Industry Trends in Criminal Health Care Fraud Enforcement

Part III in a Continuing Series on Health Care Enforcement

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This third, and final, installment in the "Year in Review" series examines how criminal health care fraud enforcement has changed in the past year, including the use of non-health-care-related statutes, the focus on specific industries, and the increased number of alleged violators targeted in takedowns. This piece discusses specific cases illustrating recent trends in criminal investigation and enforcement, and provides our perspective on what new tactics and strategies employed by the federal government in these cases might mean for the future. Finally, it also considers how recent health care reform measures, such as new regulations, enhanced sentencing guidelines, and data analysis technology, will contribute to strengthening enforcement and enforcement strategies in 2012.

Criminal Health Care Fraud Enforcement Statistics Show "Bigger, Stronger, and Faster" Fraud Investigations

The government's successes in prosecuting and winning health care fraud cases result from continued interagency collaboration such as Medicare Strike Force (Strike Force) and Health Care Fraud Prevention Enforcement and Action Team (HEAT) investigations. In press releases, the government has touted the ties between the Department of Justice (DOJ), the Federal Bureau of Investigation (FBI), the Department of Health and Human Services' Office of the Inspector General (HHS-OIG), and local United States Attorneys' Offices (USAOs) and Medicaid Fraud Control Units (MFCUs) in health care fraud investigations. Coordination among the agencies has increased in recent years. These established ties make it easier for the agencies to detect, investigate, and prosecute large-scale fraud schemes. As advanced data-mining techniques further strengthen the links between investigatory and enforcement agencies, large-scale investigations and prosecutions will become even easier for the government to pursue in the coming years.

According to the latest Health Care Fraud and Abuse Control Program (HCFAC) report, "[c]onvictions under the [HCFAC] increased by over 27 percent (from 583 to 743) between 2009 and 2011, and the number of defendants facing criminal charges filed by federal prosecutors in 2011 increased by 74 percent (from 821 to 1430) compared with 2008."[i/]

The HCFAC Report, released in February 2012,[ii/] highlights the following statistics from criminal enforcement efforts by health care, and other, agencies in FY 2011:

- The DOJ opened 1,110 new criminal health care fraud investigations involving 2,561 potential defendants.
- Federal prosecutors:
  - investigated 1,873 pending health care fraud criminal cases involving 3,118 potential defendants;
  - filed 489 criminal cases in the courts against 1,430 defendants; and
  - obtained convictions of 743 defendants charged with health-care-fraud-related crimes.
- HHS-OIG excluded 2,662 individuals and entities: 1,015 (38%) based on criminal convictions for crimes related to Medicare and Medicaid and 233 (8.7%) for crimes related to other health care programs.

Medicare Strike Forces Continue to be a Model for Interagency Collaboration

Interagency collaborations were especially effective in criminal health care fraud prosecutions. Since the first Strike Force team was formed in 2007, federal criminal enforcement agencies have become more sophisticated and more efficient in uncovering alleged fraud schemes. In FY 2011, Strike Force teams located in each of the nine Strike Force cities produced the following overall results:

- 132 indictments, informations, and complaints involving charges against 323 defendants;
- 172 negotiated guilty pleas;
- 17 jury trials with guilty verdicts won against 26 defendants; and
- 175 defendants sentenced to terms of imprisonment averaging more than 47 months.[iii/]

Additionally, in a January 2012 presentation, DOJ Trial Attorney Joseph Beemsterboer, of the Health Care Fraud Unit of the Criminal Division, observed that, from the start of the Strike Force in 2007 until September 2011, only 12 Strike Force defendants were acquitted and only 31 cases against individual defendants were dismissed.[iv/] Strike Force efforts, through their advanced data analysis techniques and identification of suspicious billing patterns to find fraud "hot spots," are credited with accelerating "the Government's response to criminal fraud, *decreasing by roughly half the average time from an investigation's start to the case's prosecution* [emphasis added]."[v/]

Most, if not all, of the DOJ's press releases in 2011 mentioned statistics related to HEAT or the Strike Force. Two such press releases highlighted the biggest takedowns in criminal health care enforcement history. On February 17, 2011, the same day that HHS and DOJ announced the expansion of the Strike Force model to Dallas and Chicago, DOJ issued a press release reporting that it had filed charges against 111 defendants in nine cities "for their alleged participation in Medicare fraud schemes involving more than $225 million in false billing."[vi/] On September 7, 2011, the interagency team announced another nationwide takedown by Strike Force operations in eight cities resulting in charges against 91 defendants "for their alleged participation in Medicare fraud schemes involving approximately $295 million in false billing."[vii/] Although neither takedown related to only one single fraud scheme, it is clear that the federal government is using this coordinated "shock and awe" approach to show that it can handle alleged nationwide criminal fraud enterprises and is seeking such cases.

