MEDICAID FRAUD AND ABUSE DIVISION ANNUAL REPORT

2002-2003

OFFICE OF THE KANSAS ATTORNEY GENERAL
PHILL KLINE

During this reporting period, June 30, 2002 to July 1, 2003, the Kansas Attorney General's Medicaid Fraud and Abuse Division obtained court ordered restitution, investigation costs, civil settlements and penalties totaling more than $2.9 million.

In addition, the Medicaid Fraud and Abuse Division was the lead investigation agency in a cased involving alleged fraudulent transportation claims. The investigation resulted in the indictment of two individuals for alleged fraud of over $2 million. This constitutes the largest Medicaid fraud case ever charged in the state of Kansas.

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

Currently, the Division staff consists of a Deputy Attorney General serving as Director, one Assistant Attorney General, an Auditor, a Chief Investigator, one Investigator and a Research Analyst/Investigator. 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 eleven years experience investigating and prosecuting white collar and violent crimes. The Deputy is cross-designated as a Special Assistant United States Attorney.

The **Assistant Attorney General** is an experienced attorney with trial experience.

The **Chief Investigator** has extensive experience in criminal investigation. He served as a sheriff for eight years and prior to being appointed the Chief Investigator he served for five years as an investigator in the Medicaid Fraud Control Unit. Is currently a member of the Capital Area Major Case Squad and a part-time Criminal Justice instructor at a local community college.

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 **Investigator** is a Kansas certified law enforcement officer and a registered nurse with experience in nursing in the private sector, regulation and oversight of medical providers at the state level, and criminal investigation experience. She is also a member of the Capital Area Major Case Squad.

The **Research Analyst** has significant and varied experience in data analysis of both private insurance, medicare and medicaid billing. Last year, the analyst became a state certified law enforcement officer.

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) Adult 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. 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 100 open cases involving 23 out of 24 provider categories for which Medicaid will pay for services. Currently, the Division has 76 open cases involving 12 provider categories.

State Prosecutions

During this reporting period the Division prosecuted the following criminal cases in state courts:

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 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 defendant waived her right to a jury trial and the matter is set for trial before the court on September 17, 2003.

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

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 alleged that between March and June, 2001, Parker submitted fraudulent time sheets for reimbursement from the Medicaid Home and Community Bases Services waiver program. Parker claimed to have provided services in the home of a medicaid recipient who was actually incarcerated at the time.

On December 10, 2002, Parker pleaded guilty to one misdemeanor count of Making a False Claim, Statement or Representation to the Medicaid

Program. He received a suspended sentence of ninety days in jail and was ordered to serve one year of probation. He was also ordered to pay restitution of $742.00 and court costs. An additional amount wrongfully paid to an innocent billing agent was administratively recovered by the Single State Agency.

State of Kansas v. Lillian Meirink, Shawnee County District Court, Case No. 03CR457

On February 28, 2003, Lillian Meirink was charged with two misdemeanor counts of mistreatment of a dependent adult. The criminal filing alleges that between November and December 2001, Meirink took unfair advantage of the financial resources of two dependent adults residing in a sheltered living setting. The case was filed by the Medicaid Fraud & Abuse Division based upon a joint investigation with the Topeka, Kansas Police Department and investigators with the Attorney General's Medicaid Fraud and Abuse Division.

Meirink was booked into the Shawnee County Jail on March 7 and released on bond. Trial is set for August 28, 2003, in Shawnee County District Court.

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

State of Kansas v. Less Dooley

On January 17, 2003, Leslie Dooley, 49, was charged with one count of aggravated criminal sodomy and one count of sexual battery of two separate nursing home residents on November 29, 2002. Dooley was employed at the facility when the alleged crimes were said to have occurred. The adult care home cooperated in the criminal investigation. The Jefferson County Attorney's office filed the charges after a joint investigation by the Jefferson County Sheriff's office and investigators with the Attorney General's Medicaid Fraud and Abuse Division.

The County Attorney accepted Dooley's no contest plea to two misdemeanor counts of sexual battery and on May 8, 2003, Dooley was sentenced to two consecutive years in the county jail and will be required to register as a sex offender.

Federal Prosecutions

The Medicaid Fraud and Abuse Division regularly works with the United States Attorney's Office. The Director of the Medicaid Fraud and Abuse Division is cross-designated as a Special Assistant United States Attorney. The Division's investigators, with OIG investigators and the United States Attorney's office jointly investigated the following case which resulted in a grand jury indictment in federal district court:

State of Kansas v. M&M Transportation Inc., United States District Court for the District of Kansas, Case No. 03-40054

On June 19, 2003 a federal grand jury indicted Molly Meier, 33, Topeka, Kansas, and Cynthia Maze Moten 33, Topeka, Kansas, with conspiracy and a scheme to defraud Medicaid of over $2,000,000. The case is the result of a three-year investigation by the Kansas Attorney General's Medicaid Fraud and Abuse Division, the U.S. Department of Health and Human Services, Office of Inspector General, and the U.S. Attorney's Office.

