MEDICAID FRAUD AND ABUSE DIVISION ANNUAL REPORT

2001-2002

OFFICE OF THE KANSAS
ATTORNEY GENERAL
CARLA J. STOVALL

During this reporting period, June 30, 2001 to July 1, 2002, the Kansas Attorney General's Medicaid Fraud and Abuse Division obtained court ordered restitution, investigation costs, civil settlements and penalties totaling more than $2.2 million.

This report briefly describes the Division, its staff and cases involving criminal charges and settlements which occurred during the reporting period. This report does not contain information regarding matters currently under investigation or the subject of on-going negotiations.

Purpose

The purpose of the state Medicaid Fraud Control Unit (MFCU) is to deter and combat fraud against 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 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 in board and care facilities and misappropriations of patients' private funds by health care facilities receiving Medicaid payments and investigate and prosecute or refer to the appropriate prosecuting authority those cases that have substantial potential for criminal prosecution; and

3. Maintain staff to include attorneys experienced in investigation and prosecution of civil and/or criminal fraud, auditors experienced in reviewing 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*. The Act provides in part:

> "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, 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 Division

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. Since then, the Division has annually obtained certification.

Staffing

The Division staff consists of a Deputy Attorney General as Director, two Assistant Attorneys General, an Auditor, a Research Analyst, a Chief Investigator and three Investigators. The staff are professionals with extensive and complimentary experience in the investigation of fraud and physical abuse cases.

Staff Qualifications

The **Deputy Attorney General** is a prosecutor with more than ten years experience investigating and prosecuting white collar and violent crimes. The Deputy is cross-designated as a Special Assistant United States Attorney.

The **Assistant Attorneys General** are experienced attorneys with backgrounds in Medicaid administration and criminal prosecution.

The **Chief Investigator** has extensive experience investigating white collar crime. Before joining the Division he served for 25 years in the United States Postal Inspection Service and the Office of Criminal Investigations of the Food and Drug Administration. He also served on special details assigned to the United States Congress.

The **Auditor** is an experienced white collar crime investigator. Before joining the Division he served for 25 years as an agent with the United States Internal Revenue Service.

The **Investigators** are Kansas certified law enforcement officers with 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, state and federal levels involving both crimes against persons and property/financial crimes.

The **Research Analyst** has significant and varied experience in data analysis of both private insurance, medicare and medicaid billing.

Interagency Partnerships

Provider Fraud

The Kansas Attorney General's Medicaid Fraud and Abuse Division works with the Medicaid Single State Agency, the Department of Social and Rehabilitation Services ("SRS"), pursuant to a Memorandum of Understanding "MOU." The MOU sets forth the responsibilities of the Medicaid agency and the Division in the referral, review and prosecution of cases.

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.

The Division has effective working relationships with the Medicaid program integrity section of SRS and the Medicaid fiscal agent. Recently, SRS entered into an agreement with a new fiscal agent. The new entity will not be fully in place until 2003. In addition, SRS and the new fiscal agent are developing and implementing a new management information system. The Division anticipates that due to these changes there will be fewer case referrals from SRS during the transition.

As in the past, the Division will continue to maintain constant communication with the single state agency and the fiscal agent in the following ways:

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

2. Use of a referral form; and

3. Individual case consultations.

Abuse/Neglect

The Division reviews complaints of abuse, neglect and misappropriation of patients' private funds by obtaining information from state level agencies such as: the Department of Social and Rehabilitation Services (SRS), the Kansas Department of Health and Environment (KDHE), the Kansas Department on Aging (KDOA) Adnlt Protective Services and local law enforcement agencies. The Division also assists local law enforcement agencies with both investigation and prosecution.

KDHE is the state agency with regulatory and licensing authority of nursing homes and adult care facilities. The Division reviews all category 1 and 2 severity level incident reports KDHE receives. Pursuant to an agreement with KDHE, the Division has computerized access to this information. With authorization from the United States Department of Health and Human Services Centers for Medicare and Medicaid Services, the Division also has computerized access to the federally mandated Minimum Data Sets (MDS) of nursing home resident assessment and care screening.

