MEDICAID FRAUD AND ABUSE DIVISION ANNUAL REPORT

1998-1999

OFFICE OF THE KANSAS
ATTORNEY GENERAL
CARLA J. STOVALL

Annual Report
1998-1999

Purpose

The purpose of the state Medicaid fraud control unit is to deter and eliminate fraud in the State Medicaid Program through a single, identifiable entity of state government that can investigate and prosecute Medicaid providers across the state. The United States Department of Health and Human Services' Office of Inspector General provides funding and works in partnership with each state's Medicaid fraud control unit.

Federal Law defines the responsibilities of the MFCU's

Every MFCU is to:

1. Conduct a statewide program for investigating and prosecuting violations pertaining to fraud in the administration of the Medicaid program or the activities of Medicaid providers;
2. Review complaints alleging abuse or neglect of patients and misappropriations of patients' private funds by programs receiving Medicaid payments; and
3. Maintain staff to include attorneys experienced in investigation or prosecution of civil and/or criminal fraud, auditors experienced in commercial and/or financial records, investigators experienced in commercial and/or financial investigations, and other professional staff knowledgeable about the provision of medical assistance and the operation of health care providers.

Authority for Prosecution

The Kansas Attorney General's Medicaid Fraud and Abuse Division receives its specific authority from the Kansas Medicaid Fraud Control Act ("the Act") - K.S.A. 21-3844 et seq.

> K.S.A. 21-3852. (a) There is hereby created within the office of the attorney general a Medicaid fraud and abuse division.

"(b) The Medicaid fraud and abuse division shall be the same entity to which all cases of suspected Medicaid fraud shall be referred by the department of social and rehabilitation services, or its fiscal agent, for the purpose of investigation, criminal prosecution or referral to the district or county attorney for criminal prosecution.

"(c) In carrying out these responsibilities, the attorney general shall have all the powers necessary to comply with the federal laws and regulations relative to the operation of the Medicaid fraud and abuse division, the power to investigate and criminally prosecute violations of this act, the power to cross-designate assistant United States attorneys as assistant attorneys general, the power to issue, serve or cause to be issued or served subpoenas or other process in aid of investigations and prosecutions, the power to administer oaths and take sworn statements under penalty of perjury, the power to serve and execute in any county, search warrants which relate to investigations authorized by this act, and the powers of a district or county attorney."

Background of the Unit

The Kansas Medicaid Fraud and Abuse Division was established in 1995. Application for certification as a state Medicaid Fraud Control Unit was submitted by Attorney General Carla Stovall and Governor Bill Graves to the United States Department of Health and Human Services in August 1995. The Office of Inspector General certified the Division in October 1995 and has granted continuing certification annually thereafter. Certification establishes that the Division meets the federal requirements set forth at 42 CFR 1007.15.

Staffing

The Division is staffed with a Deputy Attorney General as Director, two Assistant Attorneys General, an Auditor, a Research Analyst, a Chief Investigator, four Fraud Investigators, a Legal Assistant and a Legal Secretary. The staffing brings together a corp of professionals with extensive and complimentary experience that maximize the capabilities of the Division to accomplish its goals of effective and efficient investigation and prosecution. Staff qualifications are listed on page 19.

Interagency Partnerships

Kansas Medicaid Program

The Kansas Medicaid program's budget in state fiscal year 1999 is $1 billion. Medicaid services are delivered to an average of 244,303 persons by 17,925 providers serving Medicaid recipients in 105 counties. On average, the Medicaid program devotes 26 percent of total expenditures to adult care homes and 22 percent to Home and Community Based Waiver services. Seventy-eight and one half percent of expenditures are paid on behalf of recipients who receive Supplemental Security Income or who are either aged or have a disability and have incomes insufficient to meet their medical costs.

Provider Fraud

Partnership between the Kansas Attorney General's Medicaid Fraud and Abuse Division and the Kansas Medicaid agency, the Department of Social and Rehabilitation Services (SRS), is required to ensure that suspected cases of provider fraud are appropriately referred, requests for provider records or computerized data are provided, and assistance in recovery of overpayments is given. The Division has instituted formal working procedures with SRS through a Memorandum of Understanding

that outlines, in detail, the responsibilities of the Medicaid agency and the Division in the referral, review and prosecution of cases.

With realignment of management of long term care reimbursement and HCBS/FE services from SRS to the Kansas Department on Aging (KDOA) in July 1997, coordination processes for referrals from KDOA and its partner agencies, Area Agencies on Agency (AAA) have been instituted.

In addition to the state Medicaid agency as a referral source, the Division receives reports of fraud from federal, state, and local law enforcement agencies, social service agencies, regulatory boards, and the general public.

Effective working relationships with the Medicaid fiscal agent, Blue Cross and Blue Shield, and the Program Integrity Section of SRS, insure that the investigation and prosecution of cases proceed efficiently. Ongoing communication is the key to effective sharing of information that is necessary to open and pursue an investigation and successfully prosecute those cases with substantial potential for criminal prosecution. Such understanding helps to insure that the referrals processed to the Division are appropriate. Creating this understanding continues to be fostered in the following ways:

1. Monthly meetings between Division staff, fiscal agent staff, and Medicaid agency staff;

2. Training sessions presented by the fiscal agent, the Program Integrity Section and various program staff from SRS and KDOA, to Division staff;

3. Training presented by the Division to the fiscal agent and Program Integrity Section, various program staff from SRS and KDOA;

4. Use of a referral form;

5. Individual case consultations; and

6. Collaboration on revising the Medicaid Provider Agreement to incorporate fraud and abuse language.

Abuse/Neglect

Coordination of interagency cooperation in the review of complaints of abuse, neglect and misappropriation of patients' private funds, requires the interaction of three state level agencies: SRS, the Kansas Department of Health and Environment (KDHE), and KDOA. The efforts of these agencies are then integrated into local law enforcement efforts when the matter has been brought to the attention of law enforcement authorities.

The Division is an active member of the Adult Protective Services Executive Task Force. This multi-agency work group is designed to address issues and develop solutions for coordinating referrals, sharing information, developing and advocating for regulatory and statutory tools, and implementing training.

In an effort to develop strategies to address the problem of elder abuse in community settings, the KDOA has provided funding to the Kansas Coalition Against Sexual and Domestic Violence to coordinate an Elder Abuse Council. The mission of the Council is a commitment to the prevention of domestic abuse of Kansas seniors by promoting awareness, providing training, and developing prevention strategies.

