UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

UNITED STATES OF AMERICA	*	**CRIMINAL NO. 21-98**
v.	*	**SECTION: "I"(4)**
SHIVA AKULA	*	
	*	
	*	
*	*	*

MEMORANDUM COCNERNING LOSS AND RESTITUTION AMOUNTS

The United States of America, through the undersigned Assistant United States Attorneys, hereby submits this memorandum in advance of the April 10, 2024, sentencing hearing. For the reasons below, the draft presentence investigation report's calculation of the loss amount as totaling at least $84 million, *see* Rec. Doc. 390, ¶ 54, is correct. Additionally, as explained below, the Court should order restitution in the amounts of $42,121,351.05 to Medicare and $219.00 to Blue Cross and Blue Shield of Louisiana.

FACTS AND PROCEDURAL HISTORY

This Court summarized the facts and procedural history of this case in its order denying defendant Shiva Akula's motions for a new trial and judgment of acquittal. *See* Rec. Doc. 391. As recounted in the order:

> On August 5, 2021, a grand jury returned an indictment charging Akula with twenty-three counts of health care fraud in violation of 18 U.S.C. § 1347. Counts 1 through 8 of the indictment charged Akula with fraudulently billing Medicare at the General Inpatient ("GIP") level for three patients who did not qualify for GIP billing. Counts 9 through 11 charged Akula with fraudulent billing under Common Procedural Terminology ("CPT") code 99236 for History and Physical forms ("H+Ps") that Akula's niece—an extern at Akula's company, Canon Hospice ("Canon")—copied from H+Ps

> prepared by referring physicians. Counts 12 through 17 charged Akula with fraudulent billing under CPT code 99233, which Canon used to bill for physician services on top of the hospice per diem rate even though the per diem rate is intended to cover all physician services within the scope of hospice care. Counts 18 through 23 charged Akula with fraudulent billing under CPT code 99350, which Canon used to bill for physician services during home visits in outpatient settings on top of the hospice per diem rate. On November 6, 2023, following a five-day trial, a jury returned a verdict of guilty on all counts.

Rec. Doc. 391, pp. 1-2.

After Akula's trial, in anticipation of sentencing, the government reviewed Medicare claims data it received from the Centers for Medicare & Medicaid Services.[1] Specifically, the government reviewed four categories of claims submitted to Medicare by Canon during the scheme to defraud charged in the indictment (January 2013 to December 2019, *see* Rec. Doc. 1, p. 9:

- First, the government reviewed all GIP claims Canon submitted for all patients and found that they equaled $31,745,430.40. Medicare paid Canon $27,588,601.41 based on these claims.
- Second, the government reviewed all claims Canon submitted for all patients under CPT Code 99233 and found that they equaled $3,045,595.44. Medicare paid Canon $2,917,598.32 based on these claims.
- Third, the government reviewed all claims Canon submitted for all patients under CPT Code 99236 and found that they equaled $262,491.26. Medicare paid Canon $255,419.80 based on these claims.

[1] This same claims data was used as evidence at Akula's trial.

- Fourth, the government reviewed all claims Canon submitted for all patients under CPT Code 99350 and found that they equaled $650,487.06. Medicare paid Canon $636,253.15 based on these claims.
- Finally, the government reviewed any remaining billing for New Orleans patients for whom Canon either lacked notice of election forms or had notice of election forms, but the notice of election forms were missing dates, meaning that Canon could not bill for those patients under the hospice rate—in other words, those New Orleans patients who were not hospice eligible.[2] This amount equaled $48,836,598.93. Medicare paid Canon $10,723,478.37 based on these claims.

Additionally, on December 8, 2023, the government received a victim impact letter from private insurer Blue Cross and Blue Shield of Louisiana. *See* Blue Cross Letter, attached hereto as Government's Exhibit A. In its letter, Blue Cross explained that Canon submitted claims under CPT Codes 99233, 99236, and 99350 to Blue Cross totaling $167,603.93, with Blue Cross paying Canon $219.00 based on those claims. *See* Gov. Ex. A.

Added together, the amounts Canon fraudulently billed to Medicare and Blue Cross total $84,708,207.02. The amounts Canon received from Medicare and Blue Cross based on its fraudulent claims total $42,121,570.05.

On January 31, 2024, United States Probation issued the draft PSR, which found a loss amount of "at least $84,140,601," PSR, ¶ 54; total offense level of 42, PSR, ¶ 77; and advisory guidelines imprisonment range of 360 months to life. PSR, ¶ 127. Akula's sentencing hearing is currently scheduled for April 10, 2024. Rec. Doc. 399.

[2] For hospice eligibility, in addition to the Medicare claims data, the government also reviewed notice of election forms in Canon's patient files to see if they were properly dated.

