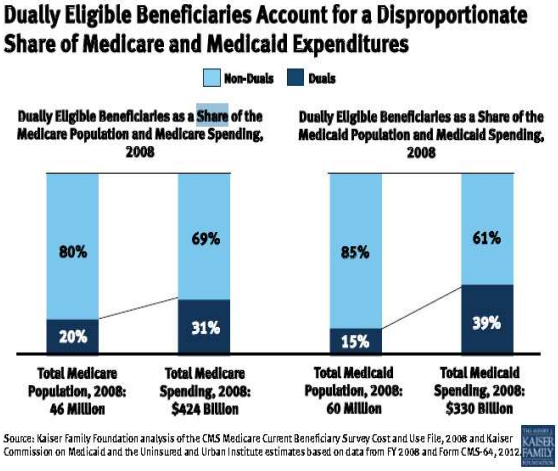
Dual Eligible Medicare/Medicaid

This program serves a third distinct group of medical entitlement program beneficiaries. They have disproportionately lower incomes compared to other Medicare and Medicaid beneficiaries, with 55% of dual eligible beneficiaries having annual incomes below $10,000.

These individuals dually qualify for Medicare and Medicaid. About 9-million people in the United States are covered by both Medicare and Medicaid, including low-income seniors and younger people with disabilities. These dual eligible beneficiaries have complex and generally costly health care needs.

Dual eligible beneficiaries are among the nation's most vulnerable populations. They have a higher prevalence of multiple chronic conditions and correspondingly complex health care needs. As demonstrated in the following graphs, these individuals comprise 15% of all Medicaid enrollees, but account for nearly 40% of all costs. Dual eligible beneficiaries represent 20% of all Medicare beneficiaries, but generate more than 30% of all costs. In 2009, that generated over $250 billion being spent on behalf this group.





The Dual eligible program's design enables beneficiaries to receive medical and social services paid for by both Medicare and Medicaid. The scope of benefits is in excess of either Medicare or Medicaid. Medicare pays for medical services and pharmaceutical products whereas Medicaid pays for beneficiary support including long-term institutional, transportation and in-home support services. These beneficiaries also receive subsidization in paying for Medicare premiums and co-payments.

Thus, this beneficiary population represents a hybrid of cultures described for the Medicare and the Medicaid programs above. Both of the criminal syndicates that are described above target this program. In addition, given the level of complexity and chronicity of the medical problems these individuals manifest, the opportunity to submit expensive claims is magnified within this group of beneficiaries. The combined solutions recommended above for both Medicare and Medicaid apply to this program.

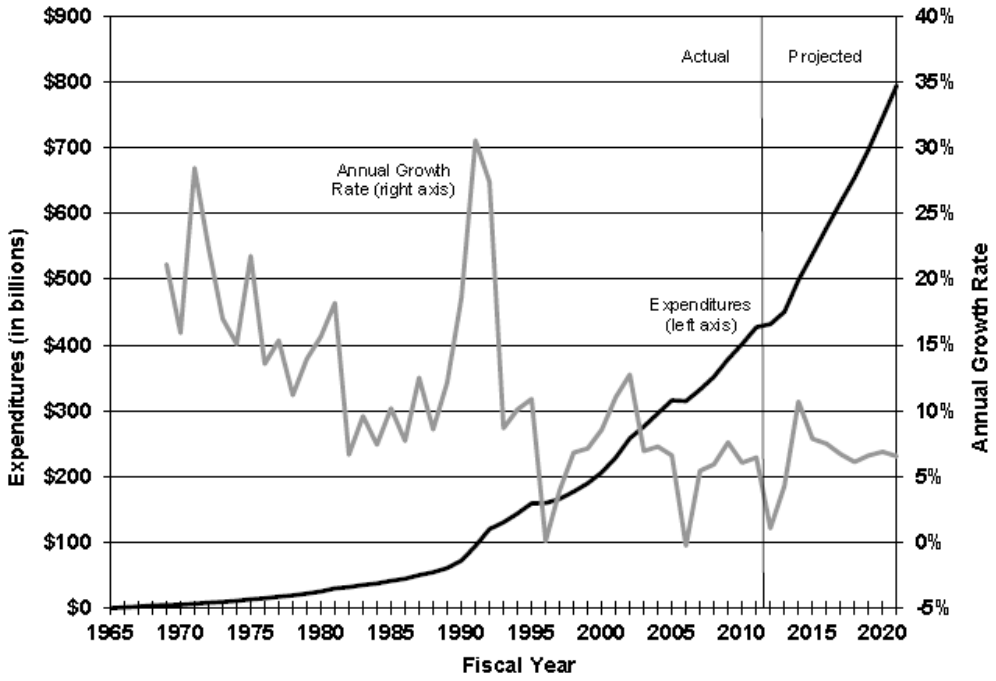
8. *While you are working with policy makers at the federal level on plan design, you also need to work with the various state legislatures to increase the reimbursement rates for providers, particularly in the Medicaid program.*