Collaborative Efforts

The Division's investigators routinely work with federal and state investigation agencies on cases involving Medicaid and other federally funded health care programs. The Deputy Attorney General and the Chief Investigator are members of the Health Care Fraud Working Group, which is jointly sponsored by the FBI and the United States Attorneys' Offices for the District of Kansas and the Western District of Missouri. In addition, the Director is cross-designated as a Special Assistant United States Attorney. In this capacity he works with the United States Attorney in the investigation and prosecution of fraud cases in federal district court.

The Division also works closely with several regulatory and licensing entities to receive and refer cases. These include the following:

Kansas Board of Healing Arts

Kansas Board of Nursing

Kansas Dental Board

Kansas Board of Pharmacy

Kansas Insurance Department

Kansas Department on Aging Long Term Care Ombudsman

Medicaid Fraud and Abuse Division Case Activity

The Chief Investigator and the Director serve as contacts to receive reports of fraud and abuse. The Division uses an assessment process that is designed to effectively review referrals and complaints to identify those matters which have substantial potential for criminal prosecution. The Research Analyst has online access to Medicaid claims information and routinely is involved in the assessment process. Those matters that do not merit further investigation are referred, when possible, to the appropriate regulatory, civil administration or law enforcement authority.

Current Case Activity

The cases under investigation by the Division involve a wide range of Medicaid 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 communities throughout the state.

The Division is also currently involved in criminal investigations in cooperation with the FBI, the United Stated Department of Health and Human Services Office of Inspector General, and the United States Attorney's office for the District of Kansas.

Case Data Information

At the beginning of the reporting period, the Division had 92 open cases involving 12 out of 22 provider categories for which Medicaid will pay for services. Currently, the Division has 100 open cases involving 13 provider groups.

State Prosecutions

The Division prosecuted the following criminal cases:

State of Kansas v. Fidelia A. Okoronkwo aka Fidelia A. Nwosu, Shawnee County District Court Case No. 99CR3167

On August 9, 1999, Okoronkwo was charged with one count of involuntary manslaughter. Okoronkwo was employed as a certified nurse aid/certified medication aid at an adult care home. According to the complaint, on October 21, 1997, Okoronkwo unintentionally and recklessly killed a resident of the adult care home by feeding the resident unpureed food in violation of a doctor's order. On May 13, 2002, Okoronkwo pleaded no contest to one felony count of mistreatment of a dependent adult. On June 7, 2002, the court sentenced Okoronkwo to 18 months in prison but suspended the sentence and ordered 24 months of intensive supervised probation.

State of Kansas v. Christine Allen, Wyandotte County District Court Case No. 01CR145

On February 1, 2001, Christine Allen was charged with five counts of Mistreatment of a Dependent Adult. According to the criminal complaint, Allen was the owner of an adult care home that provided care for five persons suffering from severe and persistent mental illness or senile dementia. On November 29, 2000, the home was declared unfit for habitation after a law enforcement officer found that one resident had wandered away from the home. Later, inspectors found that the home had no running water, no heat, a defective sewage system, exposed electrical wiring and rotted floors. In addition, rotten food was observed on the kitchen counters and in the refrigerators and freezers. The case is currently pending in Wyandotte County District Court.

The charge is merely an accusation and the defendant is presumed innocent unless proven guilty.

State of Kansas v. Arlene Pratt, Shawnee County District Court Case No. 01CR344

Arlene Pratt was charged on March 15, 2001 with Medicaid Fraud. The criminal complaint alleged that Pratt conspired with three caregivers to submit false time sheets regarding home and community based services to be provided to her autistic son.

Pratt pleaded guilty to a felony count of Medicaid Fraud. In November, 2001, she was sentenced to one year probation and ordered to pay $10,964.22 in restitution.

State of Kansas v. Larry Joe Fondren, Shawnee County District Court Case No. 01CR847

On June 14, 2001, Fondren was charged with one felony count of making a false claim, statement or representation to the Medicaid program. Fondren completed time sheets claiming that he provided personal care attendant services between June 1, 1997, and August 30, 1999, when, in fact, he was incarcerated, or the recipient was incarcerated or receiving in-patient hospital services.

