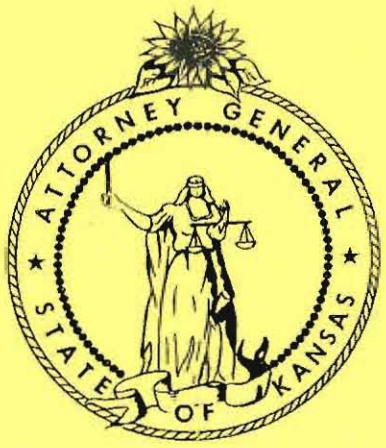
MEDICAID FRAUD AND ABUSE DIVISION ANNUAL REPORT



2005-2006

OFFICE OF THE KANSAS ATTORNEY GENERAL PHILL KLINE

KANSAS ATTORNEY GENERAL MEDICAID FRAUD CONTROL UNIT

2005-2006 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, 2005 through June 30, 2006, and provides the information required by 42 C.F.R. § 1007.17. 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 number completed or closed, categorized by type of provider are:

Provider	Initiated Cases	Closed Cases
1. Nursing Facilities	0	1
2. Hospitals	1	1
3. Other Institutions	0	0
4. Substance Abuse/Rehab Ctr.	0	1
5. Free Standing Clinic	0	0
6. Other Facilities	0	4
7. MD/DO	0	3
8. Dentists	1	0
9. Chiopractor	0	0
10. Podiatrist	0	0
11. OD/Optamologist	0	0
12. Psychiatrists	0	0
13. Other Practioners	0	1
14. Pharmacy	8	5
15. DME	4	1
16. Lab	0	0
17. Transportation	5	1
18. Home Health Care	50	19
19. X-Ray/Imaging	0	0
20. Psychologist	0	0
21. Other Medical Support	0	0
22. Pre-Paid Health	0	0
23. Patient Abuse/Neglect	10	8
24. Theft/Misuse of Patient Funds	5	2
25. Other/Activity	4	1
TOTAL	88	48

Open Cases as of 07/01/2005	153
Add: Cases Initiated During Period	88
Less: Cases Closed/Completed	(48)
Open Cases as of 06/30/2006	193

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

10

Number of cases finally resolved and their outcomes:

16 Sixteen convicted by pleas of guilty or no contest.

1 Acquitted on six of eight charges. The jury hung on the remainder. (The Unit will seek to re-try the defendant on the two charges on which the jury was unable to reach verdicts.)

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

15

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

4,075

Every complaint received by the Kansas Department of Aging (formerly the Kansas Department of Health and Environment) regarding abuse and neglect in healthcare facilities and from consumers or the public is reviewed.

Number of such complaints investigated by the Unit:

5

Number of complaints referred to other state agencies:

17

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

0

Number of recovery actions referred to another agency:

26

Total amount of overpayments identified by the Unit:

For this reporting period the unit identified, and referred to the single state Medicaid agency, matters of apparent overpayments but left the determination of the amount up to the single state agency.

Total amount of overpayments actually collected by the Unit:

$ 427,871.06 (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.

(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 Division of Health Policy and Finance.

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

For this reporting period, no 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 state Medicaid agency during this reporting period was the Division of Health Policy and Finance.

The unit has no way of independently tracking the overpayments actually collected by the Division of Health Policy and Finance, and must rely on the information provided to us by that agency.

For this reporting period, $ 28,430.68 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. Although the anticipated increase in staffing did not occur, the Unit's statistics show that the projection as to the effectiveness of the Unit was accurate.

The Unit has been operating for several years with only two attorneys while the third attorney on staff has been on active military duty. The third attorney's active service is terminating and she has expressed her intention to return to the Unit as early as August 1, 2006. Furthermore, our FY2007 budget request includes a request to add another investigator.

During this reporting period, the Kansas Legislature passed a bill which created within the Office of the Attorney General, the "Abuse, Neglect and Exploitation of Persons with Disabilities Unit." The unit will be separate from the Medicaid Fraud Control Unit and will not be funded in any part by the grant to the MFCU. The new unit will work in partnership with the agency in Kansas which is designated under federal law and by the Governor as the state protection and advocacy agency. The jurisdiction of this new unit in abuse, neglect, and exploitation matters will overlap, but will be more broad than the jurisdiction of the Medicaid Fraud Control Unit. The new unit is not yet fully operational. It is anticipated that for FY2007 the impact of the new unit on the abuse cases that the Medicaid Fraud Control Unit investigates and prosecutes will be minimal. Protocols for the coordination of the efforts of the new unit and the MFCU will be discussed just as soon as the new unit is operational.

The current Attorney General of the State of Kansas is running for re-election. Neither the current Attorney General nor his challenger have opposition in the state primary election scheduled for August 1, 2006. The identity of the Attorney General for the next four year term commencing on January 8, 2007 will be decided in the state general election on November 7, 2006.

