United States General Accounting Office

GAO

Report to the Ranking Minority Member, Committee on Commerce, House of Representatives

July 1995

MEDICARE

Allegations Against ABC Home Health Care

GAO/OSI-95-17

GAO

United States
General Accounting Office
Washington, D.C. 20548

Office of Special Investigations

B-261406

July 19, 1995

The Honorable John D. Dingell
Ranking Minority Member
Committee on Commerce
House of Representatives

Dear Mr. Dingell:

This letter responds to your request that we investigate specific allegations regarding ABC Home Health Care's (now known as First American Health Care) participation in the Medicare home health care program. Specifically, the allegations were that (1) ABC employees altered or forged medical records to ensure continued or prolonged home health care visits; (2) ABC employees made more visits to patients than were necessary; and (3) ABC charged Medicare for costs not related to patient care. This report discusses our findings on each of these allegations. You subsequently asked that we review ABC's cost reports regarding legal expenses for appealing denied claims. As agreed, this issue will be addressed in separate correspondence.

Background

The Health Care Financing Administration (HCFA)—an agency of the Department of Health and Human Services—administers the Medicare home health care program. The home health care program has been part of Medicare since it began in 1965 and serves as an alternative to lengthy inpatient hospitalization. To be eligible, patients, except when receiving outpatient services, must be confined to their home (i.e., "homebound") as certified by their doctor. Among the services that patients receive in the home health services are (1) part-time or intermittent skilled nursing care; (2) physical, speech, and occupational therapy; (3) home health aide services as an adjunct to skilled nursing or therapy care; (4) medical social services; and (5) medical equipment and supplies. These services can be provided by a Medicare-certified home health agency (HHA) or by others under contractual arrangement with such an agency. ABC is one of some 8,100 Medicare-certified HHAs.

ABC is the largest privately held home health care provider in the United States, and Medicare reimbursement represents approximately 95 percent of its total revenues. ABC is headquartered in Brunswick, Georgia. Robert "Jack" Mills has led ABC since 1978 and is its current Chairman and Chief Executive Officer (CEO). In the last few years, ABC had grown rapidly. In 1990, ABC had 141 local offices in 10 states. It had 21,431 patients,

performed almost 1.3 million visits, and had Medicare revenues of $83.5 million. At the end of 1994, ABC had 354 offices in 21 states, made 7.8 million visits to 58,330 patients, and had Medicare revenues totaling $615.9 million.

In February 1995, the Office of the Inspector General (OIG), U.S. Department of Health and Human Services, sent ABC an exclusion letter, seeking to exclude it from participation in the Medicare program for 7 years. (See app. I for a copy of the letter.) The letter charged, in part, that ABC had submitted false or fraudulent charges to the Medicare program for patient-related services allegedly rendered during the course of 3 fiscal years—1987, 1988, and 1992. Among the improper charges, the letter listed a number of items that were acquired "solely for the personal use or enjoyment of the Mills family," e.g., condominium utility expenses, maid services, and automobile lease payments. The Inspector General charged that ABC knew or should have known that these costs were not related to patient care as required by federal law and regulations and that, therefore, they should not be reimbursed. ABC has appealed the proposed exclusion letter; an administrative hearing is pending.

We have shared information concerning possible illegal activities with appropriate law enforcement authorities. Some of these activities are under investigation. We discussed the nature of the allegations that we investigated with ABC's CEO, Mr. Mills, and the principal attorney for ABC. They replied that ABC has not knowingly violated Medicare law or regulations. They added that the regulations are vague and subject to broad interpretation and selective enforcement. As reported previously by GAO,[1] a lack of specificity and ambiguity in HCFA guidelines could invite exploitation of the Medicare system.

Results in Brief

In the Medicare program, providers may receive reimbursement only for those expenses that are reasonable in amount and related to patient care for eligible patients. Current and former employees told us that local ABC office managers directed them to alter records to make it appear that patients continued to need home health visits. Additionally, managers directed employees to continue visiting patients who, in the employees' opinion, did not qualify for home health care because they no longer met

[1]Medicare: Need to Strengthen Home Health Care Payment Controls and Address Unmet Needs (GAO/HRD-87-9, Dec. 2, 1986) and Medicare: Better Guidance Is Needed to Preclude Inappropriate General and Administrative Charges (GAO/NSIAD-94-13, Oct. 15, 1993). A GAO report on another HCFA program has a similar finding—Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes (GAO/HEHS-95-23, Mar. 30, 1995).