Meier and Moten are each charged with one count of conspiracy to defraud Medicaid; twenty-five counts of health care fraud; fifteen counts of money laundering; two counts of obstruction of a criminal investigation; and one count of forfeiture of the proceeds from the commission of these offenses.

According to the indictment, Meier and Moten were owners, officers and operators of several businesses including Toddler Town Special Purpose Child Care Center, Inc., which later became known as Community Therapeutic Center, Inc., L.L.C., in which Moten was the President and Meier the Secretary; and Toddler Transport, Inc., a commercial non-ambulance medical transportation company in which Meier was the President and Moten was the Secretary. Meier was also the Secretary of M & M Transportation, Inc., a commercial non-ambulance medical transportation company.

According to the indictment, Toddler Town Day Care, with Moten as the President and Meier as the Secretary, was a partially and provisionally licensed special purpose child day care facility with buildings at 616 and 630 Western Avenue in Topeka, Kansas.

The indictment alleges that from January 1998 through January 2003, Meier and Moten, knowingly engaged in a scheme to defraud Medicaid of over $2,000,000. The scheme involved making false claims to the Medicaid non-ambulance medical transportation program and obstructing the investigation by asking employees to falsify documents and by submitting false documents to investigators in response to an official subpoena.

The indictment alleges that Meier and Moten submitted false claims to Medicaid for:

- **non-ambulance medical transportation services that were not provided**, that is, claims for transporting children who were not at Toddler Town Day Care on the day of the claimed services;

- **non-ambulance medical transportation services that were not for a medical purpose**, such as transportation to and from Toddler Town Day Care, fast food restaurants, a swimming pool, movie theaters, a zoo, a park, a bowling alley, a museum, and a library.

The indictment alleges that Meier and Moten used M&M Transportation, Toddler Transport, Inc., and other entities to submit the false claims to Medicaid.

The indictment also alleges that Meier and Moten laundered the proceeds of their fraudulent scheme.

The indictment further alleges that from January 2000 through February 2002, Meier and Moten hired a psychologist to work at Toddler Town Day Care to provide individual and group therapy to children enrolled at the day care and submitted false transportation claims to Medicaid as though the children were transported to psychological therapy every day, knowing that the psychologist did not see the children every day.

If convicted, Meier and Moten each face a maximum of five years in federal prison, without parole, for conspiracy and obstructing a health care fraud investigation and a maximum of ten years for health care fraud and money laundering.

The charges are merely contain allegations of criminal conduct. Meier and Moten are presumed innocent unless proven guilty.

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 entered into a settlement agreement wherein Bayer agreed to pay the state of Kansas $2,202,456.01.

A *qui tam* suit was filed in Boston and the federal government investigated allegations that Bayer failed to report "best price" information for the anti-biotic drug Cipro Flaxcin and the anti-hypertensive drug Nifedine. Bayer entered into an agreement with the federal government and all states, except Arizona and states that do not have Medicaid Fraud Control Units (Nebraska, Idaho and North Dakota).

The settlement agreement is based upon the following actions by Bayer. Beginning in August 1995, Bayer privately labeled Cipro for Kaiser Permanente. Pursuant to an agreement, Bayer manufactured, packaged and shipped Cipro to Kaiser, however, Bayer substituted the kaiser National Drug Code ("NDC") number for the Bayer NDC number on the label for Cipro and added to the label the words "Distributed by Kaiser Foundation Hospitals." The purpose of the arrangement was to provide Kaiser with $1.5 million annually in additional price discounts without reporting the discounted price as Bayer's "best price". Thus, Bayer avoided the obligation to pay additional rebates under the Medicaid rebate program.

Similarly, in April 1997, Bayer began private labeling Adalat CC for Kaiser. In 1998, Bayer agreed to private label Adalat CC for PacificCare, an HMO,

and sell the private label Adalat CC to PacificCare at a discounted price. They also substituted Kaiser's NDC number. Bayer provided Kaiser additional discounts on Adalat CC without reporting the newly discounted price to the Medicaid rebate program, and there by avoided paying additional rebates to the program.