Because the philosophy and vision of the current Attorney General are known, we project that under his continued leadership the Unit and its effectiveness will continue to improve. The other candidate for the office of the Attorney General is also a prosecutor; and while the Unit has not had an opportunity to discuss with him his philosophy regarding our mission or his vision for the Unit we anticipate that he would fully support our efforts.

(g) Costs incurred by the Unit:

$ 728,436	Total federal and state direct costs during this reporting period.
$ 89,954	Total federal & state indirect costs during the period
$ 818,390	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. Also during this reporting period one attorney and one investigator were out of the office preparing for and assisting in the prosecution of a major case for approximately a month. In addition we are working at least two major fraud cases involving millions of dollars. Notwithstanding those facts, as shown by paragraphs (a) and (b) above, the investigative case load increased by 40 and the number of cases resolved also increased. Those numbers are a reflection of the skill, dedication and passion of the members of the unit.

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. As mentioned in the Projection section, we expect to be back to a full staff of attorneys very soon and our FY2007 budget request includes a request to add another investigator.

Several legislative initiatives proposed by the Unit to the Kansas Legislature were passed during this reporting period. One of the new laws provides for the forfeiture of assets derived from fraudulent Medicaid billings. The legislature also strengthened our investigative tools by amendments to our obstruction of justice laws. Our efforts to obtain a civil false claims act were unsuccessful. We supported a bill to create an office of an inspector general to oversee the administration of the Medicaid program. The legislature approved funding for an inspector general to be appointed by the Kansas Attorney General for a term to begin in January 2007.

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 remained 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. As of July 1, 2006 the responsibility for the administration of the Medicaid program was transferred to the newly created Health Policy Authority, made up of nine-members, including a retired regional administrator for Centers for Medicare and Medicaid Services.

It is hoped that with the assistance of the Inspector General we will be able to convince the new Health Policy Authority that it needs to implement a change in philosophy that would require all providers and program administrators to strictly comply with federal laws and regulations and with all program requirements. Such a change in policy would assist the MFCU in its recovery efforts and increase the effectiveness of the fiscal intermediary and the SURS function, resulting in a greater protection of the integrity of the Medicaid program.

During this reporting period, the single state Medicaid Agency continued to engage in the practices of waiving program requirements; discounting, settling, or otherwise forgiving provider overpayments which have been identified by the fiscal intermediary hired by the single state Medicaid Agency; and otherwise failing 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. It is hoped that with the creation of the office of an Inspector General and the change of entity administering the Medicaid program that there will be a change in not only the philosophy toward fraud waste and abuse but an improvement in the relationship between the Unit and the single state Medicaid agency.

During this reporting period we continued our attempt to remedy the situation with the single state Medicaid agency by dialogue with the general counsel for, and other key individuals of, the single state Medicaid agency. Those discussions remained cordial and polite did not produce 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. We intend to reach out to the Health Policy Authority in an effort to encourage program changes that would protect and preserve the integrity of Medicaid program from fraud, abuse and waste.

We also intend to continue to make legislative proposals during the next legislative session to strengthen our enforcement tools.

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

United States of America vs Arlan D. Kaufman and, Linda J. Kaufman

This case involved physical abuse of mentally ill residents at Kaufman House, a group home in Newton, Kansas by the owners Arlan Kaufman, a one-time licensed clinical social worker with a doctorate degree in social work, and his wife Linda, a registered nurse.

The Kaufmans managed the medical and financial affairs of the residents at their facility. Rather than lawfully and responsibly carrying out their duties as caregivers, the Kaufmans used physical force and threats to intimidate the residents, to isolate them from their families and to sexually humiliate them. At times residents were forced to strip naked and confined to a seclusion room, forced to urinate and defecate into a wastebasket, shocked on the genitals with a stun gun, and forced to perform sexual acts while being videotaped. The residents were repeatedly warned that if they did not obey their abusers they could go to jail or a state mental institution.

While the abusive conditions existed at Kaufman House, the Kaufmans submitted false claims to Medicare totaling more than $200,000 seeking payment for therapy services that were not provided and services that did not meet Medicare standards. Patients and their families also received bills totaling hundreds of thousands of dollars for services that were not rendered.

This case was referred to the United States Attorneys office for prosecution because of the Medicare fraud and because federal laws provided greater remedies for the abusive actions than did state laws. The Medicaid Fraud Control Unit remained involved and provided investigative and legal assistance both prior to trial and during the month long trial; including trial testimony.

The federal jury found Arlan Kaufman guilty on 31 counts including conspiracy, forced labor, involuntary servitude, health care fraud, money laundering, mail fraud and obstructing a federal audit. Linda Kaufman was found guilty on 30 counts. Arlan Kaufman was subsequently sentenced to serve 30 years and Linda Kaufman was sentenced to serve 7 years.