Politicians all love to expand entitlement programs but lack the courage necessary to adequately fund these programs. The Medicaid program is a classic example. Inadequate funding only attracts and breeds criminal activity. You cannot reduce the reimbursement rate low enough to discourage fraudsters. They just bill for services that they do not deliver. You do however drive honest providers out of the program and eliminate adequate access to the delivery system for the beneficiaries with this behavior.

The funding problem has two aspects. The first is the growth in the size of the beneficiary population. The second is the acuity level of the beneficiaries being enrolled.

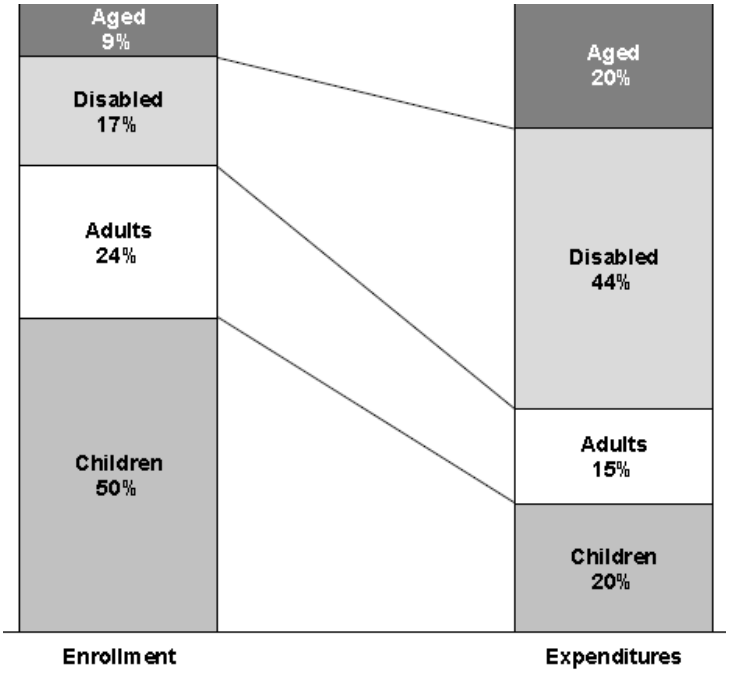
Projections by the CMS Office of the Actuary, predict that the number of Medicaid enrollees will increase by about 18 million in 2021 as a result of the Patient Protection and Affordable Care Act's implementation. The following graph in that report demonstrates the growth and program enrollees while it also shows the growing gap in program funding to cover those new enrollees.

Historical and Projected Medicaid Expenditures and Annual Growth Rates, FY 1966–FY 2021



The acuity level of the participating beneficiaries is illustrated in the following graph, also taken from the CMS Actuary's report. With the growth in the dual eligibility program discussed above, the growth in spending is concentrated on the disabled. Thus, spending for services on the beneficiary population for whom the program was originally designed – pregnant women and children – is being progressively compressed.

Estimated Medicaid Enrollment and Expenditures by Enrollment Group, as Share of Total, Fiscal Year 20111



The following table taken from the 2014 Kaiser average annual growth in Medicaid spending report demonstrates the unpleasant reality facing Medicaid's inadequate funding going forward.

Average Annual Growth in Medicaid Spending

Location	FY 1990-2001	FY 2001-2004	FY 2004-2007	FY 2007-2010	FY 2010-2012
United States	10.9%	9.4%	3.6%	6.8%	3.3%

This pattern of progressively underfunding the services promised is doing profound damage to the health care delivery system in this country. It is the primary source for perverse economic incentives within the system. It drives inflationary trends in the private sector when providers cost shift to make up for Medicaid's funding shortfall. Finally, it is the major breeding ground for criminal syndicate development within our economy. In short, Medicaid is doing more harm than good despite it good intentions.

The policy makers must confront this issue. Otherwise the program is not sustainable and the problem of criminal activity within these entitlement programs cannot be resolved.

9. *Stop making the investigation of billing practices of individual doctors a priority.*

This recommendation is based upon pragmatism not in the defense of unsavory professionals. The reality is that the government rarely prevails in court when it challenges the clinical judgment of a doctor who has ostensibly examined a patient. Cases like Dr. Robert A. Glazer's previously referenced in the *WSJ* article at this letters opening generate sensational headlines but produce limited measurable results. These cases have a high failure rate in court and generate little in the recovery of taxpayer funds.