An investigation revealed that Bayer never private labeled any single source drug besides Cipro and Adalat CC at anytime and never private labeled Cipro for any other buyer other than Kaiser or Adala CC for any buyers other than Kaiser and PacificCare.

Bayer also agreed to plead guilty to a charge of violating the Food Drug Cosmetics Act in the United States District Court in Boston and pay an additional fine to the federal government of $5.5 million dollars.

GlaxoSmithKline

The Medicaid Fraud and Abuse Division entered a settlement agreement wherein Glaxo Smith Kline agree to pay the state of Kansas $649,267.28.

The United States Attorney's Office for the District of Massachusetts conducted an investigation regarding the price reporting for Flonase, a nasal spray, and Paxil an anti-depressant. Flonase was manufactured and sold by Glaxo Wellcome. SmithKline Beecham manufactured and sold Paxil. The two companies merged in December 2001 and have done business as GlaxoSmithKline.

Thereafter, the federal government and member states of the National Association of Medicaid Fraud Control Units, with exception of the state of Arizona, entered into negotiations. Nebraska, Idaho and North Dakota, which are not members of the National Association of Medicaid Fraud Control Units, did not participate.

The settlement agreement is based upon allegations that from the first quarter of the 1997 through the first quarter of 2000, Glaxo Wellcome privately labeled Flonase for Kaiser Permanente. Pursuant to an agreement, Glaxo Wellcome substituted the Kaiser National Drug Code ("NDC") number for the Glaxo Wellcome NDC number on the label. The purpose of the arrangement was to provide Kaiser with additional price discounts without

reporting the discounted price as Glaxo Wellcome's "best price." In this way Glaxo Wellcome avoided the obligation to pay additional rebates under the Medicaid rebate program.

Similarly, during the third quarter of 2000, SmithKline began private labeling Paxil for Kaiser. SmithKline also substituted Kaiser's NDC number and provided Kaiser additional discounts without reporting the newly discounted price to the Medicaid rebate program, and thereby avoided paying additional rebates to the program.

GlaxoSmithKline also entered into a Corporate Integrity Agreement. That agreement will require GlaxoSmithKline to certify its rebate process and GlaxoSmithKline will submit to an independent review organization to certify how medicaid rebates are calculated.

Abbott Laboratories - Ross Products Division

Abbot entered into a settlement and agreed to pay $311,730.73 for causing false claims to Medicaid.

In December 2002, the United States Attorney's Office for the Southern District of Illinois requested the National Association of Medicaid Fraud Control Units ("NAMFCU") to collect utilization data for several procedure codes relating to enteral feeding, to assist with an FBI investigation.

The investigation revealed that the largest supplier, Abbott Laboratories ("Abbott Labs") acting through its Ross Products Division ("Ross"), provided free enteral feeding pumps to DMEs and nursing homes in exchange for agreements from the DMEs and nursing homes to purchase a predetermined amount of tubing necessary to operate the pumps. Ross also paid monetary inducements to some DMEs and nursing homes. Ross' representatives told the DMEs and nursing homes that they could submit claims to Medicare and Medicaid for the pumps; some of the MDEs and nursing homes did submit such claims. There is no information or allegations that there was overutilization of enteral feeding supplies or no medical necessity. Most of the activity affected the Medicare program, but Medicaid did pay both crossover claims and "straight" claims.

C.G. Nutritionals, an Abbott Labs subsidiary, agreed to plead guilty to Obstruction of a criminal investigation of Health Care Offense, 18 U.S.C. §

1518. The company will also pay a $200 million fine.

Pfizer, Inc.

Pursuant to an agreement Pfizer agreed to pay $303,591.97 to settle allegations that the company, as successor in interest to Warner-Lambert company, failed to report "best price" information for the drug Lipitor.

A *qui tam* action alleged that Pfizer failed to correctly report "best price" to the Governmnet for the drug Lipitor in 1999. Lipitor was developed by Warner-Lambert. Pfizer purchased Warner-Lambert in 2000 and Pfizer assumed successor liablity for Warner-Lambert's alleged false reporting.

The suit alleged that Warner-Lambert knowingly misreported and underpaid its Medicaid rebates for Lipitor. Generally, Warner-Lambert was required to calculate and pay rebates to each state Medicaid program based on the difference between the Average Manufacturer Price and its "best price." During the time of the covered conduct Warner-Lambert provided educational grants and program funding to managed care organizations in exchange for access to the drug Lipitor. Warner-Lambert is alleged to have failed to factor such payments into the best price calculations and thereby under-paid its rebates to all states participating in the Medicaid program, excluding Arizona and Tennessee.

AstraZeneca, Inc.