LAW AND ARGUMENT

I. Legal framework.

A. Loss amount calculation for health care fraud.

The applicable provision of the Sentencing Guidelines for loss amount attributable to health care fraud is U.S.S.G. § 2B1.1(b). Application Note 3 to § 2B1.1 "states that the applicable loss amount is 'the greater of actual loss or intended loss.'" *United States v. Mazkouri*, 945 F.3d 293, 303 (5th Cir. 2019) (quoting U.S.S.G. § 2B1.1. cmt. n.3(A)).[3] "For healthcare fraud, the amount fraudulently billed to Medicare is prima facie evidence of the intended loss, though it is not conclusive, and the parties may introduce evidence to suggest that the amount billed overstates or understates the billing party's intent." *Id.* at 303-04; *see also United States v. Ainabe*, 938 F.3d 685, 693 (5th Cir. 2019) ("[T]he Guidelines impose a presumption that Ainabe intended for each company to be paid the full amount that it billed, and Ainabe has the burden of rebutting that presumption."). Additionally, "[w]hen fraud is so pervasive that separating legitimate from fraudulent conduct is not reasonably practicable, the burden shifts to the defendant to make a showing that particular amounts are legitimate." *Mazkouri*, 945 F.3d at 304

[3] In *United States v. Banks*, 55 F.4th 246 (3d Cir. 2022), the Third Circuit held that the plain meaning of the word "loss" in § 2B1.1 includes only actual loss and not intended loss. *Banks*, 55 F.4th at 258. The Fifth Circuit has not adopted *Banks*'s reasoning, and at least one other court has questioned its holding. *See United States v. You*, 74 F.4th 378, 397 (6th Cir. 2023) ("*Banks*'s attempt to impose a one-size-fits-all definition is not persuasive."); *see also United States v. Rao*, No. 3:19-CR-507-L, 2023 WL 4243230, at *5-6 (N.D. Tex. June 26, 2023) (refusing to adopt *Banks* and stating, "In keeping with this longstanding Guidelines deference to the definition of 'loss,' the Fifth Circuit has interpreted 'loss' in the context of Section 2B1.1 to include intended loss. Accordingly, this court must follow existing, controlling law as it is not its role to divert from precedent to anticipate what the Fifth Circuit may decide.") (citations omitted). Moreover, post-*Banks*, the Fifth Circuit has continued to rely on intended loss. *See United States v. Tolliver*, No. 23-30292, 2023 WL 5803713, at *1 (5th Cir. Sept. 7, 2023). Further, the underlying argument in *Banks*—that Guidelines commentary is not authoritative—has been expressly rejected by the Fifth Circuit in a case involving controlled substance offenses under U.S.S.G. § 4B1.2. *See United States v. Vargas*, 74 F.4th 673, 677-78 & n.2 (5th Cir. 2023) (en banc) (disagreeing with *United States v. Nasir*, 17 F.4th 459 (3d Cir. 2021) (en banc), the case relied upon in *Banks*). Thus, sentencing courts in the Fifth Circuit should continue to use the greater of actual loss or intended loss.

(quotation marks omitted).[4] "In the absence of such evidence from the defendant, the district court may reasonably treat the entire claim for benefits as intended loss." *Id.* (quotation marks omitted).

"The Court is not limited to the losses resulting from the specific conduct for which the defendant was convicted, and it may also include relevant conduct in its calculation." *United States v. Thomas*, 548 F. App'x 987, 994 (5th Cir. 2013) (citing *United States v. Randall*, 157 F.3d 328, 331 (5th Cir. 1998)) (quotation marks omitted). As described in U.S.S.G. § 1B1.3, relevant conduct includes "all acts and omissions . . . that were part of the same course of conduct or common scheme or plan as the offense of conviction." U.S.S.G. § 1B1.3(a)(2); *see also Ainabe*, 938 F.3d at 689. "For two or more offenses to constitute part of a common scheme or plan, they must be substantially connected to each other by at least one common factor, such as common victims, common accomplices, common purpose, or similar modus operandi." U.S.S.G. § 1B1.3 cmt. n.5(B)(i).

B. Restitution calculation under the Mandatory Victim Restitution Act.

The Mandatory Victim Restitution Act "limits restitution to the actual loss directly and proximately caused by the defendant's offense of conviction." *United States v. Mathew*, 916 F.3d 510, 516 (5th Cir. 2019). "An award of restitution cannot compensate a victim for losses caused by conduct not charged in the indictment or specified in a guilty plea." *Id.* "Therefore, when the

[4] The rule allowing for the burden to shift to the defendant in cases with extensive and pervasive schemes is not limited to health care fraud—for example, the Fifth Circuit has applied it in a case involving FEMA fraud. *See United States v. Hebron*, 684 F.3d 554, 563 (5th Cir. 2012). Based on the Fifth Circuit's holdings in the health care fraud context that "the amount fraudulently billed to Medicare is prima facie evidence of the intended loss," *see Mazkouri*, 945 F.3d at 303-04, it is unclear if the Court must also make a separate finding that the scheme was extensive and pervasive in order to shift the burden to a health care fraud defendant, as it would in cases involving other types of fraud. In the event the Court concludes that a finding of pervasiveness is necessary, sufficient evidence—including the duration of Akula's scheme and the number of claims involved—make such a finding appropriate here.