Medicare rules defining homebound status. ABC also reportedly charged Medicare for the cost of acquiring other HHAs by paying owners a small sum up front and the balance in the form of salary under employment agreements. HCFA officials and the Medicare fiscal intermediary[2] believe that this practice is inconsistent with Medicare regulations for reimbursement. Finally, according to former employees, some managers directed employees to market ABC and its services with the intent of charging Medicare for costs that HCFA does not reimburse.

ABC Modified Medical Records to Continue to Provide Services to Patients Who May Be Ineligible

Current and former ABC employees told us that medical records were altered and forged to ensure continued or prolonged home health care visits. We found instances in which ABC's records appeared to justify home visits, but the patient seemed no longer eligible.

Medicare patients qualify for visits if they are confined to their home (except when receiving outpatient services), under the care of a physician who approves a plan of home care, and are in need of intermittent skilled nursing care or physical or speech therapy.[3] Neither Medicare law nor regulations establish a ceiling on the number of visits a patient may receive.

Physicians certify the initial need for home health services and recertify the need for continued services at least every 2 months.[4] However, physicians are generally not required to see patients to recertify continued need for home health visits. We found that physicians typically rely on nurses' verbal and/or written recommendations, which are part of the patient's records. In this regard, nurses and aides are required to make notes for the services they performed during each patient visit.

At 10 locations, according to current and former employees, ABC office managers directed staff to alter nursing notes so that they would not reflect indications of patient improvement. This practice was intended to create the appearance that continued home health visits were needed. In one office, a manager highlighted nurses' notes that the manager wanted changed to make it appear that continued care was necessary and dictated what the rewritten language should be. After one nurse declined to describe the conditions of her patients inaccurately, the manager asked

[2]A fiscal intermediary is a private contractor that processes claims and audits HHAs on behalf of HCFA.

[3]42 C.F.R. § 424.22.

[4]42 C.F.R. § 424.22(b).

another nurse to change nursing notes although she had not seen these patients. Another office manager directed a nurse to record visits that were never made. That manager also forged physicians' signatures on plans of care that described the treatment. In another instance, a local ABC Quality Assurance Coordinator traced physicians' signatures onto a physician recertification form. In another office, after plans of care were signed by physicians, nurses added language that increased the number of visits, without consulting with the physicians.

Several former ABC nurses and aides said that local ABC managers stressed "negative charting." Under this concept, they were encouraged to include only the negative aspects of a patient's condition and to ignore any improvements. This strategy, therefore, highlighted the appearance of the need for the continued care of patients who were purportedly confined to the home. Nurses and aides provided the following examples of negative charting.

In one instance, a diabetic home health care patient walked to church regularly without assistance, but a manager directed the patient's nurse to omit any reference to this fact. Another patient had had an accident, lacerating a hand, while he was driving; however, a manager told the nurse to change the cause of the injury to a fall as a result of "a dizzy spell" to reflect the patient's need for continued home care. Another patient never used a cane; however, a nurse was asked to record that the patient required the use of a cane.

In other cases, patient records simply reflected that the patients continued to be homebound. The patients continued to receive visits, according to current and former ABC nurses, even after they were no longer confined to their homes. For example, we visited one such patient who routinely drove a vehicle to go grocery shopping. Another patient usually walked alone once a day to eat at the local senior citizens' center a few blocks away.

ABC Managers Emphasized Need to Maximize Patient Visits

Industry officials and current and former ABC employees told us that, for those patients who were eligible for home health care, ABC visited patients more frequently than did other HHAs. According to these individuals, such frequent visits occurred partially because ABC managers emphasized the need to increase patient visits. Each month the corporation sent out what it termed "High Rollers Memos" that congratulated those offices with the largest number of visits for that

month. Employees stated that the primary purpose of the memorandums was to promote an increase in patient visits and Medicare reimbursements.

A former manager told us that a senior manager had told local administrators, "Increase the number of visits. Whatever it takes to get that done, do it." Nurses and aides told us they felt pressured to prolong treatment or to make more frequent visits. In their opinion, they made frequent visits in order to keep the patient visit count high. When they expressed their concerns to management about visiting patients who did not qualify for home visits, they were told by managers either to continue with the visits or to reduce the frequency of visits to the patients. According to nurses and aides, managers were more likely to decrease the visit frequency for patients no longer eligible for home care rather than to discontinue visits altogether.

We found that some patients and their families complained that ABC visited too often. In Florida, for example, the family of a patient complained that ABC nurses continued to come to their home despite their objections. On some days, the family would complete a certain task that the nurse or aide was scheduled to do before the individual arrived at the home; therefore, for that day, a visit would not be needed. Nevertheless, the nurse or aide would ask the family to sign a form so that they could get paid for the task that they were scheduled to perform. Similarly, in Pennsylvania, a former ABC nurse recalled that a patient questioned her as to why she was being seen. The nurse acknowledged that, in her opinion, the woman did not require home care.