New Criminal Investigation and Enforcement Tactics

The large takedowns described above involve not only numerous defendants, but also the use of an expanded set of statutes under which to charge the individuals and corporate entities involved, reflecting another of the salient trends that characterized health-care-related criminal prosecutions in FY 2011.

Charging Conduct Under Broadly Worded Criminal Statutes

Another strategy that the federal government is employing with growing success is filing charges under broadly worded criminal statutes that are not specific to health care fraud and that, perhaps more importantly, do not require proof of specific intent. By bringing charges under such statutes, the government is able to capture a wider range of conduct than that covered by health-care-specific statutes, and reduce the evidence of criminal intent or activity necessary to secure a plea, conviction, or settlement agreement. Such a strategy shifts the balance of power heavily in the government's favor with respect to both investigation and enforcement efforts. With broad discretion to file charges that require less proof of intent, the government can use the threat of conviction to secure more favorable pleas and settlements.

Consider the statutes themselves. Although criminal cases involving a lead charge under the federal health care fraud statute, 18 U.S.C. § 1347, historically have been and continue to be high, FY 2011 saw a staggering increase in prosecutors filing charges under the mail fraud and wire fraud statutes, among others. Specifically, in FY 2011 there was a 60.2% increase in the number of cases filed under the mail fraud statute and a *1550%* increase in charges filed under the wire fraud statute. A detailed examination of the proof required for conviction under each statute sheds some light on the possible reasons for this trend.

The health care fraud statute, 18 U.S.C. § 1347, targets defendants who "…***knowingly and willfully*** [execute], or [attempt] to execute, a scheme or artifice (1) to defraud any health care benefit program… [emphasis added]." Thus, to secure a conviction under this statute, the federal government would have to prove beyond a reasonable doubt that a defendant acted knowingly *and* willfully (in addition to other elements of the crime).

In contrast, the federal wire fraud statute, 18 U.S.C. § 1343, criminalizes sending by wire any writing or signal (among other items) by persons who have devised or intend to devise any scheme or artifice to defraud for purposes of executing that scheme. Thus, conviction under this statute does not require proof of criminal intent – only proof that the defendant devised a scheme (or intended to) and sent a message via wire for purposes of executing the scheme. That the level of proof required by the wire fraud statute is significantly lower than that of the health care fraud statute may explain the dramatic jump in cases filed under this statute in FY 2011. The implications of such a charging pattern are frightening for potential defendants.

Consider, again, the wire fraud statute. Because the conduct captured by this statute is so broad and the proof required for conviction is so much less than for health-care-specific criminal statutes, the government could conceivably bring charges under the wire fraud statute in nearly every health care fraud case – and then use those charges as leverage in gaining favorable plea agreements and

settlements. The case brought against Patrick Ita (the owner of Masspoint Medical Equipment & Supplies and of PUITA Research & Procurement Inc., a medical billing company located in Texas) is a good example of the ease with which the government can charge – and convict – a defendant of wire fraud in the health care context.

In September 2011, Mr. Ita was sentenced to 78 months in federal prison, followed by three years of supervised release, after pleading guilty to charges that he engaged in a conspiracy to defraud Medicare of more than $5 million and also committed wire fraud. These criminal charges stemmed from a 13-month scheme through which Mr. Ita billed Medicare using a specific code created by Medicare to expedite the approval and payment of claims for durable medical equipment (DME) lost or destroyed by Hurricanes Katrina and Rita. Mr. Ita submitted claims using this modifier for power wheelchairs that his company allegedly replaced when, in fact, the beneficiaries for whom the claims were submitted either (1) did not have a power wheelchair before the hurricanes; (2) had a wheelchair that did not sustain any damage from the hurricanes; (3) never received a wheelchair from Mr. Ita; or (4) received a scooter instead of a power wheelchair.