On February 25, 2002, Fondren pleaded no contest to one count of misdemeanor theft. The court sentenced Fondren to 12 months in the county jail. The sentence was suspended and Fondren was placed on one year of supervised probation. The court also imposed restitution and investigation costs in the amount of $594.50.

State of Kansas v. Robert A. Rosevear, D.D.S., P.C., Shawnee County District Court Case No. 01-CR-1208

In August, 2001, Robert A. Rosevear, an orthodontist and president and owner of Robert A. Rosevear, D.D.S., P.C., a Missouri corporation doing business in Leawood, Kansas, pleaded guilty on behalf of the corporation to a misdemeanor count of negligently failing to maintain adequate Medicaid records.

The criminal complaint alleged that between July, 1996, and January, 2000, Rosevear's orthodontic practice failed to keep records concerning

orthodontic services to children paid for by Medicaid.

Pursuant to a plea agreement, Rosevear's corporation paid full restitution in the amount of $34,710.20 and investigation costs in the amount of $9,149. Also, Dr. Rosevear agreed to a voluntary lifetime exclusion from participating in the Medicaid program and all other federally funded health care programs.

State of Kansas v. Sharon Thomas and Thelma Booker, Atchison County Court No. 01-CR-249A

In August 2001, Thomas and Booker were each charged with Medicaid fraud. The criminal complaint alleged that the two defendants submitted false time sheets claiming payment for Home and Community Based Personal Attendant services that were not provided. Thomas submitted time sheets claiming she provided services to Booker when Thomas was actually incarcerated in the county jail. Booker and Thomas also submitted time sheets claiming Thomas provided services during the time when Booker was actually hospitalized.

Most of the false time sheets were discovered by a billing agent before Medicaid paid for the claimed services.

Both women pleaded guilty to one misdemeanor each count of Medicaid fraud and were placed on probation. The judge ordered suspended jail sentences and placed Thomas and Booker on one year supervised probation. Thomas was ordered to pay $119 restitution and both women were ordered to pay court costs.

State of Kansas v. Kinta Hayes, Jefferson County District Court No. 01 CR 251

In September 2001, Hayes, a licensed practical nurse, was charged in a multiple count complaint in connection with incidents that occurred while she was working in a nursing home. Hayes took OxyContin pills from a nursing home resident's medication supply and replaced them with another drug. On another occasion, Hayes diluted a resident's prescribed liquid OxyContin with water and gave the mixture to the resident.

After being charged, Hayes voluntarily surrendered her license.

In January 2002, Hayes pleaded guilty to one felony count of drug possession, one misdemeanor count of mistreatment of a dependent adult and two misdemeanor counts of adulterating drugs. In March 2002, Hayes was sentenced to seven months in jail and one year of supervised probation.

(After the reporting period, the court, over the State's objection, released Hayes from jail after serving four months.)

State of Kansas v. Pamela Sayers, Shawnee County District Court Case No. 01 CR 1866

On November 19 2001, Sayers was charged with one felony count of Medicaid Fraud. Sayers was a Medicaid Home and Community Based Services attendant who was supposed to provide services to her grandmother. Between February 1998 and April 2001 Sayers submitted false time sheets to the Medicaid program and was paid for health care services which she did not provide because during the times the claims were submitted, the Medicaid recipient was actually a patient in a hospital or a resident of a nursing home. The Medicaid program paid nearly $20,000 for services that Sayers did not actually provide.

The Single State Agency recovered some of the payments through administrative action.

In April, 2002, Sayers pleaded guilty as charged. Pursuant to a plea agreement, Sayers agreed to pay restitution for the money she received plus interest and investigation costs for a total of $11,248.00. Sayers was sentenced to one year of supervised probation.