Collaboration with law enforcement and prosecutors is a key aspect of the Council's efforts. The Division participates in the Council with a special emphasis on assisting with the development of law enforcement/prosecution/Adult Protective Services interagency agreements, joint training, and the development of legal materials for use in educating professionals and the public.

To further the work at the local level of interagency collaboration on combating adult abuse in community based settings, the Division also is a member of the Topeka Coalition on Adult Abuse. This Coalition was formally created in 1999. The Coalition seeks to develop interagency collaboration among those who provide

services to vulnerable adults in the greater Topeka area and put into practice strategies and procedures to deal with serving abused adults and prosecuting their abusers.

The Division assisted in efforts to educate prosecutors and victims' rights professionals about elder abuse. The Division coordinated the involvement of an elder abuse prosecutor from San Diego in the 1998 Fall Conference of the Kansas County and District Attorneys Association and an elder abuse prosecutor from San Francisco in the Attorney General's 1999 Victim's Rights Conference.

Collaborative Efforts

Case referrals and joint prosecution efforts are an ongoing collaboration between federal and state authorities. The Division's investigative staff routinely works with federal investigative agencies in support of cases involving both Medicaid and other federal health care programs. The Division has received numerous tips from the general public, professionals, and other sources that have resulted in referrals of potentially significant state, regional, and national fraud schemes in a wide variety of provider services.

The Office of the U.S. Attorney for Kansas has developed a special work group consisting of the ACE (Affirmative Civil Enforcement) Unit of that office, the Division, OIG, and designated staff from KDHE, KDOA, and SRS. This work group will focus on the investigation and prosecution of quality of care and health care fraud in long term care.

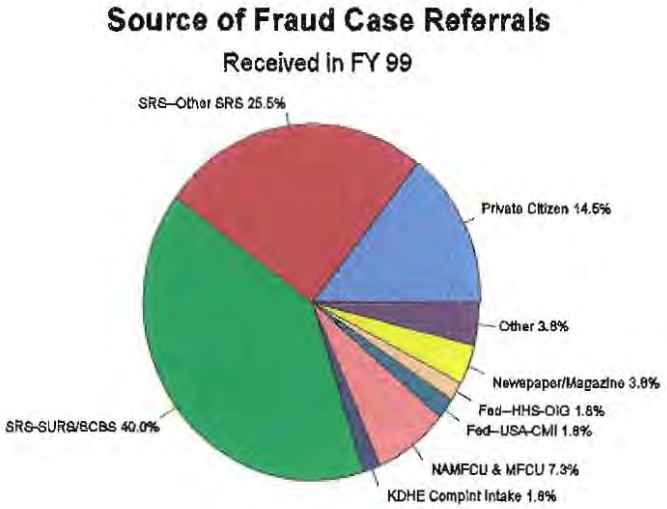
Additional groups with which collaborative efforts have occurred are found in Appendix A.

Medicaid Fraud and Abuse Division Case Activity

Current Case Activity

The cases under investigation by the Division cover a wide range of Medicaid supported services and provider groups. Affected Medicaid recipients are receiving the services in long term care settings, community-based settings, and traditional medical services delivery systems. The cases are located in rural and urban settings spread across the state.

The Division uses an assessment process that is designed to effectively review contacts to efficiently determine those matters which have substantial potential for criminal prosecution. The following chart breaks down the contacts referred to our Division by source type.



The Chief Investigator and Legal Assistant are the front line assessment team. The team efficiently assesses those contacts without substantial potential for criminal prosecution and refers them for appropriate processing. In those contacts needing additional information to determine the potential for full investigation, the skills of the Auditor and Research Analyst are used.

Case Data Information

At the beginning of the reporting period, the Division had 125 cases open representing 16 out of a possible 22 provider categories for which Medicaid will pay for services. Referrals during the period generated 138 additional case openings. Investigative and prosecution activity resulted in 118 cases being closed. By the end of the reporting period, the Division had 145 cases open representing 18 provider categories.

More than 1,342 complaints of abuse/neglect of patients in health care facilities were reviewed from the KDHE complaint database. Seventy-six cases involved serious allegations of abuse/neglect warranting additional investigation. Of these 76, seven have criminal charges filed or pending, 16 are still under investigation and the remaining have been closed. Referrals on closed cases are not necessary because KDHE has already taken action in response to the complaint simultaneous to our review.

The Kansas Medicaid Fraud and Abuse Division referred 11 cases for consideration for investigation/prosecution by other agencies. One case was referred to the U.S. Department of Health and Human Services, nine were referred to SRS, and one was referred to a State Licensing Board.

State Criminal Cases

State of Kansas v. Greg Youvan, 98-CR-60PA: Greg Youvan, a case manager, was to provide case management services to clients for the mental health facility in Parsons, Kansas. The Kansas Medicaid program was then billed for reimbursement for those services. Between August 1996 and January 1997, Youvan either did not provide those services or provided services for a shorter time period than he claimed. Youvan also submitted false expense vouchers for the services.

On February 25, 1998, Youvan was charged with one count of Medicaid Fraud and five counts of Presenting a False Claim. On April 26, 1999, Youvan entered a plea of nolo contendere to one felony count of Medicaid Fraud. The remaining charges were dismissed.

On June 21, 1999, Youvan was sentenced to a term of six months, but was granted probation for a term of 24 months. As a condition of his probation, Youvan was ordered to pay full restitution to the Kansas Medicaid program in the amount of $4,190. Youvan also was ordered to pay restitution to the mental health facility in the amount of $149.50 for false travel vouchers. Finally, Youvan was ordered to pay investigative costs to the State of Kansas in the amount of $3,027.74.

A request has been made to OIG to exclude Youvan from participation in Medicare, Medicaid, and all federal health care programs.

State of Kansas v. William F. Radford, 98-CR-340: William F. Radford, a personal care attendant, provided personal care services to his mother. Radford completed a time sheet purporting to have provided services on April 29 and 30, 1998, when in fact,

he was incarcerated in the Atchison County, Kansas jail on those days. Radford also signed his mother's name to the time sheet without her authorization. Radford submitted the time sheets to a Medicaid billing agency, which, upon learning of his incarceration, prevented the further processing of a claim to the Medicaid program.

On October 6, 1998, Radford was charged with one count of Forgery, a felony, and one count of Attempted Medicaid Fraud, a misdemeanor.