In various locations, former employees told us that office managers directed nurses and home health aides to visit new patients for a specified number of consecutive days regardless of their condition. For example, some employees told us that managers told nurses to visit new patients the first 5 days regardless of condition, while other employees stated that ABC stressed visiting new patients daily for the first 14 or 21 days of care regardless of condition. Generally, HCFA will not question daily visits during the first 21 days of care.

ABC Reportedly Charged Medicare for Costs of Purchasing Home Health Agencies and for Gifts Given to Physicians

ABC reportedly charged Medicare for questionable costs when ABC included expenses associated with the purchase of other HHAs in its cost reports. Allowable costs of an acquisition are primarily depreciation, over a period of years, of the value of the business assets acquired and interest expense for necessary borrowing related to acquiring those assets. Typically, HHAs own a limited number of assets, such as office furniture, equipment, and leases. We found that this was true for those ABC acquisitions that we reviewed. Therefore, the amount that ABC could reasonably include in its Medicare cost reports would be minimal. According to former corporate officials and owners we interviewed, ABC would pay owners a small amount to cover asset values and enter into an employment agreement with the owners to cover the remainder of the purchase price. In some cases, former owners worked for their salaries; in other instances, they performed minimal work or no work for their salaries. Additionally, former employees told us that, with the intent of obtaining Medicare reimbursement, ABC managers directed employees to incur "educational" expenses that were actually gifts made to physicians in return for patient referrals.

Employment Agreements With Former HHA Owners to Fund Agency Purchases

HCFA officials and the Medicare fiscal intermediary do not view ABC's reported method for charging Medicare for the overall purchase price of other HHAs as appropriate. Former owners who had sold their HHAs to ABC maintain that ABC masked the total price of purchasing their HHAs by paying HHA owners a small sum up front and the balance in the form of salary under employment agreements over a number of years. As a result, former owners and former managers concluded that ABC had charged most of the purchase price to Medicare by claiming that the salary paid under the employment agreements was not for the HHA acquisition price but for work performed by the former owners.

Since the late 1980s, at least 20 former home health care agency owners signed employment agreements with ABC. The terms of the employment agreements stated that the former owners would devote their "working time to the affairs of the company," as specified, and report directly to Mr. Mills. One of the seven former owners that we contacted stated that she had signed the employment agreement with the understanding that she would perform no work for ABC. The other six indicated that when they signed the agreements, they understood that ABC was expecting them to work under the terms of the employment agreement. However, in these seven cases, ABC gave the former owners minimal duties and/or prohibited them from entering the office to do any work, although they

continued to draw a salary. Additionally, ABC later terminated these employment agreements and removed the former owners from the payroll before their agreements expired, alleging that the former owners had failed to fulfill the terms of their agreements. After they had been prohibited from working, these former owners questioned whether the employment agreements were merely a way for ABC to have Medicare unknowingly pay for the HHA purchase price.

One former owner signed a 5-year employment contract that specified that his duties would be limited to part-time community affairs. There was no purchase price for his agency; however, ABC paid him $12,000 for used furniture, signed a 5-year lease for his building, and provided him with a 5-year employment contract at $35,000 a year plus fringe benefits with a salary escalator clause. However, he told us that he worked less than 1 month a year under his employment contract because he was occupied with his other businesses and ABC did not want him to interfere with its operation. A former ABC manager told us that when other employees told Mr. Mills that this former owner was trying to help run the HHA, Mr. Mills asked, "Why doesn't he just stay home?" When this former owner learned that ABC was charging his salary to Medicare, he became concerned that he might be targeted for fraud because of his minimal work. He told us that he then negotiated a buyout slightly over 2 years into the employment agreement. According to ABC's attorney, ABC negotiated the buyout because the former owner had refused to report to a female supervisor.

A second former owner entered into an employment agreement with ABC for 5 years with an automatic extension for another 5 years at a salary rate of $50,000 per year. Although he was supposed to do community affairs work under the terms of his agreement, he acknowledged that he did so only a few hours a day. In addition to the work he performed for ABC for more than 5 years, he ran another business and had a part-time position elsewhere. He stated that his employment agreement also provided for a bonus if he increased the number of patients for ABC. He indicated that after receiving a bonus at the conclusion of the first year of his agreement, Mr. Mills told him that Medicare would not pay for bonuses in the future. According to ABC's attorney, ABC released the former owner because he had declined to give up a part-time position outside ABC.