State of Kansas v. Tara Reilly, Johnson County District Court Case No. 01CR3011

On November 27, 2001, Tara Reilly was charged with one felony count of mistreatment of a dependant adult and one count of misdemeanor battery. Reilly was employed as an assisted living assistant at a nursing facility. According to the complaint, Reilly knowingly and intentionally injured a

dependent adult at that facility by dragging the resident by his feet across a carpeted floor. On April 10, 2002, Reilly pleaded guilty to one count of felony attempted mistreatment of a dependant adult. On May 30, 2002, the court sentenced Reilly to eight months in the custody of the Secretary of Corrections, but suspended the sentence and placed Reilly on eighteen months of supervised probation.

State of Kansas v. Lisa Gordan, Osage County District Court Case No. 02CR01

On January 2, 2002, Lisa Gordan was charged with one count of misdemeanor battery. Gordan was employed as a certified nurse aide at a nursing home. According to the complaint, Gordan intentionally injured a resident when Gordan placed the resident into a headlock while trying to shave the resident's face. On February 13, 2002, Gordan pleaded guilty as charged. The court sentenced her to a 10 day jail term but suspended the sentence and placed Gordan on one year of supervised probation.

State of Kansas v. Steven A. Parker, Linn County District Court Case No. 02CR180

On June 19, 2002, Parker was charged with one felony count of Making a False Claim, Statement or Representation to the Medicaid program. The criminal complaint alleges that between March and June, 2001, Parker submitted fraudulent time sheets to the Department of Social and Rehabilitation Services for reimbursement from the Medicaid program. Parker claimed to have provided services in the home of a medicaid recipient who was incarcerated at the time.

The charge is merely an accusation. The defendant is presumed innocent unless proven guilty.

Federal Prosecutions

The Medicaid Fraud and Abuse Division assisted in the following federal investigation at the request of the United States Attorney's office for the District of Kansas.

United States v. Herbert Daniels, United States District Court for the District of Kansas Case No. 99-40099-01-DES.

Daniels was charged in a multiple count indictment with health care fraud and mail fraud. The indictment alleged that Daniels falsified patients' files regarding their need for various types of ear, nose and throat surgeries, that he performed unnecessary surgeries and filed claims for surgical procedures he did not perform.

In September 2000, a trial resulted in a hung jury. Daniels was re-indicted and in December, 2001, a federal jury found him guilty of 33 counts of health care fraud, seven counts of mail fraud and three counts of perjury.

In May 2002, Daniels was sentenced to prison for six years followed by three years supervised probation. Daniels also agreed to a fifteen year exclusion from participating in federally funded health care programs.

Multi-Jurisdiction Settlements

The Division participates when possible in multi-state and federal cases that involve criminal prosecution and civil claims. Such cases generally include nation-wide false claims to Medicaid, Medicare and other federally funded health care programs.

The National Association of Medicaid Fraud Control Units has established procedures to assist states in participating in these cases. The Division is a member of the association and has obtained recoveries in such cases.

For this reporting period, the Division obtained settlements in the following cases:

Bayer Corporation

The Medicaid Fraud and Abuse Division recovered $91,962.00 from Bayer Corporation, the pharmaceutical manufacturer. The payment was made pursuant to a settlement agreement reached between Bayer, the federal government and 45 states. The settlement agreement resulted from a three year federal investigation of pharmaceutical companies.

According to the Justice Department, for at least seven years Bayer overstated average wholesale prices for drugs used in the treatment of cancer, hemophilia and HIV. Those prices were the benchmark used to set the reimbursement rates that the Medicaid program paid for the drugs. Bayer denied the Justice Department allegations, but pursuant to the agreement, the company agreed to pay restitution to the federal government and to the states.

In addition to the payment, Bayer agreed to cooperate with prosecutors in ongoing investigations of other pharmaceutical manufacturers. The company also agreed to submit information so that the Medicaid program can pay accurate prices for Bayer's drugs.

HCA, Inc.-The Hospital Company, formerly known as Columbia/HCA

The Division recovered $1,388,299.20 in restitution and penalties from HCA, Inc.-The Hospital Company for alleged unlawful billing practices. The company is a Delaware corporation that operates or has operated more than 400 hospitals, more than 500 home health agencies and numerous ancillary healthcare facilities nationwide. The settlement with the federal government and 33 states included criminal guilty pleas.