As part of the prosecution of this case, Mr. Ita was charged with wire fraud because he filed fraudulent Medicare claims with Palmetto GBA (a Medicare contractor located in Columbia, South Carolina) and received all payments from Medicare (based on the fraudulent claims) by electronic funds transfer from Columbia to Mr. Ita's bank account in Houston. The conduct charged under the wire fraud statute in Mr. Ita's case is quite telling – and alarming. Given that many providers submit claims and receive payments electronically, it appears that the wire fraud statute could be implicated in nearly all criminal cases involving alleged fraud, thereby providing the federal government with a very large stick with which to enforce its health care fraud initiatives.

Treating Health Care Fraud Like "Blue Collar" Crime

The Ita case also demonstrates another trend in criminal health care fraud enforcement: treating health care fraud like "blue collar" crime. Historically, individuals under investigation for health-care-related offenses were treated like any other "white collar" criminal. Rarely was bail imposed in criminal health care matters, and investigations were often resolved financially – with no jail sentence imposed. This landscape is quickly changing.

In FY 2011, the federal government adjusted its criminal investigation and enforcement techniques to mirror those used in what some might consider more "blue collar" criminal cases. For example, following Mr. Ita's arrest in January 2011, he was held without bond. In fact, he remained in the custody of the U.S. Marshals Service until he was transferred to prison following his sentencing in September 2011. Until recently, the imposition of bond – and holding a defendant without bond – was unheard of in health care fraud cases.

The federal government has also begun using other "classic" criminal enforcement techniques in the context of health care fraud. For example, a review of DOJ press releases reveals an increased use of search warrants, raids, and wiretapping – all of which are tactics generally associated with more "blue collar" crime than health care fraud. To the same end, HHS-OIG has implemented a "Most Wanted" list of health care criminals. Some might call these strategies "scare tactics" designed to instill fear into po-

tential targets. Others might attribute these new measures to the increased seriousness with which the government approaches criminal enforcement. In either case, it seems that the days of treating health care crimes as a "white collar" offense may be coming to an end.

Larger Schemes Pursued for Enforcement in the Same Historical Target Industries

Health care fraud enforcement in 2011 was particularly prolific in industries increasingly associated with alleged, concerted, multi-provider/multi-entity fraud: DME, home health, and therapy/clinic-related fraud (e.g., physical therapy, occupational therapy, and infusion therapy).

From the beginning of the Strike Forces in 2007, DME, home health, and therapy/clinic-related industries have been the bread and butter of the criminal health care fraud agencies. Across these industries, the government pursues all participants in a given alleged scheme: patient recruiters who allegedly solicit Medicare numbers from beneficiaries; physicians and other licensed health care professionals who allegedly use their provider numbers to bill for unnecessary or never-provided services associated with these fraudulently obtained numbers; and the owners of the companies who allegedly pay fraud facilitators from the gains of the scheme. Government investigations often target schemes where one owner, physician, or patient recruiter is allegedly linked to numerous companies and multiple fraudulent schemes. For example, one case involving a husband and wife who owned or used straw owners to operate four DME supply companies in the Los Angeles area resulted in their conviction after a two-week trial.[viii] The federal government continued to focus on these key industries in FY 2011.

DME Fraud Highlights

Many of the DOJ's prosecutions relating to DME fraud pertain to the massive DME fraud scheme involving the three owners of American Therapeutic Corporation (ATC), its management company, Medlink Professional Management Group, Inc. (Medlink), American Sleep Institute, and 19 individual defendants charged with and convicted of various health care fraud offenses. As of mid-March 2012, the government had convicted both ATC and Medline, obtained guilty pleas or convictions for ten of the individual defendants charged, and awarded over $87 million dollars in court-ordered criminal fines and restitution as a result of these prosecutions.[ix] Other related trials are beginning this month.