AstraZeneca paid $170,826.35 to settle allegations that its marketing practices inflated the price Medicare & Medicaid paid for the prostate cancer drug Zoladex.

As a result of a *qui tam* suit pursuant to the Federal False Claims Act, the United States Attorney's Office of Delaware conducted criminal and civil investigations related to AstraZeneca's marketing practice for Zoladex between 1993 and 1999. It is a direct competitor of Lupron, which was the subject of a similar settlement with TAP Pharmaceuticals in 2001.

The investigation was based upon allegations that AstraZeneca employees supplied free quantities of Zoladex to physicians; that AstraZeneca operated a program to encourage physician purchases of Zoladex, which inflated the Average Whole Sale Price, and offered discounted prices to the physicians

while advising them not to report the discounts to Medicare. AstraZeneca also allegedly provided educational grants, consulting fees and entertainment expenses in exchange for orders of Zoladex but failed to include those items in its Best Price reporting and thereby underpaid Medicaid Drug Rebates.

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 Attorney General's 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 Attorney General's 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 Attorney General's 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
Nashville, TN	2-10-03	Auditing Nursing Home Cost Reports for Fraud	Ronald Scheid
Parkville, Mo	4-3-03	Firearms Qualification	Ronald Scheid
STATE	**DATE**	**TRAINING**	**ATTENDEES**
Oskaloosa	9-11-02	Crime Scene Investigation and evidence integrity	Pamela Horn
Oskaloosa	9-11-02	Crime Scene Investigation and evidence integrity	Ronald Scheid
Oskaloosa	9-11-02	Crime Scene Investigation and evidence integrity	Philip McManigal
Oskaloosa	9-11-02	Crime Scene Investigation and evidence integrity	Jerry Martens
Oskaloosa	9-11-02	Crime Scene Investigation and evidence integrity	Marla Meyers
Oskaloosa	10-8-02	Advanced Force Tactics	Philip McManigal
Oskaloosa	11-13-02	Firearms Qualification	Philip McManigal
Oskaloosa	11-13-02	Firearms Qualification	Marla Myers
Lawrence	12-18-02	Firearms Qualification	Marla Myers
Lawrence	12-18-02	Firearms Qualification	Pamela Horn
Holton	01-13-03	Offender supervision practices	Philip McManigal
Maple Hill	1-23-03	Registration of Sex Offenders	Philip McManigal
Lawrence	3-4-03	Protecting the Elderly	Ronald Scheid
Lawrence	3-4-03	Protecting the Elderly	Philip McManigal

Lawrence	3-4-03	Protecting the Elderly	Marla Myers
Lawrence	3-4-03	Protecting the Elderly	Jerry Martens
Lawrence	3-4-03	Protecting the Elderly	Denise Desch
Lawrence	5-21-23-03	M-Squad School	Philip McManigal
Oskaloosa	6-20-03	Firearms Qualification	Philip McManigal
Oskaloosa	6-20-03	Firearms Qualification	Marla Myers
Oskaloosa	6-20-03	Firearms Qualification	Denise Desch
LOCAL	**DATE**	**TRAINING**	**ATTENDEES**
Topeka	10-24-02	Digital Photography	Philip McManigal
Topeka	02-14-03	Pressure Ulcer Prevention/Management	Marla Myers

Appendix B

DATE OF PRESENTATION	TOPIC	PRESENTER	SPONSORS	LOCATION	ATTENDEES	APPROX ATTEN-DANCE
October 22, 2002	Introduction to the Medicaid Fraud and Abuse Division	Jon Fleenor, Ron Scheid	Single State Agency	Topeka	SURS and Single State Agency employees	50
November 13, 2002	Attorney-Client Privilege and Health Care Fraud Investigations	Jon Fleenor	Kansas Association of Hospital Attorneys	Topeka	General Counsel for area medical providers	50
November 20-21, 2002	Adult Care Homes: Investigating Criminal Liability.	Jon Fleenor	Kansas Center for Assisted Living	Topeka	Adult care home owners and operators	75
April 3, 2003	Fraud Detection	Jon Fleenor, Ron Scheid	EDS Quality Assurance Team	Topeka	Fiscal Intermediary employees	20
April 8, 2003	Fraud, Abuse & Neglect of the Elderly: Health Care Provider Crimes	Jon Fleenor,	Kansas Department of Health and Environment	Topeka	registered nurse surveyors, social workers, sanitarians, and administrative staff	90
Apri. 10, 2003	Elder Abuse	Jon Fleenor,	Johnson County Elder Abuse Committee	Overland Park	Johnson County District Attorney's office, Johnson County Area Agency on Aging	100