The company operated up to five hospitals and five home health agencies in Kansas at various times in the 1990's. The facilities were located in Kansas City, Wichita, Overland Park, Dodge City and Halstead.

The government alleged that between 1989 and 1998 the company billed the Medicaid program for tests without regard for whether the tests were medically necessary or properly ordered by physicians; that the company's hospitals "upcoded" claims to the Medicaid program for inpatient hospital

admissions by assigning diagnosis codes that were not supported by physician documentation in patient files; and that its home health agencies submitted several types of improper claims to the Medicaid program, including claims for services not provided, for patients who were not qualified and for services not supported by physician authorization.

TAP Pharmaceuticals, Inc.

The Division recovered $534,361.24 in restitution and penalties frm TAP Pharmaceuticals, Inc. as part of a settlement between the company, the federal government, 45 states, the District of Columbia and a false claims relator. As part of the agreement, TAP also agreed to plead guilty to federal conspiracy charges.

The settlement was reached after a lengthy investigation into TAP's marketing practices. The practices centered around TAP's provision of free dosages of its cancer drug Lupron to physicians and other providers, knowing that these providers would bill the free dosages to health care insurers, including Medicaid and Medicare. The government alleged that when TAP failed to include the free Lupron in the calculation of its "best price" as required under the federal Medicaid Drug Rebate program, the State Medicaid programs received lower rebate amounts than were lawfully due.

A second marketing practice addressed by the settlement involved TAP's inflation of "Average Wholesale Price (AWP)." Medicare and many State Medicaid programs, including Kansas, base some pharmaceutical reimbursements on "AWP." By inflating the "AWP," the states alleged that TAP created an economic incentive for physicians to prescribe its product because the physicians kept the difference between the true purchase price and the reported "AWP." This resulted in damage to the various Medicaid programs by causing inflated reimbursement to physicians and others who used TAP's products.

As part of the agreement, TAP is required to report accurate pricing information on all its products to the Medicaid program as well as to the commercial price reporting services that provide pricing information to the states. Additionally, TAP agreed to cooperate with the states in investigating other health care providers, including physicians, who

defrauded the Medicaid programs by participating in TAP's marketing schemes.

National Medical Care, Inc.

The Division recovered $95,858.59 in restitution and penalties from Nation Medical Care, Inc., a wholly owned subsidiary of Fresenius Medical Care Holdings, Inc., the world's largest provider of kidney dialysis products and services. The settlement was reached between the company, the federal government, 50 states and the District of Columbia.

The settlement was one part of federal criminal and civil false claims cases. In those related matters, three NMC subsidiaries pleaded guilty to three separate conspiracies. NMC Home Care pleaded guilty to conspiracy to defraud the United States by submitting false, fraudulent and misleading claims for nutritional therapy for dialysis patients, inflating the number of administration kits used to provide the therapy, and paying kickbacks for dialysis units. NMC LifeChem pleaded guilty to conspiracy to obtain Medicare payments for thousands of medically unnecessary laboratory blood tests. The former vice president of marketing of LifeChem previously pleaded guilty to participation in this conspiracy, and four other NMC executives were criminally charged. NMC Medical Products pleaded guilty to conspiracy to pay kickbacks in return for referrals for testing by LifeChem.

Eckerd Corporation

The Division obtained $23,348.90 in restitution and penalties from Eckerd Corporation. The settlement was reached between Eckerd, the federal government and 18 states.

The settlement is the result of negotiations over the past several years to resolve civil false claims against Eckerd for its practice of billing the various states' Medicaid programs for partially filled prescriptions. The basis of the allegations was that Eckerd, when faced with insufficient stock to completely fill a given prescription, would fill a part of the prescription, give the customer an IOU for the balance, but bill Medicaid for the entire amount of the prescription. If the customer failed to return to pick up the balance of the prescription, Eckerd would not routinely credit the Medicaid program for the difference. The settlement covers the time period of January 1986 to May

2000. As part of the settlement, ECK MD, Inc., a wholly owned affiliate of Eckerd, entered a guilty plea last year in federal court and agreed to pay a criminal fine.