Law enforcement agencies are still targeting false front companies, patient recruiters, and other low-hanging fruit in the DME industry. For instance, in a case based in Baton Rouge, Louisiana, the government established at trial that a DME company owner had been paying patient recruiters to invite Medicare beneficiaries to attend "health fairs" hosted by the recruiters at churches and other locations in the community. A physician co-conspirator also attended these health fairs and prescribed medically unnecessary power wheelchairs to attendees. In turn, all of the parties to the scheme received a kickback for each prescription filled. This conduct, which lasted from late 2003 until 2009, resulted in the submission of $4.7 million in false claims to Medicare.[x] After a two-week trial, the DME company owner, the physician, and the two patient recruiters were each convicted of "one count of conspiracy to commit health care fraud and one count of conspiracy to defraud the United States and to pay and receive illegal health care kickbacks."[xi] As of the date of this article, only the owner and a patient recruiter have been sentenced: the owner to 60 months in prison and the patient recruiter to 55 months.

Home Health Care Fraud Highlights

A noteworthy home health services fraud case received a lot of DOJ attention in the Southern District of Florida in early 2011. The indictments in this case alleged that numerous individuals associated with ABC Home Health Care (ABC) and Florida Home Health Care Providers, Inc. (FHHCP) acted in concert to fraudulently bill for unnecessary home health and therapy services prescribed for patients with fictional medical conditions. This scheme occurred between 2006 and 2009 and involved $25 million in Medicare dollars. To investigate this case, law enforcement authorities pursued patient recruiters and physicians who referred patients and wrote unnecessary prescriptions for therapy and medications. By September 2011, the government had secured 15 guilty pleas to various conspiracy charges related to health care fraud, which resulted in sentences ranging from 6 to 87 months.[xii/]

Therapy/Clinic-Related Fraud Highlights

The government's investigation of HIV infusion clinics began in South Florida; however, the DOJ has implemented the lessons learned in Miami nationwide – literally following the fraud from Miami to Detroit. Last year, in Detroit, the owners of Dearborn Rehabilitation and Medical Center (DRMC) and a money launderer associated with them were convicted of conducting a $9.1 million Medicare fraud scheme. Through this scheme, the owners of DRMC paid kickbacks to patients in exchange for their Medicare information. Claims were then submitted to federal health care programs for services that were either never rendered to these patients or that were unnecessary. A patient recruiter for DRMC received a 77-month sentence in June 2011 after pleading guilty to one count of conspiracy to commit health care fraud and one count of money laundering conspiracy. Additionally, in November 2011, two sisters, Clara and Caridad Guilarte, formerly on the OIG's "Most Wanted List," were each sentenced to 14 years' imprisonment for their roles as DME company owners complicit in the same scheme involving DRMC. All told, at least 12 defendants were charged and sentenced with respect to this scheme.

Post-Affordable Care Act (ACA) Sentence Lengths on the Rise

According to data reported by the Strike Force in 2008, "the average Strike Force prison sentences exceeded by 20 percent the overall national average sentence in federal health care fraud cases."[xiii/] Congress appears to want this trend to continue for all convicted health care fraud defendants. In 2010, it enacted legislation as part of ACA (the health care reform law) that directs the United States Sentencing Commission to

> amend the Federal Sentencing Guidelines and policy statements applicable to persons convicted of Federal health care offenses involving Government health care programs to provide that the aggregate dollar amount of fraudulent bills submitted to the Government health care program shall constitute prima facie evidence of the amount of the intended loss by the defendant[.][xiv/]

The ACA's provisions, as enacted, increase the federal sentencing guidelines for health care fraud offenses by 20% to 50% for crimes that involve more than $1 million in losses.[xv/] Most likely, defendants convicted of health care fraud offenses will receive longer sentences than before. Some estimate that the sentences recommended under the Federal Sentencing Guidelines will increase by approximately

23% to 37%, depending on the sophistication of the fraud scheme, and that "the recommended sentences for most criminal masterminds in health care fraud cases will now reach or exceed the statutory maximum sentence of ten years."[xvi]

In remarks to the American Health Lawyers Association and Health Care Compliance Association's 2011 Fraud and Compliance Forum on September 26, 2011, Assistant Attorney General Lanny Breuer touted the federal courts' recent responses to health care fraud defendants at sentencing. For example, a Miami judge imposed a 50-year prison sentence upon Lawrence Duran, as well as $87 million in criminal restitution to be paid jointly and severally by the co-defendants with whom he orchestrated a $205 million scheme involving the fraudulent operation of partial hospitalization programs (PHPs) for the treatment of severe mental illness in seven different locations throughout South Florida and Orlando.[xvii] Three days after Mr. Duran's sentencing, his co-conspirator, Marianella Valera, was sentenced to a 35-year prison term.