On February 18, 1999, Radford pleaded guilty to one count of Forgery while the Attempted Medicaid Fraud was dismissed.

On March 4, 1999, Radford was sentenced to a term of 10 months, but was granted probation for a term of 24 months.

OIG, file number 6-99-40334-9, has excluded Radford from participation in Medicare, Medicaid, and all federal health care programs for a minimum period of five years.

State of Kansas v. Rosa Lee Perry, 99-CR-13A: Rosa Lee Perry was employed as a licensed practical nurse at a nursing home in Arkansas City, Kansas. On December 26, 1997, Perry threatened an Alzheimer's resident with a pair of scissors and hit the resident because the resident would not cooperate in the removal of a pair of soiled underpants.

On January 14, 1999, Perry was charged with one count of Aggravated Assault, a felony, and one count of misdemeanor battery. Perry had moved to Arizona. Authorities in the Medicaid Fraud Control Unit of the Arizona Attorney General's Office and the Maricopa County Attorney's Office assisted the Kansas Attorney General's Medicaid Fraud and Abuse Division in the arrest and extradition of Perry from Arizona.

On May 24, 1999, Perry pleaded nolo contendere to one count of Criminal Threat, a felony.

On June 28, 1999, the court sentenced Perry to a term of six months, but granted her probation for a term of 24 months. Perry was ordered to complete 100 hours of community service. She also was ordered to reimburse the State of Kansas for extradition costs and expert witness fees in the amount of $2,990.

State of Kansas v. Ellyn Jacobs, 99-CR-484: Ellyn Jacobs was a Home and Community Based Services Personal Care Attendant. Jacobs was to provide personal care attendant services to a Home and Community Based Services recipient in the Kansas City metropolitan area. Between April and August 1997, Jacobs either did not provide those services or provided services for less time than she claimed in time sheets used to bill the Medicaid program.

On February 25, 1999, Ellyn Jacobs was charged with one count of Medicaid Fraud.

On May 14, 1999, Jacobs pleaded guilty to one class A misdemeanor count of Medicaid Fraud in violation of K.S.A. 21-3846(a)(1), (b)(3). She was sentenced on the same date to a 30 day suspended jail sentence and one year of supervised probation. Pursuant to the plea agreement, Jacobs paid full restitution to the State of Kansas' Medicaid program and investigative fees for a total of $8,965.33.

A request has been made to OIG to exclude Jacobs from participation in Medicare, Medicaid, and all federal health care programs.

State of Kansas v. Glenn E. Miller, 99-CR-965: On March 19, 1999, Glenn Miller of Topeka, Kansas, was charged with two felony counts of Medicaid Fraud for allegedly defrauding the Medicaid program of more than $27,000 between July 1997 and December 1998. Miller is a former Medicaid Home and Community Based Services recipient.

Miller allegedly misrepresented the age of a minor, had her sign time sheets claiming she performed personal care attendant services for Miller, and then took the money Medicaid paid based upon his false statements. Miller also is accused of signing time sheets for other personal care attendant services that were not performed and receiving money from Medicaid based upon the false time sheets.

Miller was taken into custody in Tennessee by members of the Tennessee Bureau of Investigation and the Gallatin Police Department and awaits extradition.

State of Kansas v. Deborah R. Ullery, 99-CR-966: Deborah Ullery is charged with one count of Medicaid Fraud in the Shawnee County District Court in Topeka, Kansas. Ullery allegedly claimed she provided personal care attendant services to Glenn Miller, a former Medicaid Home and Community Based Services recipient. Miller is charged in a separate case with two felony counts of Medicaid Fraud.

The criminal complaint against Ullery alleges that between May and July, 1998, she signed time sheets claiming payment for services that she did not provide. Ullery is charged with defrauding the Medicaid program of more than $4,000.

Trial is set for September 20, 1999.

State of Kansas v. Paul Jeffery Wright, D.D.S., Chartered, 99-CR-1472, Dr. Paul J. Wright, D.D.S., 99-CR-1473 and Janet Wright, 99-CR-1474: Dr. Paul J. Wright, D.D.S., Janet Wright and Dr. Wright's corporation were charged with one count each of Medicaid Fraud in Sedgwick County District Court in Wichita, Kansas, on Monday, May 24, 1999. According to the criminal complaint, between July 1996 and February 1998, the three defendants filed fraudulent claims with the Kansas Medicaid program for services that were not provided and for services that Dr. Wright alleges he provided when, in fact, another dentist provided them.

The case is scheduled for preliminary hearing in Sedgwick County District Court on September 2, 1999.

Local Prosecutions

As a result of cooperative work with local law enforcement and prosecutors, the Division has supported the effort to achieve an increase in prosecution of adult abuse, neglect, and exploitation. The following cases reflect the outcome of such collaborative efforts:

- In Johnson County, Kansas, in the Kansas City metropolitan area, a social services worker was charged with one count of felony theft for embezzling more than $1,000 from the resident trust fund account. The defendant pleaded guilty to felony theft and was sentenced to a six month imprisonment, but was granted probation for a term of 24 months.

  A request has been made to OIG to exclude participation in Medicare, Medicaid, and all federal health care programs.

- In Geary County, Kansas, in the central part of the state, a licensed practical nurse at a nursing home pleaded nolo contendere to two misdemeanor counts of Obtaining a Prescription-Only Drug by Fraudulent Means. The charge was the result of her ordering 1,500 dosage units of pain

medication for three residents and converting the medication to her personal use. The defendant was sentenced to six months in the county jail on each count, to run concurrently, but was granted probation for two years. She also was ordered to pay restitution to the Kansas Medicaid program in the amount of $835.89.

OIG, file number 6-99-40189-9, has excluded participation in Medicare, Medicaid, and all federal health care programs for a minimum period of five years.

- In Johnson County, Kansas, a defendant was charged and convicted of Mistreatment of a Dependent Adult. The defendant was one of a few persons in the State of Kansas who was charged and convicted under the criminal statute designed to prosecute elder abuse. In a case of first impression, the defendant appealed her conviction challenging the constitutionality of the statute. The Kansas Court of Appeals affirmed the conviction and upheld the constitutionality of the statute, but issued an opinion not designated for publication. The Division filed a Motion to Publish the opinion arguing the case established an important precedent. The motion is pending.

Federal Cases

In the District of Kansas in Wichita, Kansas, a pathologist agreed to pay $75,000 to settle allegations he submitted false claims to the Kansas Medicaid program misrepresenting the services he performed. The settlement was the result of a joint investigative effort between the Kansas Attorney General's office and the Affirmative Civil Enforcement Unit of the United States Attorney's office for the District of Kansas.