Case Activity Projections

The Division anticipates a reduction in case referrals from the Single State Agency because of the change of the fiscal agent and claims information system. The Division believes the decrease will be temporary, but it could affect the volume of activity occurring in the next annual reporting period.

Training

The Division has committed itself to providing staff the opportunity to experience a wide variety of training to educate them on the basics of health care fraud and the skills and techniques needed to investigate fraud and physical abuse cases which occur in health care programs. A list of the training received by the Division staff is contained in Appendix A.

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 makes presentations to 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. A table describing presentations made by the Division is contained in Appendix B.

Policy and Procedure Manual

The Kansas Medicaid Fraud and Abuse Division has actively developed policies and procedures to use in the accomplishment of Division responsibilities. The topics covered address investigation and prosecution procedures, as well as office procedures. The manual is a working document that may be 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. A report of expenditures is attached as Appendix C.
12. A Unit should maintain an annual training plan for all professional disciplines.

Appendix A

OFFICE OF THE KANSAS ATTORNEY GENERAL
MEDICAID FRAUD AND ABUSE DIVISION

TRAINING

NATIONAL	DATE	TRAINING	ATTENDEES
Brunswick GA	9-1-01 to 9-11-01	Advanced Medicaid Fraud Training - Instructor	Ronald F. Scheid
Kansas City MO	11-28-01	DME, Home Health, Hospice Fraud Training	Marla Myers
Kansas City Mo	11-28-01	DME, Home Health, Hospice Fraud Training	Ronald F. Scheid
Brunswick GA	2-27-02	Rule 4.2	Ronald F. Scheid
Brunswick GA	2-25-02 to 3-1-02	Advanced Medicaid Fraud Training - Instructor	Ronald F. Scheid
Kansas City MO	4-22-02 to 4-26-02	Financial Record Examination and Analysis	Pamela S. Horn
Blue Springs, MO	5-22-02	Firearms Qualification	Ronald F. Scheid

STATE	DATE	TRAINING	ATTENDEES
Lawrence	10-17-01	Firearms Qualifications	Pamela Horn
Oskaloosa	10-24-01	Firearms Qualifications	Phil McManigal
Oskaloosa	10-24-01	Firearms Qualifications	Marla Myers
Ozawkie	1-24-02	Methamphetimine Labs	Phil McManigal
Holton	2-2-02	Federal Explosives Law	Phil McManigal
Overland Park	3-11 to 3-13-02	Financial Investigation Practical Skills	Pamela Horn

Overland Park	3-14 to 3-15-02	Financial Investigation Practical Skills	Phil McManigal
Lawrence	5-22-02	2002 M-Squad School	Phil McManigal
Oskaloosa	5-29-02	Firearms Qualification	Phil McManigal
LOCAL	**DATE**	**TRAINING**	**ATTENDEES**
Topeka	8-14-01	Contract Compliance Review of Dental Offices	Pamela Horn
Topeka	8-15-01	FAA Conditions for Carrying Fireams on Aircraft	Phil McManigal
Topeka	8-15-01	LEO Flying Armed	Marla Myers
Topeka	10-9-01	Medicaid Fraud and Elder Abuse	Marla Myers
Topeka	10-09-01	Medicaid Fraud & Abuse of the Elderly	Phil McManigal
Topeka	10-22 to 10-26-02	Kansas County and District Attorney Association Fall Conference	Jon Fleenor
Topeka	11-27-01	Critical Issues in Terrorism	Ron Scheid
Topeka	11-27-01	Critical Issues in Terrorism	Marla Myers
Topeka	12-19-01	NCIC Re-certification Training & Testing	Pamela Horn
Topeka	1-30,31 & 2-1-02	Child Abuse	Marla Myers