A third former owner signed an employment agreement which stated that she would receive $10,000 per month for 5 years. The former owner, who understood that there would be no work required of her, said Mr. Mills told her she could spend her time tending to her garden and her antiques.

During the 23-month period in which she remained on the payroll, she did not perform any work but received her full salary. ABC subsequently terminated her employment, citing her inability to perform any work. A former ABC corporate official stated that he believed she had sold her business in good faith to Mr. Mills with the understanding that there would be very little "up front" money and that the salary stipulated in the employment agreement was her form of reimbursement for the buyout of the business. When the former official objected to the generous salary provided to the former owner for doing no work, the former official quoted Mr. Mills as replying, "You just don't understand. I am paying her for the purchase price of her agency through the employment contract."

In another instance, a physician entered into a contract with ABC for the purchase of his HHA. Terms of the agreement provided for hiring the physician as a consultant at a fee of $5,000 per month for a 6-month period. Despite the physician's objections, Mr. Mills prohibited the physician from performing any kind of active role in the operation of the business once the sale had been consummated and did not pay him anything. According to ABC's attorney, this former owner had "personality problems" and had not disclosed the true financial condition of his HHA.

A former ABC manager told us of hearing Mr. Mills state on several occasions that the high price of salaries paid to former owners under the employment agreements was, in part, the purchase price of the HHAs. Referring to the former owners, the former ABC manager quoted Mr. Mills as making such statements as the following: "I don't care if they don't do a thing." "I would really rather they not work." "I don't care if they come into the office or not." "I don't care what they do." The former manager added that after he and another management official became concerned about the impropriety of charging Medicare for such salaries, Mr. Mills replied, "Medicare won't pay to buy agencies but will reimburse for salaries."

Mr. Mills told us that some owners did not abide by the terms of their agreements; thus, he subsequently released them for due cause. In response, some of the former owners pursued legal action against ABC. Some of these cases are still being litigated.

ABC Reportedly Charged Nonallowable Marketing Expenses to Medicare

According to former employees, ABC directed them to market its services to physicians and the community with the intent of charging Medicare for these nonallowable expenditures. Although Medicare reimbursement is available for the expenses of educating health professionals and the

community at large, HCFA regulations on cost reimbursement do not provide for payment for marketing home health care services.

The primary responsibility of certain ABC employees was to solicit patient referrals from physicians. In return for referrals, the employees gave physicians gifts and other items of value. Former employees stated to us that ABC managers told them not to use the term "marketing" when identifying the nature of such expenses but rather to disguise it as a "health education" expense. According to the former employees, they purchased meals or gifts for physicians on a regular basis and gave gifts to physicians and their spouses in recognition of special events, e.g., birthdays and new births. On at least one occasion, a physician received golf tickets to a Professional Golf Association tournament.

ABC also instructed employees to promise extra services for those physicians making numerous referrals. For example, according to individuals who attended one national ABC employee conference, a corporate official suggested that employees tell physicians, "Give us your next two patients, and here is what we can do for you." The official then told the employees to elaborate on the different services the corporation could provide at no cost in exchange for referrals, such as the services of nurses for blood pressure screening and lab work. According to a former employee who attended another conference, Mr. Mills remarked that it was ". . . great to see all my salespeople, I mean educators." Mr. Mills also said, "We don't market here. Whatever we do is education or in-service." Employees who attended the conference stated that attendees laughed at Mr. Mills' comment, because they knew that their jobs were to market ABC.

ABC used the title "Coordinator of Field Management Development" (CFMD) for marketing employees. ABC believed that HCFA would not reimburse the expenses for marketing but would be more likely to reimburse the costs of a CFMD, because the latter implied community education. When local administrators declined to submit expenses of CFMDs for Medicare reimbursement, citing that they were not patient care-related, Mr. Mills directed that CFMDs report their expenses to corporation managers other than the local administrators. However, according to HCFA and the Medicare fiscal intermediary, these expenses are not allowable because they are not patient-related.

According to former employees, ABC managers told employees to conceal the cost of items given to physicians in their expense reports so that HCFA

would reimburse the cost without question. Managers wanted these costs to be labeled as "educational," "training," "luncheon," or "mileage" costs. Further, they told employees that to be reimbursed, they should charge certain expenditures, such as liquor for physicians, on their personal credit cards. This would make tracing the true expenditures more difficult. One former employee disclosed that his supervisor recommended purchasing a restaurant receipt book from a stationery store for use when submitting these types of expenses for reimbursement.

