United States Courts
Southern District of Texas
FILED

JUN 21 2018

David J. Bradley, Clerk of Court

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

UNITED STATES OF AMERICA,	§	
	§	**Criminal No.**
v.	§	
	§	**UNDER SEAL**
ANGELA M. AKO,	§	
	§	18CR349
Defendant.	§	

INDICTMENT

Sealed
Public and unofficial staff access to this instrument are prohibited by court order.

The Grand Jury charges:

General Allegations

At all times material to this Indictment, unless otherwise specified:

1. **Medicare.** The Medicare Program ("Medicare") is a federal health care program providing benefits to persons who are over the age of 65 or disabled. Medicare is administered by the United States Department of Health and Human Services ("HHS") through its agency, the Centers for Medicare & Medicaid Services ("CMS"). Individuals who receive benefits under Medicare are referred to as Medicare beneficiaries.

2. Medicare is a health care benefit program, as defined by 18 U.S.C. § 24(b).

3. Healthcare providers that provide services to Medicare beneficiaries are required to apply for and obtain a "provider number". Part of this application process requires that the healthcare providers certify that they understand and will abide by the federal laws and regulations governing their participation in Medicare, including a specific understanding of the Anti-Kickback Statute, 42 U.S.C. § 1320a-7(b).

4. A health care provider that receives a Medicare provider number is able to file claims with Medicare to obtain reimbursement for services provided to beneficiaries. A Medicare

claim is required to set forth, among other things, the beneficiary's name and Medicare information number, the services that were performed for the beneficiary, the date the services were provided, the cost of the services and the name and identification number of the physician or other health care provider that ordered the services.

5. Part A of the Medicare program covers eligible home healthcare services provided by a participating home health agency ("HHA") provided to Medicare beneficiaries who are confined to their homes and have a medical need for skilled nursing care, physical therapy, speech therapy, or an ongoing need for occupational therapy. Claims for qualifying home healthcare services are typically reimbursed in full to the HHA based on contract rates determined by Medicare.

6. Upon enrollment, Medicare providers are issued a provider manual that describes the requirements to participate as a provider in the Medicare program. Providers also periodically receive newsletters advising them of the additional requirements for participation and instructions on what services are or are not covered by Medicare.

7. Since October 2000, Medicare compensation to home health care agencies has been based on the Prospective Payment System (PPS). Under this system, Medicare pays a home health care agency a base payment, which is adjusted based on the severity of the beneficiary's health condition and care needs. The PPS payment provides home health care agencies with payments for each 60-day episode of care for each beneficiary. If the beneficiary is still eligible for home health care after a home health episode, they may be recertified for another 60-day home health episode. There is no limit to the number of home health episodes that a beneficiary may receive, so long as the beneficiary is still eligible for home health services.

8. According to 42 Code of Federal Regulations (CFR) section 409.42, for home health services to be covered and therefore compensable by Medicare, all of the following eligibility requirements must be met:

a. The beneficiary must be confined to the home or an institution that is not a hospital (i.e., homebound).

b. The beneficiary must be under the care of a physician who establishes the plan of care.

c. The beneficiary must be in need of skilled services such as intermittent skilled nursing services, physical therapy, speech-language pathology services, or continuing occupational therapy services.

i. More specifically, in section 409.44, where a service can be safely and effectively performed (or self-administered) by non-licensed staff without the direct supervision of a nurse, the service cannot be regarded as a skilled service even if a nurse actually provides the service.

d. The beneficiary must be under a plan of care that meets the requirements specified in section 409.43.

e. The home health services must be provided by, or under arrangements made by, a participating home health care agency.

9. **Homebound Status**: In order for a patient to be eligible to receive covered home health services under both Medicare Part A and Part B, the law requires that a physician certify that the patient is confined to the home. The condition of the patients should be such that there exists a normal inability to leave home and, consequently, leaving home would require a considerable and taxing effort. If a patient does in fact leave the home, the patient may

nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment.

10. **OASIS and Plan of Care**: To determine the proper level of care for a beneficiary and ultimately to help determine the amount of payment the provider will receive, Medicare requires that home health care agencies perform a patient-specific, comprehensive assessment that accurately reflects the patient's current health and provides information to measure his progress. In making this assessment, home health care agencies are required to use a tool called the Outcome and Assessment Information Set (OASIS).