Global Settlements

The Division is participating in multi-jurisdictional cases described as global cases. These cases are reflective of the complexity of

health care fraud. They are complex multi-party, multi-state and multi-issue cases which are most effectively investigated and prosecuted through the team efforts of Medicaid Fraud Divisions acting cooperatively across the country.

The cases arise because of fraudulent conduct by a provider initially discovered and investigated by another state Medicaid Fraud Division or federal investigative agency. The investigations establish that the fraudulent conduct has resulted in losses to Medicaid programs in many or all states.

Currently, the Division is participating in seven separate global cases; the Chief Investigator is a member of the settlement team for one of these ongoing cases.

Case Activity Projections

As discussed in the 1997-98 Annual Report, the impact of the growth in Medicaid services delivered in community based settings was seen in the work of the Division during this reporting period. The fraud schemes prosecuted reflect the opportunities that exist when services are delivered by one entity, billings are submitted by another entity, and oversight is delivered by a variety of private and public entities.

Because of the volume of referrals of fraud in HCBS waiver programs coming into the Division, efforts are being made to work with the KDOA and various commisions within SRS to manage this area of service delivery that appears to be so vulnerable to abuse. Work will focus on developing mechanisms to manage more effective oversight of self directed care by HCBS recipients, to implement procedures to administratively manage cases reflective of program abuse rather than intentional criminal fraud, and to implement procedures and policies that will more clearly establish provider responsibilities.

The Division's goal in the coming year is to effectively use investigative and prosecutor time in those cases that will have an

impact in deterring abusive practices that are prevalent in HCBS and a range of other provider areas presently under investigation, and in prosecuting cases of abuse to insure that justice is achieved for the victims of such abuse, and that through OIG exclusion other vulnerable persons are safe from future acts of abuse.

Training

The Division has committed itself to providing staff the opportunity to experience a wide variety of training targeted to educating them on the basics of health care fraud and the skills and techniques needed to understand and anticipate the changes that are happening in the field of investigation and prosecution, as well as the health care economy and public sector health care programs.

Advanced computer-related training continues to be emphasized during this reporting period. Experience in the development of advance data analysis of evidence and computer data seizure have provided both opportunities and the necessity to seek out appropriate training that will help Division staff develop their existing skills and build new skills that will best serve the unit.

The Division collaborated with the National White Collar Crime Center to sponsor CyberCop 101, a training designed to educate law enforcement and prosecutors in the technical and legal aspects of computer crime, computer seizure and the use of computer evidence in criminal cases.

The Chief Investigator's extensive experience in white collar crime investigation has been shared as a trainer through the National Association of Medicaid Fraud Control Units Advanced Investigations training and Annual Training Conference. Investigative, audit, and legal staff participated as trainees in the Advanced Investigations training allowing them the opportunity to experience the use of their investigative and trial skills among their peers from other MFCUs.

Public Awareness

The Kansas Medicaid Fraud and Abuse Division is dedicated to providing education to the public and Medicaid providers about the Kansas Medicaid program, state and national health care fraud issues and specific provider-oriented education. The Division educates legal and health care professionals, state workers, and the general public on the content and purpose of the Kansas Medicaid Fraud Control Act, health care fraud, and abuse, neglect, and exploitation.

The Division also supports the commitment of the Office of the Attorney General to educate the public about law enforcement and criminal prosecution as a career and about the role of law enforcement and criminal prosecution in the community.

The Division became a part of the World Wide Web when the Internet web site for the Office of the Kansas Attorney General went online during the reporting period. The Division's section of the website provides a variety of information including Division Annual Reports, news releases on Division activities, information on health care fraud and adult abuse, and links to other sites of interest. The web site is located at http:\\www.ink.org\public\ksag.

A table outlining presentations made by the Kansas Medicaid Fraud and Abuse Division is contained in Appendix B.

News Articles

Kansas Attorney General Carla Stovall has made a commitment to fight health care fraud and criminal abuse, neglect and exploitation of vulnerable persons. The news articles contained in Appendix C demonstrate the success Attorney General Stovall has had in these endeavors.

Policy and Procedure Manual

The Kansas Medicaid Fraud and Abuse Division has developed policies and procedures to use in the accomplishment of Division responsibilities. The topics covered address investigative and prosecution procedures, as well as office procedures. The Manual is a working document that is changed to reflect the need for guidance and procedures adequate to assist in the accomplishments of the tasks of the Division.

Federal Performance Standards

The Kansas Medicaid Fraud and Abuse Division is required to comply with federal performance standards. The standards are used by the United States Department of Health and Human Services, Office of Inspector General, to recertify a Division and to assess its effectiveness during on-site reviews. Each section of this Annual Report is in response to specific performance standards. The Annual Report demonstrates that the Kansas Medicaid Fraud and Abuse Division has met the performance standards.

1. A Unit will be in conformance with all applicable statutes, regulations and policy directives.
2. A Unit should maintain staff levels in accordance with staffing allocations approved in its budget.
3. A Unit should establish policies and procedures for its operations, and maintain appropriate systems for case management and case tracking.
4. A Unit should take steps to ensure that it maintains an adequate workload through referrals from the single State agency and other sources.
5. A Unit's case mix, when possible, should cover all significant provider types.
6. A Unit should have a continuous case flow, and cases should be completed in a reasonable time.

7. A Unit should have a process for monitoring the outcome of cases.
8. A Unit will cooperate with the OIG and other Federal agencies, whenever appropriate and consistent with its mission, in the investigation and prosecution of health care fraud.
9. A Unit should make statutory or programmatic recommendations, when necessary, to the state government.
10. A Unit should periodically review its Memorandum of Understanding (MOU) with the single State Medicaid agency and seek amendments, as necessary, to ensure it reflects current law practice.
11. A Unit director should exercise proper fiscal control over the Unit resources.
12. A Unit should maintain an annual training plan for all professional disciplines.

Staff Qualifications

The **Deputy Attorney General** brings direct experience in the administration of public benefits programs with specific expertise in Medicaid, home and community based services, and elder law, as well as long-term working relationships with local, state, and federal governmental entities and private organizations that serve Medicaid recipients.

The **Assistant Attorneys General** are experienced criminal prosecutors with backgrounds in all aspects of prosecution at the state level.