Methodology

We conducted our investigation from January 1994 through May 1995. It addressed issues involving ABC's participation in the Medicare home health care program. The issues we examined included ABC's policies and practices regarding patient eligibility and visits and the appropriateness of certain expenses to the Medicare program. To examine these issues, we reviewed applicable laws and regulations, HCFA directives, correspondence between HCFA and ABC, documents presented by ABC and its employees, and ABC and HCFA patient file information for select locations. Finally, we reviewed court documents and evidence presented by ABC, HCFA, a Medicare fiscal intermediary, and individuals associated with civil litigation issues involving ABC.

We interviewed current and former ABC employees and patients and their families in selected locations, state regulatory officials in several of the states in which ABC does business, federal investigators and regulatory officials at HCFA, representatives from two fiscal intermediaries that process Medicare claims, various home health practitioners, and representatives of home health care trade associations. We conducted our work in Colorado, Florida, Georgia, Illinois, Maryland, Michigan, Pennsylvania, Tennessee, Texas, Virginia, and Washington, D.C.

If you have questions concerning this report, please contact me or Assistant Director Barney Gomez of my staff at (202) 512-6722.

Sincerely,

Richard C. Stiener
Director

Exclusion Letter

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

FEB 24 1995

BY CERTIFIED MAIL - RETURN RECEIPT REQUESTED

SEE ADDRESSEES BELOW

Dear Addressees:

Pursuant to the authority delegated to me by the Secretary and Inspector General of the United States Department of Health and Human Services, I am proposing to exclude the individuals and entities referenced below (collectively referred to as "you") from participation in the Medicare program, title XVIII of the Social Security Act (the "Act"), 42 U.S.C. §§ 1395-1395ccc, and all State health care programs, as defined in section 1128(h) of the Act, 42 U.S.C. § 1320a-7(h), for the period of seven (7) years.

This action is authorized under section 1128(b)(7) of the Act (42 U.S.C. § 1320a-7(b)(7)), and 42 C.F.R. § 1001.901. Section 1128(b)(7) of the Act authorizes the Secretary to exclude any individual or entity that has been determined to have committed an act in violation of section 1128A of the Act (42 U.S.C. § 1320a-7a) or section 1128B of the Act (42 U.S.C. 1320a-7b). The proposed exclusion is based on my determination, as set out more fully below, that you presented or caused to be presented to an agent of the United States, the Medicare Intermediary (Aetna), claims for medical items or services that you knew or should have known were false or fraudulent, in violation of section 1128A(a)(1)(B), 42 U.S.C. § 1320a-7a(a)(1)(B). The specific facts that have led to my determination are as follows.

I. INDIVIDUALS AND ENTITIES SUBJECT TO PROGRAM EXCLUSION

During calendar years 1987 through 1992, ABC Home Health Services, Inc. (ABC) was a corporation organized under the laws of the State of Georgia. During all times relevant, ABC provided "home office" services to a number of providers of home health services under the Medicare Program.[1] ABC wholly owned and controlled these providers of home health services, which together with ABC, comprised a chain organization.

[1] ABC used M & J Leasing as a conduit to provide many of the home office services. M & J Leasing is a partnership wholly owned and controlled by Robert J. and Margie Mills.

At all times relevant to this proceeding, Margie Mills was the President and Chief Operating Officer of ABC, and Robert J. (Jack) Mills was the Chairman and Chief Executive Officer of ABC. The following are home health agencies, owned and controlled by ABC, which filed cost reports for fiscal year (FY) 1988 with Aetna Insurance Company, the fiscal intermediary responsible for administering the Medicare program on behalf of the United States, falsely and fraudulently seeking reimbursement for services provided to Medicare program beneficiaries:

Group I

	Agency Name	Provider Number
1.	ABC Home Health of Ocala	10-7145
2.	ABC Home Health of Florida-Inverness	10-7324
3.	ABC Home Health of Brunswick	11-7034
4.	ABC Home Health of Dublin	11-7079
5.	ABC Home Health of Atlanta	11-7061
6.	ABC Home Health of Broward	10-7122
7.	ABC Home Health of Milledgeville	11-7035
8.	ABC Home Health of Macon	11-7084
9.	ABC Home Health of Leesburg	10-7317
10.	ABC Home Health of Alabama	01-7063
11.	ABC Home Health of Crystal River	10-7199
12.	ABC Home Health of Valdosta	11-7073
13.	ABC Home Health of Chicago	14-7197
14.	ABC Home Health of Albany	11-7085

The following are home health agencies, owned and controlled by ABC, which filed cost reports for FY 1992 with Aetna, falsely and fraudulently seeking reimbursement for Medicare services provided to program beneficiaries:

Group II

	Agency Name	Provider Number
1.	ABC Home Health of Birmingham	01-7063
2.	Home Health of Jefferson County	01-7076
3.	ABC Home Health of Arkansas (Cabot)	04-7070
4.	ABC Home Health of AR (Augusta)	04-7088
5.	ABC Home Health of Sacramento	05-7701
6.	ABC Home Health of Colorado	06-7180
7.	ABC Home Health of Plant City	10-7116
8.	ABC Home Health of Broward	10-7122
9.	ABC Home Health of FL at Naples	10-7251
10.	ABC Home Health of FL (Inverness)	10-7324
11.	Home Health of Marion County	10-7403
12.	First Florida Home Health Agency	10-7418
13.	ABC Home Health of St. Petersburg	10-7428
14.	ABC Home Health of Orlando	10-7430

15.	ABC Home Health of Atlanta	11-7061
16.	ABC Home Health of Valdosta	11-7073
17.	ABC Home Health of Illinois	14-7197
18.	ABC Home Health of Michigan	23-7063
19.	ABC Home Health of Las Cruces	32-7007
20.	ABC Home Health of Deming	32-7314
21.	ABC Home Health of PA (Pittsburgh)	39-7160
22.	ABC Home Health of TN (Loudon)	44-7132
23.	ABC Home Health of TN (Chattanooga)	44-7182
24.	ABC Home Health of TN (Cleveland)	44-7250
25.	ABC Home Health of Nashville	44-7299
26.	ABC Home Health of TN (McMinnville)	44-7454
27.	ABC Home Health of TN (Gainesboro)	44-7456
28.	ABC Home Health of TN (Dunlap)	44-7457
29.	ABC Home Health of TN (Sweetwater)	44-7489
30.	ABC Home Health of TN (Columbia)	44-7502
31.	ABC Home Health of VA (Richmond)	49-7060
32.	ABC Home Health of TX (Austin)	67-7204

II. DESCRIPTION OF THE BASIS FOR THE PROPOSED EXCLUSION

On or about March 30, 1989, you filed or caused to be filed with Aetna a Home Office Cost Statement ("Cost Statement") listing Medicare program related expenses incurred during FY 1988. The FY 1988 Cost Statement contained a number of false or fraudulent entries including items solely for the personal use and enjoyment of the Mills family. In particular, the following line items were included as Medicare program related expenses, although you knew or should have known that these items were not related to patient care, as required by Federal law and regulations, 42 U.S.C. §§ 1395x(v)(1)(A), 1395y(a)(1)(A), and 42 C.F.R. § 413.9:

	Item	Amount Included
1.	Portion of airplane costs.	$140,638
2.	Salary for pilot, the majority of whose flights were not Medicare allowable.	21,368
3.	Expenses related to Citizen Ambassador program.	4,296
4.	Senate cookout lobbying expense.	72
5.	Legal fees related to Certificate of Need.	13,180
6.	Legal fees related to Total Patient Care agency (a DME distributor).	4,263
7.	Interest on Total Patient Care debt.	45,587

8.	Legal fees related to an Alabama joint venture.	232
9.	Liquor for supervisors' meetings.	3,554
10.	Emery boards with ABC logo.	2,083
11.	Radio advertising to increase patient utilization.	250
12.	Beauty pageant program advertisement.	25
13.	Donation to drug abuse program.	408
14.	Penalties on taxes owed by M&J Leasing.	425
15.	Imputed auto costs of M&J leasing (depreciation & interest) for David and Joel Mills.	8,263
16.	M&J automobile expenses not related to patient care, including auto repairs and gas for David, Joel, Lilace Mills, and ABC Rx Shop.	9,130
17.	M&J cost for the #120 building which has no Medicare usage except for medical supply storage cost which is separately accounted for.	70,710
18.	Utilities for private beach condo.	2,432
19.	Travel and entertainment for personal use, including golf pro shop expenses and Sea Palms membership dues.	9,835
20.	TV cable charges for one year for Jack Mills' mother.	305
21.	Donation to Amity House.	80

Thereafter, on or about March 30, 1989, you filed or caused to be filed with Aetna cost reports for FY 1988 on behalf of the Group I home health agencies listed above. Each cost report sought reimbursement from the Medicare program for patient care related home office costs, and thereby incorporated and included all of the false items contained in the FY 1988 Home Office Cost Statement, as a portion of the sums sought for reimbursement.