Mr. Duran's sentence is the longest ever imposed in a Strike Force case, and the United States' memorandum in support of the sentencing of Mr. Duran and Ms. Valera provides a chilling template of how the government will likely use the ACA changes to the Federal Sentencing Guidelines. Citing the enhancements provided by the ACA amendments, the memorandum requested a 50-year sentence for Mr. Duran and 40 years of imprisonment for Ms. Valera – and the sentences imposed were nearly identical to the recommendations.[xviii]

The following chart provides examples of other sentences imposed in large health care fraud cases, including the total fraudulent billings alleged, where available.

Defendants' Roles	Total Billings Involved	Jurisdiction	Prison Sentence (not including supervised release)
DME company owner Onward Medical Supply[xix]	$2 million	Houston*	84 months (7 years)
DME Company Owners (husband and wife) OM Best Help Corporation[xx]	$1.1 million	Miami*	70 months (5 years, 10 months), and 37 months (3 years and 1 month)
Two patient recruiters, a nurse and an administrator for two home health companies (ABC and FHHCP) [xxi]	$25 million	Miami*	87 months (7 years, 3 months) – administrator 30 months (2 years, 6 months) – patient recruiter 18 months (1 year, 6 months) – nurse 6 months – patient recruiter
Patient recruiter for DRMC[xxii]	$9 million	Detroit	77 months (6 years, 5 months)

(continued...)

Defendants' Roles	Total Billings Involved	Jurisdiction	Prison Sentence (not including supervised release)
Dentist (Medicaid billings) [xxiii]	$1.6 million (in restitution ordered)	San Angelo, Texas*	70 months (5 years, 10 months)
"Operation MedScam" [xxiv] –individual large-scale distributor of prescription pain pill and physician prescriber	(unknown)	New Jersey	22 years – individual distributor who allegedly orchestrated the scheme 3 years – physician (plus 5 year exclusion from federal health care programs)

**designates a Strike Force operation.*

HHS-OIG Increasingly Wields Its Exclusion Authority

Felony criminal convictions related to health care programs result in a mandatory exclusion for a minimum of five years under 42 U.S.C. § 1320a-7(a). Nearly half of all exclusions (46.9%) in FY 2011 were based on criminal convictions for crimes related to Medicare, Medicaid, or other health care programs.[xxv] This is a 12% increase in such exclusions over those imposed in FY 2010, when only 34.6% of exclusions were based on program-related convictions.[xxvi] As fraud schemes have increased in scope and monetary impact, HHS-OIG has justified requesting longer exclusion periods based on aggravating factors such as the dollar amount of false claims submitted or restitution ordered, the overall length of the conduct at issue, the length of incarceration, if any, etc. Thus, many exclusions of individuals effectively operate as lifetime bars from participation in the federal health care programs.

In FY 2011, Dr. Stephen Schneider and Linda Schneider, a Kansas osteopath and a licensed practical nurse, respectively, were excluded from federal health care programs for a minimum of 95 years each.[xxvii] The Schneiders owned and operated Schneider Medical Clinic, LLC, which they used to illegally distribute and dispense controlled substances and defraud patients of money – a scheme commonly referred to as a "pill mill" – over a six-year period. The Schneiders' activity resulted in numerous patients being hospitalized or dying from drug overdoses. In addition, Dr. and Mrs. Schneider were ordered to pay $5 million in restitution and sentenced to 360 and 396 months of incarceration, respectively. Although this case was the most extreme exclusion case in FY 2011, it illustrates the increasing aggressiveness with which HHS-OIG is using its exclusion authority to obtain long debarments of individuals convicted of crimes.

Fraud Enforcement Targets and Investigatory Tactics to Watch for in 2012

Overall, the government has experienced increasing success in its tried-and-true industries of focus, especially this year. As such, we expect a number of trends to continue in FY 2012. First, the government will likely use its experience in historically targeted industries and expand its enforcement efforts into new areas of fraudulent activity. Second, with increased funding from Congress dedicated to health

care fraud enforcement, 2012 will likely bring even greater collaboration between federal law enforcement agencies. Third (and as is described in more detail below), the government will take advantage of its enhanced technological capabilities, such as data mining, to pursue more complicated health care fraud schemes. Finally, the government will continue to use non-health-care-specific statutes, including the Foreign Corrupt Practices Act (FCPA),[xxviii] to investigate and prosecute individuals and entities.