The **Chief Investigator** brings extensive white collar crime investigative experience from his 25 year career in the federal investigative services of the United States Postal Inspection Service and the Office of Criminal Investigations of the Food and Drug Administration.

The **Auditor** brings a background in law and accounting with direct experience in medical reimbursement in the private insurance sector and a private hospital setting.

The **Fraud Investigators** bring direct experience in nursing in the private sector, regulation and oversight of medical providers at the state level, and extensive criminal investigation experience at the local and state levels involving both crimes against persons and property/financial crimes.

The **Research Analyst** has significant and varied experience in data analysis of health care claims processing in private insurance, Medicaid, and Medicare. She brings specific experience in the use of the claims processing system of the Medicaid fiscal agent for Kansas.

The **Legal Assistant** has direct experience in supporting attorneys in the management of cases involving financial and business transactions.

The **Legal Secretary** has extensive experience working with legal professionals in a large firm setting and certification as a legal assistant.

Appendix A

COOPERATIVE MEETINGS	
Organizations	Purpose and content of meetings
Blue Cross/Blue Shield (Kansas Medicare Carrier and Medicaid Fiscal Agent) - Medicare Fraud Unit, Medicaid Utilization Management Unit and SRS Program Integrity	Monthly information sharing and coordination on fraud referrals, investigations, and prosecutions
Kansas Foundation for Medical Care, BC/BS and SRS Program Integrity	Periodic meetings of quality assurance and utilization measurement efforts
Blue Cross Blue Shield Provider Enrollment and Utilization Management, and SRS Interagency Agreement and Provider Enrollment Section	Information sharing and coordination on case related work efforts
SRS Area Customer Service Representatives	Discuss duties of Medicaid Fraud and Abuse Division and the cooperation needed from SRS Area Offices in processing fraud referrals, investigating and prosecuting cases.
SRS Commission on Mental Health and Developmental Disabilities - Management Staff	Discuss duties of MFCU Division and coordination of referrals, providing information to support investigation and prosecution of cases of provider fraud and client abuse, neglect, misappropriation of client private funds
SRS Adult Protective Services Executive Task Force	Multi-agency task force to address issues and develop solutions related to the prevention of abuse, neglect and exploitation of vulnerable adults
NAMFCU	Director is a member of Patient Abuse Work Group, Training Committee, and is NAMFCU representative to HFCA TAG. Chief Investigator is a member of global settlement team.

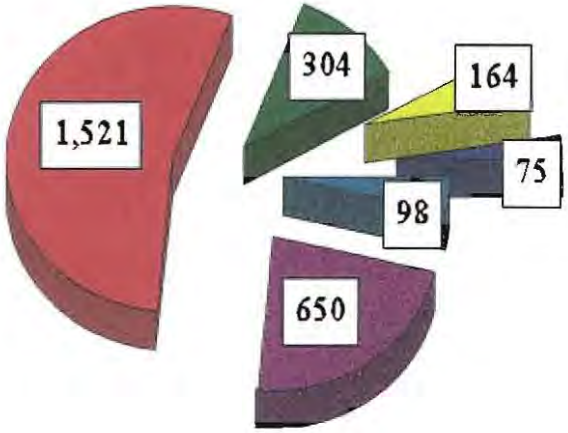
COOPERATIVE MEETINGS	
Organizations	Purpose and content of meetings
SRS Program Integrity Unit	Monthly meetings on coordination of referral, investigation, and prosecution of provider fraud
Criminal Justice Work Group - Office of the Kanas Attorney General	Coordination of efforts on investigations and prosecutions; training development and implementation for law enforcement personnel and prosecutors
Kansas County and District Attorneys Association	Assistance with development and implementation of training for law enforcement personnel and prosecutors on abuse, neglect, and misappropriation of client private funds
Kansas Health Care Fraud Working Group Nursing Home Fraud Task Force	Coordination on referral, investigation, and prosecution at state and federal level of Medicaid and federal health care program fraud
HFCA	TAG on Medicaid Fraud and Abuse
SRS Adult and Medical Services KDOA SRS MH/DD	HCBS/DD waiver, HCBS/Physically disabled waiver and HCBS/FE waiver procedures and policies
Washburn University Legal Assistant Advisory Board	Input and consultation on Legal Assistant Program effectiveness in serving legal community
Kansas State Board of Healing Arts general counsel	Coordination of referrals to Board by Medicaid Fraud and Abuse Division and Board coordination of OIG exclusion activities
Kansas Board of Pharmacy	Coordination of referrals to Board by Medicaid Fraud and Abuse Division and Board coordination of OIG exclusion activities
Kansas Board of Nursing	Coordination of referrals to Board by Medicaid Fraud and Abuse Division and Board coordination of OIG exclusion activities
Midwest Region State Medicaid program integrity staff - MFCU Staff, HCFA staff and Malcolm Sparrow	Analysis of fraud trends and state based efforts to respond

COOPERATIVE MEETINGS	
KDHE staff, LTC Ombudsman, adult care home administrators and directors of nursing	Develop guideline for prevention and reporting of neglect in adult care homes
SRS Health Programs Advisory Group	Analysis of and discussion related to issues of fraud and abuse in home and community based services
Kansas Coalition against Sexual and Domestic Violence, KDOA, SRS, Legal Aid, Topeka Police Department, LTC Ombudsman, VA	Prevention of domestic abuse of Kansas seniors by promoting awareness, training and developing prevention strategies

Appendix B

Presentation Attendees

July 1998 - June 1999: 2,812



- BCBS/SRS/Aging/Medicare
- Law Enforcement/Attorneys
- Public Groups
- Medical Professionals
- Students
- Community Based Care

Presentations

Date of Presentation	Topic	Presenter	Sponsors	Location	Attendees	Approx. Attendance
July 16, 1998	Role of Medicaid Fraud and Abuse Division in protecting victims of adult abuse, neglect and exploitation	Ron Scheid	National Victim Assistance Academy	Topeka	Victim witness program professional staff	50
July 24, 1998	Privacy issues in computer searches and seizures	Michael Russell	National White Collar Crime Center	Topeka	Law enforcement and prosecutors	24
August 20, 1998	Criminal Prosecution of abuse, neglect and exploitation	Martha Hodgesmith	SRS Adult and Medical Services	Larned	SRS Adult Protective Services Supervisors	20
August 25, 1998	Abuse, neglect and exploitation	Martha Hodgesmith	Community Developmental Disabilities Organizations	Hays	Providers of community developmental disabilities services	70
September 10, 1998	Abuse, neglect and exploitation	Attorney General Stovall, Martha Hodgesmith	Kansas Professional Nursing Home Administrators Association	Hutchinson	Nursing home administrators/ nursing home professionals	161
September 30, 1998	HCBS Fraud	Ron Scheid	Wichita Area SRS Office	Wichita	ILC Counselors	20