On or about April 27, 1993, you filed with Aetna Cost Statements indicating Medicare program related expenses incurred during FY 1992. The FY 1992 Cost Statements contained a number of false or

fraudulent entries. In particular, the following line items were included as Medicare program related expenses, although you knew or should have know that these items were not related to patient care as required by 42 U.S.C. §§ 1395x(v)(1)(A), 1395y(a)(1)(A), and 42 C.F.R. § 413.9:

	Item	Amount Included
1.	Alcoholic beverages at a Leadership Conference	$ 16,863
2.	Projects by the Borden Group to influence legislators	110,163
3.	Gourmet popcorn	84,341
4.	Projects by Black, Manafort, Stone & Kelly to influence legislators	38,695
5.	Containers of hand and body lotion	30,888
6.	ABC umbrellas	27,930
7.	ABC mugs	21,303
8.	ABC earrings and cufflinks	21,243
9.	Christmas, birthday and get well cards	20,882
10.	Emery boards	14,415
11.	Solicitations of patients and agencies	12,175
12.	Sewing kits	11,550
13.	ABC combs	4,001
14.	Non-Medicare related travel expenses for ABC's Private Duty Station	3,737
15.	ABC golf tees	2,723
16.	Luncheons with legislators	2,789
17.	98 bags of vidalia onions for out of state legislators	686

Thereafter, on or about April 27, 1993, ABC filed or caused to be filed cost reports for FY 1992 for the Group II agencies listed above. Each cost report sought reimbursement from the Medicare program for patient care related home office costs, and thereby

incorporated and included all of the false or fraudulent statements and entries and non-Medicare related line items contained in the FY 1992 Home Office Cost Statements as a portion of the sums sought for reimbursement.

III. LENGTH OF EXCLUSION

In determining the length of exclusion, I have considered the following factors, as specified in 42 C.F.R. § 1001.901.

1) The nature and circumstances surrounding the actions that are the basis for liability, including the period of time over which the acts occurred, the number of acts, whether there is evidence of a pattern, and the amount claimed.

Specifically, you presented or caused to be presented cost statements and cost reports containing a substantial number of false or fraudulent entries for Medicare beneficiary related services allegedly rendered during the course of two calendar years -- 1988 and 1992. Further, many similar non-patient related claims were contained in your 1987 Cost Statement, and related cost reports, resulting in additional false or fraudulent claims to the Medicare Program. I find that the false and fraudulent entries contained in your 1987 Home Office Cost Statement provide further evidence of a pattern of filing claims for non-patient related items. Among the specific false entries supporting your 1987 Home Office Cost Statement are the following:

	Item	Amount Included
1.	Interest paid to Jack and Margie Mills (related parties)	$41,139.00
2.	Lease payments for BMW automobile used by Joel Mills (son of Jack and Margie) for personal purposes while in college	5,132.52
3.	Golf shop expenses	3,263.46
4.	Country Club Golf course membership fees	1,045.00
5.	Maid services for Jack and Margie Mills' personal luxury condominium	3,832.43
6.	Utility fees for Jack and Margie Mills' personal luxury condominium	2,831.43

In addition, the amount claimed for non-patient related items for 1988 and 1992 was substantial.

2) The degree of culpability.

I have considered your culpability and consider it to be substantial. You operated a large and sophisticated chain organization providing home health services. Furthermore, during the relevant time period, you had in your employ various reimbursement specialists, accountants and experienced legal counsel to provide you with guidance. Yet, despite the ample resources at your command to assure accurate cost reporting, your cost statements and reports included a substantial number of false or fraudulent entries for at least two fiscal years. Furthermore, you minimized the likelihood of the Government detecting these fraudulent entries, and increased the difficulty of the Government's investigation into your activities, by intermixing non-patient related items with numerous legitimately reimbursable items. Accordingly, your case does not involve unintentional or unrecognized error.

3) Other factors as justice may require.

I have considered whether there are any other aggravating or mitigating circumstances I should take into account in the interests of justice, and have concluded that another aggravating factor exists. The substantial resources invested by the United States Department of Health and Human Services in investigating and prosecuting this action are an aggravating factor I have considered.

Based on my determination that multiple aggravating factors exist and no mitigating factors are present in this case, I have determined that seven (7) years is an appropriate length of exclusion.

IV. THE EFFECT OF THE EXCLUSION

The exclusion described in this letter will be from the Medicare, Medicaid, Maternal and Child Health Services Block Grant and Block Grants to States for Social Services programs and will apply to all other Federal non-procurement programs. See 42 C.F.R. § 1001.1901. This exclusion is in addition to any sanction an individual State or other Federal program may impose under its own authorities. Pursuant to section 1862(e)(1)(A) of the Act (42 U.S.C. § 1395y(e)(1)(A)), the effect of exclusion is that no payment may be made for any items or services furnished, ordered, or prescribed by you or at your medical direction under the Medicare program, except as provided in 42 C.F.R. §§ 1001.126(d) and (e).