Appendix B

Presentations

DATE(S) PRESENTED	TOPIC	PRESENTOR	SPONSOR	LOCATION	AUDIENCE	# OF ATTENDEES
10-09-01	Medicaid Fraud and Elder Abuse	Jon Fleenor & Philip McManigal	Kansas Law Enforcement Training Center	Topeka Police Dept.	Police Officers Across the State	
01-15-02	Fraud in the Home and Community Based Services Program	Jon Fleenor	Three Rivers, Inc.	Wamego, KS	Case Managers and Administrative Staff	20
02-14-02	Trends in Health Care Fraud	Jon Fleenor	Kansas City Metro Insurance Fraud Task Force	Kansas City Mo Police Dept.	Law Enforcement and Insurance Fraud Investigators	50
06-20-02	Crimes Against the Elderly	Jon Fleenor	Mainstream, Inc.	Holiday Inn West	Adult Protective Service workers	60

Appendix C

State of Kansas
Office of Attorney General
Division of Medicaid Fraud and Abuse

Analysis of Federal Receipts and Disbursements from 10/01/01 to 6/30/02

	TOTAL	FEDERAL	STATE
Receipts FYE 9/30/02 (3 Qtrs)	$472,004.83	$357,000.00	$115,004.83
Expenditures FYE 9/30/02 (3 Qtrs)	-$533,040.82	-$418,382.01	-$114,658.81
Add: Accrued Indirect Cost	$74,405.57	$74,405.57	
Approved Receipts for State Match	-$2,568.00		-$2,568.00
Current Year Balance	$10,801.58	$13,023.56	-$2,221.98
Current Balance of Fund 2641	$0.00		$0.00
Fraud Recoveries Not Approved for State Match	$0.00		$0.00
Balance of Fund 2615 - 10/01/01	-$3,499.61	-$14,261.11	$10,761.50
Cash Balance for Medicaid Fraud	$7,301.97	-$1,237.55	$8,539.52
Receipts FYE 9/30/96	$520,618.01	$471,045.00	$49,573.01
Expenditures FYE 9/30/96	-$495,049.46	-$445,544.51	-$49,504.95
Totals for FYE 9/30/96	$25,568.55	$25,500.49	$68.06
Receipts FYE 9/30/97	$610,135.10	$538,200.00	$71,935.10
Expenditures FYE 9/30/97	-$637,468.35	-$573,721.52	-$63,746.83
Totals for FYE 9/30/97	-$27,333.25	-$35,521.52	$8,188.27
Receipts FYE 9/30/98	$715,098.89	$649,900.00	$65,198.89
Indirect Cost Accrued	$89,539.00	$89,539.00	
Receipts - State Restitution			
Expenditures FYE 9/30/98	-$815,375.38	-$744,391.74	-$70,983.64
Totals for FYE 9/30/98	-$10,737.49	-$4,952.74	-$5,784.75
Receipts FYE 9/30/99	$720,450.60	$542,361.00	$178,089.60
Receipts - State Restitution	-$5,686.81		-$5,686.81
Indirect Cost Accrued	$92,051.00	$92,051.00	
Expenditures FYE 9/30/99	-$794,640.12	-$618,992.84	-$175,647.28
Totals for FYE 9/30/99	$12,174.67	$15,419.16	-$3,244.49
Receipts FYE 9/30/2000	$630,519.84	$447,100.00	$183,419.84
Receipts - State Restitution	-$43,142.18		-$43,142.18
Indirect Cost Accrued	$70,055.11	$70,055.11	
Expenditures FYE 9/30/2000	-$658,537.81	-$511,417.14	-$147,120.67
Totals for FYE 9/30/2000	-$1,105.04	$5,737.97	-$6,843.01
Receipts FYE 9/30/2001	$611,158.67	$431,000.00	$180,158.67
Receipts - State Restitution	-$11,299.84		-$11,299.84
Indirect Cost Accrued	$72,827.80	$72,827.80	
Expenditures FYE 9/30/2001	-$674,753.76	-$524,272.27	-$150,481.49
Totals for FYE 9/30/2001	-$2,067.13	-$20,444.47	$18,377.34
Total Prior Years - Receipts	$4,132,454.02	$3,404,078.91	$728,375.11
Total Prior Years - Expenditures	-$4,135,953.71	-$3,418,340.02	-$717,613.69
BALANCES	-$3,499.69	-$14,261.11	$10,761.42