The primary purpose for investigating individual practitioners is to flip them into generating affidavits against the syndicate and corporate criminals that employ or contract with them. They rarely have a proprietary position in the corporation. We have found that these professionals are uniquely vulnerable to coercion when their licensure status is threatened. They also become reasonably credible prosecution witnesses in court. Otherwise, limited resources are better focused elsewhere.

10. *You need to concentrate on improving the quality of the credentialing and eligibility data for both programs.*

Credentialing of providers

It should be recognized that credentialing of new vendors and providers is not credible within either the Medicare or the Medicaid programs. Furthermore, there is no existing protocol for re-credentialing eligible vendors. These vendor corporations are bought and sold, some by criminal organizations. These acquired businesses are then free to bill Medicare and Medicaid for services under the previously established credential status and use the stolen beneficiary identities to bill for goods and services that are not delivered.

As per protocol, Medicare initially credentials providers and vendors before they are eligible to participate in the Medicaid program. This federal infrastructure is clearly overwhelmed. For example, in the sub-segment of vendors providing durable goods within the Medicare program alone there are now approximately 1.3 million licensed goods suppliers. Nationwide there are 18,000 new applications coming in every month. FPI's data analysis demonstrated that the credentialing process for both vendors and providers has been overwhelmed.

Eligibility file integrity

Furthermore, the eligibility file for beneficiaries, which is the basis for adjudicating and administering claims, is not credible. For example, in FPI's claims analysis on one Medicaid program we found:

- Forty-eight Medicaid beneficiaries were found to have age classifications above the age of 116. One was classified as being 196 years old, one was 155 years old and seven were above the age of 140.
- FPI found implausible listings of male procedures performed on female beneficiaries that were paid for during our analysis period. These included such procedures as removal of testis, drainage of hydrocele, circumcision, biopsy of the prostate, penile injections and cryosurgery for penis lesions.
- Likewise, FPI found an implausible list of female procedures on male beneficiaries that were paid for during the study period. Some of the identified procedures included biopsy of the uterus lining. Post-delivery care, post miscarriage care, cesarean delivery, extraparitioneal colpopexy, division of fallopian tube, examination of vagina, fetal stress tests, insertion of uterine device, removal of uterine device, laparoscopy for tubal block, ligation of ovid ducts, obstetrical care, urine pregnancy test, vaginal examination and repair of vagina.
- Procedures on pre-pubertal girls under 10 years that were paid for during the study period included: care after delivery, cesarean delivery, dilation of the cervical canal, dilation of the vagina, hemenotomy, insertion of an inter-uterine device, obstetrical care, removal fallopian tube, repair of the perineum, and suspension of vagina.

The above examples of "never events" involving paid claims is relevant in that corrupted, out of date eligibility files preclude competent protection and management of both medical entitlement programs.

Conclusion

The bad news - it is simply unacceptable that medical entitlement programs upon which so many of our fellow citizens depend are riddled with preventable fraud now almost half a century since their implementation. These programs will not continue if the tax paying public loses confidence in the competency of CMS and the various state governments to competently manage and protect these programs.

The good news - Medicare and Medicaid fraud is readily preventable. Through the various fraud schemes are relatively sophisticated, they are derived from an old playbook. Furthermore, the criminals preying upon these programs are not particularly

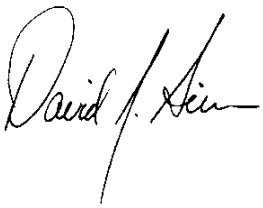
bright or innovative. Experienced law enforcement, using well-designed data mining and cross-mapped databases can readily identify and intervene proactively to prevent funding diversion to fraudulent activity.

Dr. Agrawal, your problems are readily solvable if you will but look outside the CMS bubble in which the Center for Program Integrity operates. You spend too much money and hire too many people to confront funding diversion using poorly designed programs and outdated computer capabilities.

Both Medicare and Medicaid need to have basic health plan "blocking and tackling" administrative initiatives starting with continuous credentialing and re-credentialing of providers and vendors submitting claims to the programs. In addition, given the current level of eligibility inaccuracies, there can be no effective problem resolution without rebuilding the eligibility databases.

Every American has a stake in successfully bringing the protection of these entitlement programs into consistency with existing technology capabilities. You must succeed and do so quickly. My organization stands ready to provide any assistance that we can to assist you in this effort.

Sincerely,



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