11. With limited exceptions, the OASIS assessment must be completed by a Registered Nurse (RN). The standard OASIS form is a detailed checklist that the nurse examining the prospective patient completes. The form is detailed and comprehensive, covering: clinical record items identifying the agency, the patient, the referring physician, and the period of care; demographics and patient history; living arrangements, including an evaluation of safety and sanitary conditions of the home; supportive assistance from co-habitants, relatives, and other care-givers; separate assessments of every area of the body, external and internal; mental and psychological status; functional limitations; activities of daily living such as bathing, grooming, shopping, reading and writing; permitted activities; medications and allergies; medical appliances and equipment; and therapy, teaching, training, and skilled care needs. The OASIS also contains spaces for a written analysis of findings; a projection of the number and type of treatments needed; and a description of goals, rehabilitation potential, and discharge plans for the beneficiary.

12. The OASIS information is then used to create a Plan of Care ("Form 485"). The Plan of Care specifies the frequency of home visits and describes the services to be provided to the beneficiary. The beneficiary's physician must sign the Form 485, certifying that the patient is

confined to the home and needs intermittent skilled care. Further, the physician certifies that the physician is caring for the beneficiary and that the services set forth on the plan of care are authorized by the physician.

13. **Provision of Home Health Services**: Following the initial assessment, and based upon either completion of the Form 485 or a verbal order from the doctor (later confirmed by a signed Form 485), nurses, physical therapists, and/or other home health professionals visit the patient based on the frequency ordered by the doctor and record the visit in progress notes.

14. **Documentation**: Medicare Part A regulations require HHAs providing services to Medicare patients to maintain complete and accurate medical records reflecting the medical assessment and diagnoses of their patients, as well as records documenting actual treatment of the patients to whom services were provided and for whom claims for reimbursement were submitted by the home health agency. When they fill out Medicare enrollment applications, providers must identify all locations where patient records will be kept. Among the written records required to be maintained are:

a. the Plan of Care, which includes the physician order for home health care, diagnoses, types of services/frequency of visits, prognosis/rehabilitation potential, functional limitations/activities permitted, medications/treatments/nutritional requirements, safety measures/discharge plans, goals, and physician signature;

b. the OASIS start-of-care form;

c. a signed certification statement by an attending physician certifying that the patient is under the physician's care, is confined to his or her home, and needs the planned home health services; and

d. medical records of each visit made by a nurse, therapist, or home health aide to a beneficiary, describing, among other things, any significant observed signs or symptoms, any treatment and drugs administered, any reactions by the patient, any teaching and the understanding of the patient, and any changes in the patient's physical or emotional condition.

DEFENDANTS AND RELATED ENTITIES

15. **Caring Angel Healthcare Services Inc. ("CARING ANGEL")** was a Texas corporation with a business location of 10707 Corporate Drive Suite 200 Stafford, Texas 77477.

16. **Defendant ANGELA M. AKO** was 50% owner and Director of Nursing at CARING ANGEL.

COUNT 1
Conspiracy to Commit Healthcare Fraud
(Violation of 18 U.S.C. § 1349)

17. Paragraphs 1 through 16 of this Indictment are re-alleged and incorporated by reference as if fully set forth herein.

18. From on or about January 1, 2010 through on or about January 1, 2018, the exact dates being unknown to the Grand Jury, in the Houston Division of the Southern District of Texas, and elsewhere, defendant

ANGELA M. AKO

did knowingly and willfully combine, conspire, confederate and agree with Person A and others known and unknown to the Grand Jury, to violate Title 18, United States Code, Section 1347, that is, to execute a scheme and artifice to defraud a healthcare benefit program affecting commerce, as defined in Title 18, United States Code, Section 24(b), that is, Medicare, and to obtain, by means of materially false and fraudulent pretenses, representations and promises, money and property

owned by, and under the custody and control of, said healthcare benefit program, in connection with the delivery of and payment for healthcare benefits, items, and services.

