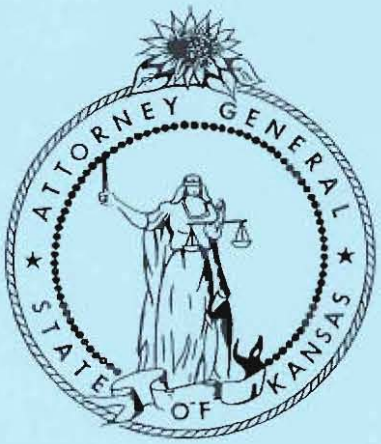
MEDICAID FRAUD AND ABUSE DIVISION ANNUAL REPORT



2004-2005

OFFICE OF THE KANSAS ATTORNEY GENERAL
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KANSAS ATTORNEY GENERAL MEDICAID FRAUD CONTROL UNIT

2004-2005 ANNUAL REPORT

The Medicaid Fraud and Abuse Division of the Kansas Attorney General's Office is the Medicaid Fraud Control Unit for the State of Kansas. (Kansas Statutes Annotated 21-3852). This annual report covers the reporting period of July 1, 2004 through June 30, 2005, and provides the information required by 42 C.F.R. § 1007.19. It is submitted in conjunction with the re-certification questionnaire requested by the Office of Inspector General.

(a) The number of investigations initiated and the nnmber completed or closed, categorized by type of provider are:

Provider	Initiated Cases	Closed Cases
1. Nursing Facilities	17	8
2. Hospitals	1	
3. Other Institutions		
4. Substance Abuse/Rehab Ctr	1	
6. Other Facilities	5	2
7. MD/DO	7	1
8. Dentists	4	4
13. Other Practioners	1	1
14. Pharmacy	7	5
15. DME	3	
17. Transportation	5	1
18. Home Health Care	46	17
20. Psychologist		1
21. Other Medical Support	1	1
23. Patient Abuse/Neglect	6	4
24. Patient Funds	6	1
25. Other	3	1
TOTALS	113	48

Open Cases as of 07/01/2004	88
Add: Cases Initiated During Period	113
Less: Cases Closed/Completed	(48)
Open Cases as of 06/30/2005	153

(b) **Number of cases prosecuted or referred for prosecution**:

26

Number of cases finally resolved and their outcomes:

12 Twelve convicted by pleas of guilty or no contest.

Number of cases investigated but not prosecuted or referred for prosecution because of insufficient evidence:

24

(c) **Number of complaints received regarding abuse and neglect of patients in health care facilities**:

2,758

Every complaint received by the Kansas Department of Aging (formerly the Kansas Department of Health and Environment) regarding healthcare facilities and consumers is reviewed. Most of the complaints are about such issues as room temperatures, dissatisfaction with food or food service, too much noise in the facility, etc.

Number of such complaints investigated by the Unit:

17

Number of complaints referred to other state agencies:

5

(d) **Number of recovery actions initiated by the Unit**:

0

Number of recovery actions referred to another agency:

36

Total amount of overpayments identified by the Unit:

For this reporting period the unit identified, and referred to the single state Medicaid agency, overpayments totaling $185,835.09.

Total amount of overpayments actually collected by the Unit:

$ 4,249,105.21 (This number includes both the federal and state shares of global settlements pursued in conjunction with the National Association of Medicaid Fraud Control Units, but does not include any penalties, attorneys fees or costs recovered in those settlements. The number also includes two settlements in conjunction with the Kansas Attorney General's Consumer Protection/Antitrust Division)

(e) **Number of recovery actions initiated by the state Medicaid agency under its agreement with the unit**:

The state Medicaid agency during this reporting period was the Kansas Department of Social and Rehabilitation Services (SRS). However, as of July1, 2005 the single state Medicaid agency became the Division of Health Policy and Finance.

The unit has no way of independently tracking the number of actions initiated by SRS or the Division of Health Policy and Finance, and must rely on the information provided to us by those entities.

For this reporting period, 7 recovery actions were reported as having been initiated by the state Medicaid agency under its agreement with the unit.

Total amount of overpayments actually collected by the state Medicaid agency under this agreement:

The unit has no way of independently tracking the amount of overpayments actually collected by SRS or the Division of Health Policy and Finance, and must rely on the information provided to us by those entities.

For this reporting period, $156,316.21 in overpayments was reported as having

actually been collected by the state Medicaid agency under its agreement with the unit.

(f) Projections:

In the last annual report it was projected that the more aggressive attitude of the current staff of the Medicaid Fraud Control Unit, which is more in line with the Attorney General's plan of vigilantly prosecuting fraud and abuse in the system and cracking down to the fullest extent of the law, coupled with an increase in staffing would continue to significantly improve the effectiveness of the unit. The unit's statistics show that the projection was accurate. As long as fraud and abuse continue, the unit projects that it will continue to grow and produce results consistent with the above described philosophy. The unit anticipates that investigations and prosecutions during the next reporting period will equal or exceed those of this reporting period.