Presentations

Date of Presentation	Topic	Presenter	Sponsors	Location	Attendees	Approx. Attendance
October 8, 1998	Non-violence in school	Bob Swafford	American Association of School Administrators and American Federation of Teachers	Pleasant Ridge High School, Topeka	High School Students	250
October 8, 1998	Medicaid fraud and abuse	Martha Hodgesmith	SRS Customer Relations	Topeka	SRS customer relations representatives	15
October 8, 1998	Medicaid fraud	Ron Scheid	Kansas Division International Association for Identification	Topeka	Law enforcement identification professionals and criminal justice students	40
October 15, 1998	Adult abuse/neglect/ exploitation reporting statute	Martha Hodgesmith	Kansas Trust Conference/Kansas Bankers Association	Manhattan	Trust officers/trust department staff	30
October 18, 1998	Nursing Home Investigation	Phil McManigal and Ron Scheid	State Organization for Crime Scene Investigators and Lab Technicians	Topeka	Crime Scene Investigators and Lab Technicians	50
October 21, 1998	Help neighborhoods take back their neighborhoods	Phil McManigal	Holton Turnaround Team	Trails Café in Holton	Residents, city officials and community improvement program leaders	24

Presentations

Date of Presentation	Topic	Presenter	Sponsors	Location	Attendees	Approx. Attendance
November 5, 1998	Health care fraud	Martha Hodgesmith	Office of Kansas Long-Term Care Ombudsman	Topeka	Staff and volunteers of Office of Long-Term Care Ombudsman	28
November 6, 1998	Health care fraud state prosecution	Martha Hodgesmith	University of Kansas Health Services Department	Overland Park	Graduate students	50
November 12, 1998	Delivering quality health care	Attorney General Carla Stovall	Kansas Hospital Association	Topeka	Hospital administrators and managers	700
November 12, 1998	Working with the Medicaid Fraud and Abuse Division - Complaint Referrals	Ron Scheid	SRS Medical Services and Blue Cross/Blue Shield	Topeka	Regional Medicaid liasons	20
November 22, 1998	Careers in the Law	Martha Hodgesmith	Kaw Valley Girl Scouts	Topeka	Teenage girls	40
January 19, 1999	State and federal focus on protecting senior adults	Martha Hodgesmith	Kansas Health Care Association and Kansas Association of Homes and Services for the Aging	Topeka	Nursing home professionals	300
February 12, 1999	Corporate Compliance	Martha Hodgesmith	University of Kansas Health Services Department	Overland Park	Graduate students	50
February 17, 1999	Health care fraud	Martha Hodgesmith	Kansas Insurance Commission	Overland Park	Insurance professionals	30

Presentations

Date of Presentation	Topic	Presenter	Sponsors	Location	Attendees	Approx. Atten-dance
February 23-24, 1999	Computer Voice Stress Analyzer	Phil McManigal	Unified School Districts #335, 336 and 337	Holton	Junior High Students	300
March 25, 1999	Law Enforcement's Perspective of Today's Society	Phil McManigal	Jackson County Development Corporation	Holton	Local business people	15
April 12, 1999	Protecting your Independence and Well Being Tools to avoid Exploitation	Martha Hodgesmith	Kansas Women's Health Initiative	Wichita	Public health nurses	230
April 29, 1999	Fraud & Abuse Investigative Process Analysis	Martha Hodgesmith	Kansas Health Information Management Association	Salina	Medical records and coding professionals	130
May 13, 1999	Medicaid Fraud & Abuse	Ron Scheid and Curt Landis	Kansas Health Care Information Society	Wichita	Information technology specialists	55
May 25, 1999	Search Warrant Planning and Execution	Ron Scheid	NAMFCU	Minneapolis	MFCU attorneys, investigators and auditors	50
June 21, 1999	Role of Medicaid Fraud and Abuse Division in protecting victims of adult abuse, neglect and exploitation	Martha Hodgesmith	National Victim Assistance Academy	Topeka	Victim witness program professional staff	60

Appendix C

Such A Crime

Nursing home resident's death questioned

Nurse faces assault, battery charges

State accuses dentist of Medicaid fraud

Topeka man arrested in Tennessee for Medicaid fraud

An Overland Park woman who worked as a personal care attendant in Lenexa has been charged with Medicaid fraud.

Radford accused of Medicaid fraud

Nursing home resident's death questioned

■ Nurse accuses a McPherson nursing home of covering up the death of a resident who'd been tied in bed.

By Dave Ranney
The Wichita Eagle

A nurse has accused a McPherson nursing home of lying to state officials about events leading up to a resident's death last year.

Vicki Unruh, a former licensed practical nurse at Highland Manor, said she discovered 68-year-old Juanita Baer entangled in a cloth restraint used to tie her in bed about 4:45 a.m. on Nov. 1, 1997. Baer, who Unruh said suffered from Alzheimer's disease, died shortly after she was found.

State law prohibits residents from being tied in their beds without their doctors' permission.

In a lawsuit filed last week in McPherson County District Court, Unruh said that Baer's doctor had not ordered the restraint and that she was unaware Baer had been tied in bed.

Unruh said that when she called the nursing home's medical records administrator, Jo Colgin, to report the death, she was told not to record the incident in Baer's medical file until she talked to Tracy Smith, the home's director of nursing. Unruh said she was specifically told not to say anything about Baer's being tied in bed.

Both Smith and the home's administrator, Larry Booth, were out of town.

Unruh said she disregarded Colgin's instructions and filled out a report on Baer's death, placed it in a manila folder, slid it under the medical records administrator's locked door and went home. The next day, a Monday, she reported the incident to the Kansas Department of Health and Environment, the state Department on Aging and the state Board of Nursing.

According to Unruh, Smith called her Monday evening to say he could not find her report. During the conversation, Unruh said, she told Smith that she had already reported Baer's death to state officials and he said, "That was your biggest mistake," and hung up.

Unruh said she was fired the next day. Since then, she said, Highland Manor officials have claimed she destroyed records and have tried to pin Baer's death on her.