Further, we are required to notify the public and appropriate State agencies of the exclusion pursuant to sections 1128(c)-(e) of the Act (42 U.S.C. §§ 1320a-7(c)-(e)). The State agencies administering State health care programs will be required to

exclude you for at least the period of time specified in this letter, and the State or local licensing or certification authorities will be requested to invoke sanctions according to State law or policy.

If you submit claims or cause claims to be submitted for items or services furnished after the effective date of exclusion for which no payment may be made under section 1862(e) of the Act, you may be subject to a civil monetary penalty and further exclusion pursuant to section 1128A(a)(1)(D) of the Act (42 U.S.C. § 1320a-7a(a)(1)(D)). This provision authorizes an assessment of up to twice the amount claimed and a penalty of not more than $2,000 per item or service claimed by a person excluded from the programs.

Furthermore, please be advised that in the event it is applicable, we also may invoke the exclusion authority of section 1128(b)(8) of the Act (42 U.S.C. § 1320a-7(b)(8)), which authorizes the exclusion of entities that are controlled (for example by virtue of the position as officer, director, agent or managing employee) by excluded individuals.

V. REINSTATEMENT

At the expiration of the specified period of exclusion, you have the right to apply for reinstatement to the Medicare and State health care programs pursuant to section 1128(g) of the Act (42 U.S.C. § 1320a-7(g)) and 42 C.F.R. §§ 1001.3001-3005. In order to apply for reinstatement to these programs, you must submit a written request to the Office of Inspector General no earlier than 90 days prior to the expiration of the period of exclusion. At that time you will be notified of the information and documentation required for us to reach a decision regarding your reinstatement.

VI. APPEAL RIGHTS

The exclusion described in this letter will automatically go into effect sixty (60) days after the date of this letter unless you appeal this decision within that time. To appeal this decision you must file a written request for a hearing before an administrative law judge under the procedures set forth at 42 C.F.R. part 1005, a copy of which is enclosed. If a timely request is made, the exclusion will not go into effect until the ALJ renders a decision.

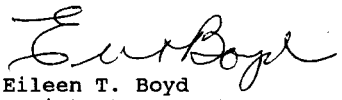
A request for hearing must be accompanied by 1) a statement as to the specific issues or findings in this notice with which you disagree; 2) the basis for your contention that the specific issues and/or findings and conclusions are incorrect; 3) the defenses on which you intend to rely; and 4) reasons why the proposed length of exclusion should be modified. See 42 C.F.R.

§ 1001.2003(a). Such a request must be made in writing, within 60 days from your receipt of this letter, to:

Mr. Gerald Choppin
Chief
Civil Remedies Division
Departmental Appeals Board
Room 637-D, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

If you have any questions, please contact Sidney Rocke at (202) 619-1525 or Larry Goldberg at (202) 619-1306.

Sincerely yours,



Eileen T. Boyd
Assistant Inspector General for
Civil Fraud and Administrative
Adjudication

Enclosure

ADDRESSEES:

ABC Home Health Services, Inc.
a/k/a First American Health Care, Inc.
3528 Darien Highway
Brunswick, Georgia 31520

Mr. Robert J. Mills
Chief Executive Officer and Chairman
ABC Home Health Services, Inc.
3528 Darien Highway
Brunswick, Georgia 31520

Ms. Margie Mills
Chief Operating Officer and President
ABC Home Health Services, Inc.
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Brunswick, Georgia 31520

ABC Home Health of Birmingham
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ABC Home Health of FL (Inverness)
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Home Health of Marion County
(Provider # 10-7403)
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First Florida Home Health Agency
(Provider # 10-7418)
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Brunswick, Georgia 31520

ABC Home Health of St. Petersburg
(Provider # 10-7428)
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ABC Home Health of Orlando
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ABC Home Health of Atlanta
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ABC Home Health of Illinois
(Provider # 14-7197)
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ABC Home Health of Michigan
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ABC Home Health of Las Cruces
(Provider # 32-7007)
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ABC Home Health of Deming
(Provider # 32-7314)
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ABC Home Health of PA (Pittsburgh)
(Provider # 39-7160)
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ABC Home Health of TN (Loudon)
(Provider # 44-7132)
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ABC Home Health of TN (Chattanooga)
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ABC Home Health of TN (Cleveland)
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(Provider # 44-7299)
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ABC Home Health of TN (Columbia)
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ABC Home Health of VA (Richmond)
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ABC Home Health of TX (Austin)
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