United State of America v. Peggy Franklin-El and Johnnie Franklin-El

Assistant Attorney General Loren F. Snell, Jr., acting under his designation of Special Assistant United States Attorney, obtained an indictment of Peggy Franklin-El and Johnnie Franklin-El from a federal grand jury. The indictment charges the couple each

with one count of conspiracy, 52 counts of health care fraud, 15 counts of money laundering, and one count of obstruction of a criminal health care investigation. The indictment alleges that the couple conspired to and knowingly engaged in a scheme to defraud Medicaid of approximately $1.24 million during the period from June 2003 to November 2004.

According to the indictment, Peggy Franklin-El and Johnnie Franklin-El owned, operated, and were officers of The Great Meeting Is On For Your Success, Inc., a not for profit corporation, that was in the business of allegedly providing counseling services, including drug and alcohol services provided to Medicaid beneficiaries under the community based drug and alcohol abuse services program.

The defendants, it is alleged, conspired and schemed to defraud the Medicaid program by billing and causing others to bill Medicaid for services that were not provided or were not necessary. In addition, it was alleged that 32% of the total funds billed to and paid by Medicaid were actually for services reportedly provided to individuals related to the defendants. The indictment also alleges that of the 67 total beneficiaries, 56 had not actually been approved for drug and alcohol abuse treatment pursuant to the Medicaid provider manual requirements.

The charge of conspiracy is punishable by not more than five years in federal prison; each count of health care fraud is punishable by up to 10 years imprisonment; each count of money laundering is punishable by up to 10 years imprisonment; the charge of obstruction of a criminal health care investigation is punishable by not more than five years in federal prison. In addition, the defendants are subject to fines of up to $2.4 million to be determined by the court.

The defendants have merely been accused and are considered innocent unless and until convicted in a court of law.

State v. Michael Wurm and Nancy Wurm

Michael Wurm and his wife Nancy were found guilty of obtaining or exerting unauthorized control over the life savings of Michael's maternal grandmother. Through a series of bank transfers Michael Wurm and his wife Nancy took $397,885.25.

In 1999, Michael Wurm became his grandmother's Power of Attorney with authority to handle her financial affairs and pay her bills, including her monthly expenses at a nursing home. Soon after becoming Power of Attorney, Michael Wurm began to transfer funds from his grandmother's checking account into his and Nancy's personal or business accounts. The victim didn't discover that her life savings of $397,885.25 was gone until her nursing home bills didn't get paid, at which time she became a Medicaid beneficiary.

Michael Wurm was found guilty of ten counts of felony theft and Nancy Wurm was

found guilty of six counts of misdemeanor theft. Under the Kansas Sentencing Guidelines both defendants were granted probation. Both were ordered to pay restitution

State v. Patricia A. Smith

Patricia A. Smith (a registered nurse) plead guilty to and was convicted of Medicaid fraud. She was granted probation from the confinement portion of her sentence; fined $5,000 and ordered to pay restitution of $16,397.16 plus interest.

The charge against Patricia Smith alleged that she knowingly and intentionally aided, abetted, or assisted Timothy W. Smith (her husband - a medical doctor) and or Molly Smith (her daughter) in submitting false and fraudulent claims in the amount of $22,086.48 to the Kansas Medicaid program. The claims were for personal care attendant services that were not or could not have been provided by Molly Smith. As a consequence the Kansas Medicaid program paid $16,397.16 for services that were not provided or were not properly billed.

Patricia Smith arranged for Molly Smith to become enrolled as a Personal Care Attendant (PCA) for her sister H.-A.S who was a Medicaid eligible minor child still living at the home of Patricia Smith and Timothy W. Smith. We believe that Patricia Smith actually completed the enrollment documents and signed Molly Smith's name to the Provider Agreement. Thereafter Medicaid claims were submitted in Molly's name for services allegedly provided by Molly for H.-A.S. That the claims were fraudulent was discovered when a non-family member who was actually providing PCA services saw blank and partially completed time sheets in the Smith home that had been pre-signed with the name of Molly Smith. Further investigation revealed that Molly Smith had signed and given blank or partially completed time sheets to Patricia Smith who completed them with fraudulent time entries and submitted them to the Medicaid program as if Molly Smith - who was living in Chicago - was actually providing the services in the Kansas City area. Patricia Smith also signed Molly Smith's name on some of the time sheets and on the payment checks sent to Molly Smith. The fraudulently obtained funds were then deposited into the family banking account. Because the Smith family has significant financial resources, we were able to obtain full restitution for the Medicaid program without the need for the program to initiate collection activities.

Conspiracy and fraud charges against Molly Smith go to trial at the end of August 2006. Charges against Timothy Smith are pending.