Unruh is seeking more than $375,000 in actual and punitive damages.

Don Brown, a spokesman for KDHE, said Baer's death is the subject of an investigation by the Kansas Bureau of Investigation.

"Back when this happened, we started an investigation," Brown said. "But before we got very far, the KBI asked us to hold up on our investigation until they completed theirs."

Becky Sable, a spokeswoman for Kansas Attorney General Carla Stovall's office, confirmed that Baer's death is part of a KBI investigation of Highland Manor. She declined further comment.

Highland Manor is one of several nursing homes owned by MedAmerica, a Chicago-based corporation. The home is managed by Mid America Health Centers Inc. of Wichita.

Paul Wurth, Mid-America's chief executive, said he had not seen a copy of Unruh's lawsuit.

"Until I've seen it, there's not much I can say," he said. "But from what I've heard, it's not consistent with our findings, and we will vigorously fight the allegations being made."

Mid-America manages seven nursing homes in Kansas.

Dave Ranney can be reached at 268-6514 or via e-mail at dranney@wichitaeagle.com.

Radford accused of Medicaid fraud

Attorney General Carla J. Stovall announced that criminal charges involving Medicaid Provider Fraud were filed against William Radford of Horton.

He is charged with one count of Forgery and one count of Attempted Medicaid Provider Fraud in Pottawatomie County.

The charges are the result of a five-month investigation of Radford by Attorney General Stovall's Medicaid Fraud and Abuse Division.

Attorney General Stovall said Radford was to provide personal care attendant services supported by the Medicaid Home and Community Based Services program.

The criminal complaint alleges that Radford completed a time sheet purporting to have provided services on April 29 and 30, 1998, when in fact he was incarcerated in the Atchison County Jail on those days.

The criminal complaint also alleges that Radford signed the Medicaid recipient's name to the time sheet without her authorization. Radford submitted the time sheets to a Medicaid billing agency, which, upon learning of his incarceration, prevented the further processing of a claim to the Medicaid program.

The charges were filed Oct. 6, 1998. Radford was booked into the Pottawatomie County Jail on Oct. 26, 1998. His bond is set at $2,500. The date for Radford's preliminary hearing is pending.

The charges are merely accusations and the defendant is presumed innocent until and unless proven guilty.

Nurse faces assault, battery charges

By The Traveler

A former Arkansas City woman has been charged with one count of aggravated assault and one count of battery in connection with incidents that took place at an Ark City nursing home Dec. 26, 1997.

The charges were filed in District Court in Ark City Jan. 14 against Rosa Lee Perry, 53, by Kansas Attorney General Carla Stovall, and are the result of an investigation by Stovall's Medicaid Fraud and Abuse divisions.

The criminal complaint alleges that Perry, a licensed practical nurse, threatened a nursing home resident with a pair of scissors and hit the resident.

Authorities in the Arizona Attorney General's Office, the Maricopa County Sheriff's Office and the Maricopa County Attorney's Office assisted Stovall's office in the arrest and extradition of Perry from Arizona.

She was returned to Kansas and was booked into the Cowley County jail on Jan. 20. Perry made her first appearance in District Court Jan. 21 and is to appear again at 9 a.m. Thursday. She is free on $3,750 bond. Assistant Attorney General Michael Russell is handling the case for Stovall.

Metropolitan digest

Date: 03/04/99 22:28

An Overland Park woman who worked as a personal care attendant in Lenexa has been charged with Medicaid fraud.

Ellyn Gail Jacobs, 35, was charged in Johnson County District Court with one felony count. She was booked into the county jail Wednesday and released after posting a $2,000 bond.

The Kansas attorney general's office filed the charge last week alleging that Jacobs falsified claims for services provided between April and August 1997. Her first court appearance is scheduled for March 12.

Topeka man arrested in Tennessee for Medicaid fraud

By KEVIN BATES
The Capital-Journal

Glenn Miller once had been thought to be connected to a baby abandonment in Topeka.

A man previously wanted for questioning in connection with the abandonment last month of a baby in Shawnee County was arrested in Tennessee for Medicaid fraud, authorities said Monday.

Glenn Miller, 52, was arrested in Gallatin, Tenn., by local police and agents with the Tennessee Bureau of Investigation, according to a news release from Kansas Attorney General Carla Stovall's office.

The attorney general's office filed charges March 19 alleging that Miller misrepresented the age of a juvenile and claimed she had acted as a personal care attendant for Miller, the release said.

The two fraud counts came at about the same time that Shawnee County Sheriff's deteetives determined that Miller's 17-year-old daughter, Daisy Kay Thompson, wasn't the mother of the baby left Feb. 10 on the doorstep of a southwest Shawnee County home.

Detectives had searched for Miller and Thompson for more than a month before new information from Tennessee surfaced, which Detective Tim Byers said ruled out Thompson as the mother.

Miller is accused of stealing more than $27,000 from the Medicaid program between July 1997 and December 1998 by having the girl sign fabricated time sheets that were filed with Medicaid and then reimbursed, the release said.

Shawnee County detectives said previously that Miller may be disabled.

A spokeswoman for the attorney general's office wouldn't confirm whether the juvenile identified in the news release is Daisy Thompson.

A Topeka woman also was arrested for defrauding Medicaid of more than $3,000 by claiming to have provided personal care for Miller. Deborah Ullery, 35, was charged with signing false time sheets, later reimbursed by Medicaid, between May and July of 1998, according to the release.

Ullery remained in the Shawnee County Jail Monday night on $3,000 bond.

Miller was arrested Thursday on a fugitive from justice warrant from Shawnee County, said Susan Morrow, Gallatin police detective. He remained in jail Monday awaiting extradition.

WICHITA

State accuses dentist of Medicaid fraud

A Wichita dentist faces accusations of Medicaid fraud from the Kansas Attorney General Carla Stovall's office, court records show.

A state prosecutor filed the one misdemeanor charge Monday in Sedgwick County District Court against dentist Paul J. Wright, his wife, Janet Wright, and his business. The Wrights were issued summonses to appear in court June 14.