In the last year, the DOJ has successfully used the FCPA's prohibitions against the bribery of foreign officials to combat both domestic and international health care fraud, as the statute's definition of "foreign officials" encompasses nearly all health care professionals in countries with government-funded health care systems. Recently, the DOJ's FCPA investigations have focused on medical device and pharmaceutical companies doing business in other countries. For example, in April 2011, the government announced that it had entered a Deferred Prosecution Agreement (DPA) with Johnson & Johnson after employees, distributors, and sales agents of the company's Greek subsidiaries facilitated the payment of kickbacks to Greek physicians in connection with medical device distribution contracts.[xxix]

Using Technology to Enhance Investigations

In addition to ramping up the "muscle" behind criminal health care enforcement, the government is now employing more cutting-edge technology to ferret out potential fraud. One such technology is data mining. For example, on February 28, 2012, the DOJ arrested Dr. Jacques Roy and six other individuals for their alleged participation in a health care fraud scheme involving approximately $375 million – the single largest fraud amount orchestrated by one doctor in the history of the Strike Force. The government discovered Dr. Roy's activities through data mining – not through a whistleblower or other, more traditional, investigative techniques. Through data analysis, the government was able to detect a spike in the number of patients that Dr. Roy certified for home health care services. HHS Inspector General Daniel Levinson commented that "[i]n this case, our analysts discovered that in 2010, while 99 percent of physicians who certified patients for home health signed off on 104 or fewer people – Dr. Roy certified more than 5,000."[xxx] That the federal government is finding new avenues of investigating and charging potential fraud suggests that providers should examine their practices more vigorously to ensure compliance and avoid the appearance of potential fraud.

Conclusions

Above all, the trends discussed above should signal at least one thing to companies and providers operating in the health care space: the importance of vigilance. As health care fraud enforcement teams become increasingly coordinated nationwide and as monetary recovery and prison sentences continue reaching new heights, all in the health care industry can expect increased scrutiny and more prosecutions. In addition, manufacturers, providers, payors, and third party consultants should be wary of aggressive programs designed to increase revenues at the expense of, and without commensurate benefits to, the federal health care programs and their beneficiaries.

ENDNOTES

[i/] The Department of Health and Human Services, Centers for Medicare & Medicaid Services, "New Tools to Fight Fraud, Strengthen Federal Health Programs, and Protect Taxpayer Dollars," (Feb. 14, 2012), *available at* http://www.healthcare.gov/news/factsheets/2012/02/medicare-fraud02142012a.html.

[ii/] The Department of Health and Human Services and The Department of Justice Health Care Fraud and Abuse Control Program, Annual Report for Fiscal Year 2011, (Feb. 2012), 1-2, *available at* http://oig.hhs.gov/reports-and-publications/hcfac/index.asp (hereinafter, the "HCFAC Report").

[iii/] *Id.* at 10-11.

[iv/] Joseph Beemsterboer, Trial Attorney, Dep't of Justice Criminal Division, Health Care Fraud Unit, Medicare Strike Force Overview: Past Successes and Future Plans, Presentation at the Health Care Compliance Association's South Atlantic Regional Conference (Jan. 27, 2012), *available at* http://www.hcca-info.org/regional/2012/Orlando/Beemsterboerprint3.pdf.

[v/] *Harnessing Technology and Innovation to Cut Waste and Curb Fraud in Federal Health Programs: Hearing Before the S. Comm. on Homeland Security & Governmental Affairs, Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security*, 112th Cong. (2011) (testimony of Lewis Morris, Chief Counsel to the HHS Inspector General (Jul. 12, 2011), *available at* http://oig.hhs.gov/testimony/docs/2011/morris_testimony_07122011.pdf.

[vi/] Press Release, Dep't of Justice, "Medicare Fraud Strike Force Charges 111 Individuals for More Than $225 Million in False Billing and Expands Operations to Two Additional Cities," (Feb. 17, 2011).