Purpose of the Conspiracy

19. It was a purpose of the conspiracy for defendant **ANGELA M. AKO**, Person A, and others known and unknown to the Grand Jury to unlawfully enrich themselves by (a) submitting and causing to be submitted false and fraudulent claims to Medicare, (b) concealing and causing to be concealed the submission of false and fraudulent claims to Medicare and the receipt and transfer of proceeds from the fraud, and (c) diverting and causing to be diverted proceeds of the fraud for the personal use and benefit of defendant **ANGELA M. AKO**, Person A, and their other co-conspirators.

Manner and Means of the Conspiracy

20. The manner and means by which defendant **ANGELA M. AKO**, Person A, and their co-conspirators, both known and unknown to the Grand Jury, sought to accomplish the object and purpose of the conspiracy included, among other things, the following:

21. Defendant **ANGELA M. AKO** and her co-conspirators maintained and caused to be maintained a Medicare provider number for CARING ANGEL, which they used to submit and cause to be submitted claims to Medicare for home health services that were not medically necessary and not provided.

22. Having certified in CARING ANGEL's Medicare enrollment documentation that she understood that Medicare would not pay claims obtained in violation of the Anti-Kickback Statute, defendant **ANGELA M. AKO** knowingly submitted and caused to be submitted, along with Person A and her other co-conspirators, claims to Medicare for CARING ANGEL

beneficiaries when she knew the claims had been obtained through illegal kickbacks and bribes. For example,

a. Defendant **ANGELA M. AKO** and her co-conspirators paid and caused to be paid illegal kickbacks to physicians in exchange for authorizing medically unnecessary home health services for Medicare beneficiaries for whom defendant **ANGELA M. AKO** and her co-conspirators submitted and caused to be submitted to Medicare.

b. Defendant **ANGELA M. AKO** and her co-conspirators paid and caused to be paid patient recruiters known and unknown to the Grand Jury for referring Medicare beneficiaries to CARING ANGEL for home health services.

c. Defendant **ANGELA M. AKO** and her co-conspirators paid and caused to be paid illegal kickbacks to Medicare beneficiaries in exchange for allowing CARING ANGEL to use their Medicare information to bill for home health services that were not medically necessary and not provided.

23. Defendant **ANGELA M. AKO** signed and caused to be signed medical records falsely representing that Medicare beneficiaries qualified for, and received, home health services when they actually did not qualify for home health services under Medicare and did not receive such services.

24. From on or about January 1, 2010 to on or about January 1, 2018, defendant **ANGELA M. AKO** and her co-conspirators submitted and caused to be submitted over $14 million in claims to Medicare for home health services purportedly provided by CARING ANGEL. Medicare paid over $16 million on those claims.

25. After Medicare deposited payments into CARING ANGEL's bank accounts, defendant **ANGELA M. AKO** and her co-conspirators used and caused to be used the fraud proceeds to pay themselves.

All in violation of Title 18, United States Code, Section 1349.

CRIMINAL FORFEITURE
(18 U.S.C. § 982(a)(7))

26. Pursuant to Title 18, United States Code, Section 982(a)(7), the United States of America gives notice to defendant **ANGELA M. AKO** that upon conviction under this Indictment, all property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of such offenses—more than $16,000,000—is subject to forfeiture.

27. Defendant **ANGELA M. AKO** is notified that upon conviction, a money judgment may be imposed equal to the total value of the property subject to forfeiture.

28. Defendant **ANGELA M. AKO** is notified that if any of the forfeitable property, or any portion thereof, as a result of any act or omission of defendant or her co-conspirators cannot be located upon the exercise of due diligence;

a. has been transferred, or sold to, or deposited with a third party;

b. has been placed beyond the jurisdiction of the Court;

c. has been substantially diminished in value; or

d. has been commingled with other property which cannot be divided without difficulty;

it is the intent of the United States to seek forfeiture of any other property of defendants up to the total value of the property subject to forfeiture, pursuant to Title 21, United States Code, Section 853(p), incorporated by reference in Title 18, United States Code, Section 982(b)(1).

A TRUE BILL

ORIGINAL SIGNATURE ON FILE

FOREPERSON

RYAN K. PATRICK
UNITED STATES ATTORNEY

DREW PENNEBAKER
TRIAL ATTORNEY
CRIMINAL DIVISION, FRAUD SECTION
U.S. DEPARTMENT OF JUSTICE