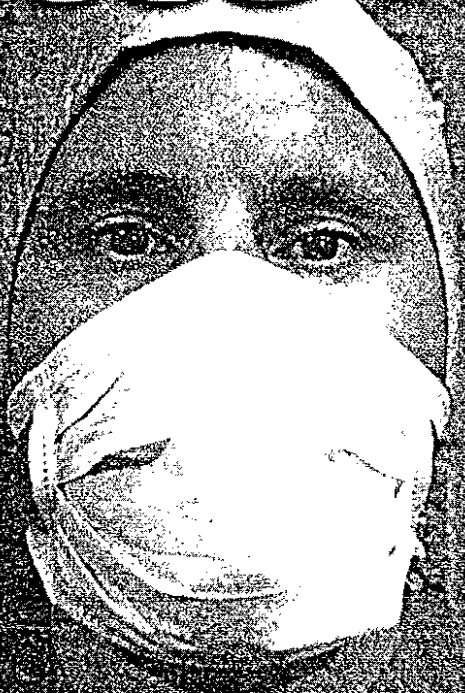
The charges allege that the defendants billed the state for services that did not occur or for those performed by another dentist.

The case was investigated by Stovall's Medicaid Fraud and Abuse division.

Clerical error: "filed the one felony charge"

SPECIAL REPORT: *Health Care* > TOP 10 LIST: *Mental Health Facilities*

Johnson County Business Times



Such A Crime

Conspiracy case against two Johnson County doctors is giving hospital administrators the shock treatment.

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March 31 – April 6, 1999 *Vol. 6, No. 13* $1.50

Continued from previous page

break on the rent. But this could be seen as a way to buy off the doctors. Thus, to avoid any appearance of mischief, the reappraisal brings the rent back in line with comparable market rates.

This also means many of the same things that are viewed as savvy business practices in any other industry could be viewed as a kickback where Medicare regulations are concerned.

"There are a lot of things that are counterintuitive about the Medicare program," Blake says.

MANY HEALTH CARE insiders say the language, and the massive rules and regulations of Medicare laws has them jumping through hoops all the time. Health care execs argue it's a system that invites mistakes.

They say the circus started when Congress began tinkering with the Medicare laws in 1977 by making it illegal to pay or solicit any form of remuneration for referring Medicare patients.

One of the subsequent results has been the development of separate massive coding systems for each aspect of the health care industry from doctors to hospitals to suppliers.

In addition, health care entities can no longer do some of the things that are common practice in other industries. For instance, health care administrators have even put a halt to giving common employee benefits, such as waiving copayments or deductibles, Blake says, because the practice sent a red flag to investigators.

"But it was customary for a long time," she says.

Blake says taking steps to comply with Medicare does not guarantee an action will not be brought. But, she says attempts to comply with the law, like correcting an ongoing coding mistake, can in themselves send a red flag to Medicare regulators.

Suppose a wheelchair vendor discovers a billing error. The vendor alerts regulators of the mistake. The mistake is corrected, but Medicare regulators may then send the information on to the Department of Justice — which means the information could trigger an investigation.

Blake says the situation has her clients asking, "What am I paying you for?"

From the government's side, the coding system used for the public programs are necessary.

"Medicare and Medicaid, from a billing perspective, are another form of insurance," says Martha Hodgesmith, deputy attorney general for the state of Kansas Fraud and Abuse Division.

Hodgesmith concedes coding and billing regulations for providers are complex.

"But the goal is to get accurate documentation so you get accurate payments," she says.

Regulations appear to be stacked against health care providers. But the Department of Health and Human Services Office of the Inspector General, Hodgesmith says, is trying to counter the perception by offering a voluntary program to clear up past coding and billing mistakes. Theoretically, the "Provider Self Disclosure Protocol" is intended to ease providers' minds when they discover errors.

JURT FILE PHOTO

UNDER THE MICROSCOPE: Johnson County doctor Ro LaHue, along with his brother Robert LaHue, is facin criminal charges of Medicare fraud. "I don't recommend to anybody," he says.

ORIGINAL CHARGES against the lawyers involved with the LaHues and hospitals were dropped. Blake says this brought a "collective sigh of relief" among area health care attorneys.

Blake says the case sends a message to the legal and health care communities the government will be active in Medicare criminal statutes.

"It has caused everyone to look at these rules, take them seriously and be more conservative," Blake says.

And while the case came down with a fury in the health care industry, Blake says between the tinkering of the laws by Congress, added funding for health care investigation and the Department of Justice making Medicare fraud a priority, the writing was on the wall for quite some time regarding the government's vigilance in pursuing fraud investigations.

Blake says one of the ways these factors translates into her practice is where clients previously would come to her to draft a document, they are now asking if a business deal will fit into the "safe harbor" regions of Medicare law.

She says Medicare regulations have created a situation where it's real eas not to know what the right answer is

Blake says health care attorneys se a lot of gray areas, but the governme sees black and white.

However, Blake says the magnit of the regulations goes too far.

"It ties providers' hands to the pl where services are not being provide she says.

Blake says Medicare regulat would be wise to get out of the litiga mode when complaints arise agai providers. She says it's often mu more reasonable to go to an ombud man to settle disputes.

THE ORDEAL WILL not be over for t LaHue brothers, even when this tr ends. Additional charges of allege fraud against both doctors are sche uled to go to trial April 6. This include one charge of witness tamper against Robert LaHue.

Bruce Houdeck, sole practitioner Bruce C. Houdek, P.C. in Kansas C Mo., is Robert LaHue's attorney. He sa the defense will request a continuan He says the outcome of the current tr will have no bearing on the ot charges.

The case against Baptist and t LaHues is a perfect example of the gra areas, Blake says. What they did can b seen as impropriety or it can be seen a good business.

Ron LaHue would certainly agree court two weeks ago, he stood up du ing a break from the proceedings.

"I don't recommend it to anybody he said.

Appendix D

Office of Attorney General
Division of Medicaid Fraud and Abuse

Report of Expenditures for the period of July 1, 1998 thru June 30, 1998

Salaries		$504,326
Payroll and Fringe Benefits		88,620
Travel		27,608
Equipment		22,879
Supplies		
Office Supplies	$6,542	
Postage and Freight	547	
Printing & Advertising	728	
One-time Items	143	
Total Supplies		7,960
Contractual Services		
Rents - Office Space	$34,272	
Rents - Leased Automobiles	9,434	
Copier Lease & Maintenance	2,717	
Security System	219	
Communication (Telephone & Computer)	12,397	
Total Contractual Services		59,039
Indirect Cost Rate – Federal Share Only		95,636
Other Expenditures		
Legal and Reference Materials	$3,652	
Membership Fees	3,450	
Registration Fees	3,990	
Witness and Consulting Cost	580	
Miscellaneous	60	
		11,732
Total Expenditures		**$817,800**