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[ix/] Press Release, Dep't of Justice, "Miami-Area Resident Pleads Guilty to Participating in $200 Million Medicare Fraud Scheme" (Mar. 13, 2012); Press Release, Dep't of Justice, "Broward County, Fla.-Area Halfway House Owner Sentenced to 24 Months in Prison for Participating in Fraud and Kickback Scheme," (Mar. 9, 2012).

[x/] Press Release, Dep't of Justice, "Four Individuals Convicted in $4.7 Million Louisiana Medicare Fraud Scheme," (Aug. 17, 2011).

[xi/] *Id.*

[xii/] Press Release, Dep't of Justice, "Ten Miami-Area Residents Plead Guilty in $25 Million Health Care Fraud Scheme," (Sep. 21, 2011); Press Release, Dep't of Justice, "Nurse, Administrator and Two Recruiters for Miami Home Health Companies Sentenced to Prison in $25 Million Health Care Fraud Scheme," (Dec. 19, 2011).

[xiii/] Fact Sheet, Medicare Fraud Strike Forces, http://www.stopmedicarefraud.gov/heatsuccess/general_fact_sheet.pdf.

[xiv/] Section 10606(a)(2)(B) of the Patient Protection and Affordable Care Act, Pub. L. 111-148 (2010), as amended.

[xv/] H. Ron Davidson and Steven P. Stavich, "The Patient Protection and Affordable Care Act and Health Care Fraud Sentences," 23 Fed. Sent. R. 233, 238 (Feb. 2011).

[xvi/] *Id.*

[xvii/] Press Release, Dep't of Justice, "Owner of Miami-Area Mental Health Company Sentenced to 50 Years in Prison for Orchestrating $205 Million Medicare Fraud Scheme," (Sept. 16, 2011).

[xviii] United States v. Lawrence Duran and Marianella Valera, No. 10-CR-20767, Government's Memorandum in Aid of Sentencing, filed Sept. 9, 2011, (S.D. Fla.), *available at* http://media.miamiherald.com/smedia/2011/09/13/19/38/aisdZ.So.56.pdf.

[xix] Press Release, Dep't of Justice, "Houston Medical Equipment Company Owner Sentenced to 84 Months in Prison for Health Care Fraud Scheme Involving More Than $2 Million in False Billings," (May 18, 2011).

[xx] Press, Release, Dep't of Justice, "Miami-Area Medical Equipment Company Owners Sentenced to Prison for Medicare Fraud Scheme," (Aug. 23, 2011).

[xxi] Press Release, Dep't of Justice, Administrator and Two Recruiters for Miami Home Health Companies Sentenced to Prison in $25 Million Health Care Fraud Scheme," (Dec. 19, 2011).

[xxii] Press Release, Dep't of Justice, "Patient Recruiter Sentenced to 77 Months in Prison in Connection with $9 Million Medicare Fraud Scam in Detroit," (Jun. 7, 2019).

[xxiii] Press Release, Texas Office of the Attorney General, "Dentist Convicted in Health Care Fraud Scheme Following a State and Federal Probe," (Sept. 22, 2011).

[xxiv] Press Release, New Jersey Office of the Attorney General, "Hudson County Man Sentenced to 22 Years in Prison as Leader of Crime Network that Defrauded Medicaid," (Sept 16, 2011).

[xxv] HCFAC Report at 38.

[xxvi] The Department of Health and Human Services and The Department of Justice Health Care Fraud and Abuse Control Program, Annual Report for Fiscal Year 2010, (Jan. 2011), 1-2, *available at* http://oig.hhs.gov/publications/docs/hcfac/hcfacreport2010.pdf.

[xxvii] HCFAC Report at 38.

[xxviii] 15 U.S.C. §§ 78dd-1, *et seq.*

[xxix] Johnson & Johnson Deferred Prosecution Agreement, (Jan.14, 2011), *available at* http://lib.law.virginia.edu/Garrett/prosecution_agreements/pdf/johnson.pdf. The DOJ has entered into additional DPAs with medical device manufacturers Smith & Nephew in February 2012 and Biomet, Inc., in March 2012 based on the same statute.

[xxx] Press Release, Dept' of Justice, "Dallas Doctor Arrested for Alleged Role in Nearly $375 Million Health Care Fraud Scheme," (Feb. 28, 2012).