(g) Costs incurred by the Unit:

$ 694,137	Total federal and state direct costs during this reporting period.
$ 89,543	Total federal & state indirect costs during the period
$783,680	Total Costs

(h) **Evaluation narrative of the Unit's performance during the period of time covered by this report:**

During this reporting period the number of active investigators and attorneys remained constant; yet as shown by paragraphs (a) and (b) above, the investigative case load almost doubled and the number of cases prosecuted almost tripled. Those numbers are a reflection of the skill, dedication and passion of the members of the unit. With the growing case load it seems inevitable that the unit may need additional staff in the near future.[1]

[1] In the 2004 Annual Report, the unit reported that its investigative staff consisted of four certified law enforcement officers (one of whom also was serving as an additional Research Analyst), and indicated a need for an additional investigator. During this reporting period the unit added an additional investigator but lost the services of the investigator who also served as a Research Analyst. Although she remains a part of the unit's staff she stopped investigating, and voluntarily relinquished her law enforcement certification, in order to concentrate on data analysis.

The overall performance of the unit could be improved by additional staff, stronger legislative tools, and a better relationship between the unit and the single state Medicaid agency. While the relationship of the unit and the fiscal intermediary (which makes up most of SURS) is good, the relationship with the single state Medicaid agency seems to be strained. It seems that the employees of the fiscal intermediary, while dedicated to the mission of protecting the integrity of the Medicaid program, are under the direction and control of certain individuals within the single state Medicaid agency who appear to be more interested in maintaining good relationships with certain providers even if that puts the program integrity at risk. There was a time when the single state Medicaid agency insisted on reviewing and approving all proposed referrals from SURS before they were made to the unit. We understood also that to some extent the single state Medicaid agency is controlling or directing the nature and scope of the SURS investigations and may be limiting what can be identified as an overpayment. We believe that referrals suffered as a result of those policies. Even though we have been told that pre-referral review by the single state Medicaid agency is no longer occurring we continue to believe - based on documented information - that the single state Medicaid agency is still controlling and directing the activities of the fiscal intermediary.

The unit's recoveries, and the effectiveness of the fiscal intermediary as well as the SURS function could be greatly improved if the single state Medicaid agency would require all providers and program administrators to strictly comply with federal laws and regulations and with all program requirements. We are often frustrated to learn that the single state Medicaid Agency has waived program requirements; discounted, settled, or otherwise forgiven provider overpayments which have been identified by the fiscal intermediary hired by the single state Medicaid Agency; or otherwise failed to comply with federal and state rules and regulations. Some of our inquires about why those thing are allowed to occur have been ignored; others appear to have caused annoyance, anger or hostility among some within the single state Medicaid agency, and there appears to be a strained relationship between the unit and the single state Medicaid agency as a consequence.

Although we have made and will continue to make program recommendations we have seen very few of our suggestions either implemented or even accepted.

We have attempted to remedy the situation with the single state Medicaid agency by opening a dialogue with the general counsel for, and other key individuals of, the single state Medicaid agency. The discussions have been cordial and polite but have not produced any significant improvement in the relationship and perhaps won't as long as the unit's insistence on strict compliance with the rules and regulations and preserving the integrity of the Medicaid program is in conflict with what sometimes appears to be the agenda of the single state Medicaid agency.

During the last reporting period the Kansas Legislature failed to pass several legislative initiatives proposed by the Attorney General at the request of the unit. Those proposals would have created a civil false claims act, a state *qui tam* act, and provided for asset forfeiture. Those proposals will carry over into the new legislative session which begins in January 2006, and their passage will once again be encouraged again by the unit.

The following are brief synopses of some of the criminal cases prosecuted by the unit during this reporting period:

State of Kansas v. Rameshia Spears and Benita Y. Givhan

Rameshia Spears (Spears) and Benita Givhan ("Givhan") are sisters. Spears was hired to provide personal care attendant services to Givhan, a Medicaid consumer. Beginning in July, 1999 and continuing to December 31, 2003 the pair, in furtherance of their conspiracy, submitted false claims to the Kansas Medicaid program for personal care attendant services which were not provided to Givhan by Spears. The pair claimed that Spears provided personal care attendant services to Givhan in Kansas from 8:00 a.m. to 5:00 p.m., Monday through Friday. However, Spears was actually employed full time by the Missouri Supreme Court in Missouri, during those hours.

Separate cases were filed which resulted in guilty pleas by both defendants. On July 19, 2004 Givhan was sentenced and ordered to repay the full $131,853.74 plus interest. On August 11, 2004 Spears was also sentenced and ordered to repay the full amount of the loss to the program. Both were eligible for and granted probation under the Kansas Sentencing Guidelines.

State of Kansas v. Jolene Harrell

The case was investigated by the local police department and referred to the unit for prosecution.

Jolene Harrell plead guilty to 22 felony counts of theft and three misdemeanor counts of theft in connection with money she took from the banks accounts of two residents at a retirement community. In addition she plead guilty to one count of Welfare fraud for applying for and receiving public assistance at a time when she was ineligible to receive public assistance.

Ms. Harrell was given access to the victims bank accounts in order to assist them with the payment of their bills. Ms. Harrell used her access to the victims' bank accounts to take money for her own benefit without permission. In addition Ms. Harrell stole, eight retirement benefits checks totaling $6,246.54 and two Medicare benefits checks totaling $226.98 from the victims.