subject offense involves a scheme, conspiracy, or pattern of criminal activity, that is, where the fraudulent scheme is an element of the conviction, restitution may be awarded to any person who is directly harmed by the defendant's course of criminal conduct." *Id.* (quotation marks and brackets omitted); *see also United States v. St. John*, 625 F. App'x 661, 669 (5th Cir. 2015) ("[B]ecause health care fraud requires proof of a scheme as an element, the conviction can support a broad restitution award.") (quotation marks and brackets omitted). "The district court must support every dollar of a restitution order with record evidence." *Mathew*, 916 F.3d at 516. "In health care-fraud cases, an insurer's actual loss for restitution purposes must not include any amount that the insurer would have paid had the defendant not committed the fraud." *United States v. Mahmood*, 820 F.3d 177, 196 (5th Cir. 2016) (brackets omitted). "The MVRA places the burden on the government to prove a victim's actual loss." *Id.* "However, the sentencing court may shift the burden to the defendant as justice requires." *Id.*

In *United States v. Emordi*, 959 F.3d 644 (5th Cir. 2020), the defendants operated a home health business through a straw owner after the Texas Department of Health and Human Services excluded them from participation in any capacity with Medicare, Medicaid, and all federal health care programs for five years. *Emordi*, 959 F.3d at 647-48. The district court ordered restitution under the MVRA in the full amount Medicare and Medicaid paid during the exclusionary period. *See id.* at 653. On appeal, one of the defendants argued that, "if he had not committed the fraud of which he was convicted, [the home health business's] patients still would have received treatment from some other Medicare/Medicaid provider, suggesting that Medicare and Medicare would have paid the same amount even if [the defendant] had not committed fraud." *Id.* The Fifth Circuit disagreed, holding that the defendant's "conspiracy and false statements regarding the exclusions caused Medicare and Medicaid to treat [the business] as an eligible provider." *Id.*

"The claims would not have been paid, though, if the fraudulent conduct had been known." *Id.* Thus, "[t]he district court did not err by using the amount paid by Medicare and Medicaid, which would not have occurred without [the defendant's] fraud, as actual loss for restitution." *Id.*

II. Analysis.

A. Loss amount.

Akula's indictment describes the scheme to defraud by alleging that Akula "unlawfully enriched himself by submitting and causing the submission of false and fraudulent claims to health care benefit programs, to include Medicare." Rec. Doc. 1, p. 8. The indictment then specifically identifies Canon's billing for GIP and under CPT Codes 99233, 99236, and 99350. Rec. Doc. 1, pp. 8-9.

At trial, the government established that Akula executed the charged scheme to defraud. For example, Akula's nephew Joshua Bruce testified that, "[i]n our marketing meetings, we would discuss that it was very important to keep the inpatient unit full and we had to make sure we had all of our patients in there as GIP." Rec. Doc. 388-5, p. 10. Bruce further testified that the rule at Canon was to always accept patients, even if they were not hospice eligible. *See* Rec. Doc. 388-5, p. 14; *see also* Rec. Doc. 388-5, pp. 16-17. Other witnesses, including director of inpatient nursing Ahsaki George-Scharpon and New Orleans administrator Sue May, testified concerning Akula's control over Canon's admissions and discharges and his focus on keeping the census as high as possible. *See* Rec. Doc. 388-8, pp. 190-91; Rec. Doc. 388-9, pp. 273-75. With respect to the CPT Codes, the government established through witnesses such as the Ochsner doctors who worked at Canon that billing under the codes was inappropriate because, among other reasons, the CPT Codes were hospital—not hospice—codes, and the services provided to the patients were already covered by the hospice per diem.

Based on this evidence, Canon's billing for all GIP, all claims under the charged CPT Codes, and any remaining billing for New Orleans patients who were not hospice eligible should count toward Akula's intended loss amount. As explained above, the amount Akula "fraudulently billed to Medicare is prima facie evidence of the intended loss." *See Mazkouri*, 945 F.3d at 303-04. That amount "is not limited to the losses resulting from the specific conduct for which [Akula] was convicted," and it may also include relevant conduct. *Thomas*, 548 F. App'x at 994. The conduct described in this filing was "part of the same course of conduct or common scheme or plan as the offense of conviction," *see* U.S.S.G. § 1B1.3(a)(2), and, based on Akula's central role in the scheme, it was reasonably foreseeable to him that the fraudulent billing would be submitted to Medicare. As a result, the PSR's loss calculation of at least $84 million is correct.

B. Restitution amount.

For similar reasons, the Court should order restitution in the amounts of $42,121,351.05 to Medicare and $219.00 to Blue Cross and Blue Shield of Louisiana. These amounts represent the funds Canon received based on its fraudulent billing for GIP, the CPT Codes, and patients who were not hospice eligible. Thus, Medicare and Blue Cross are victims who were directly harmed by Akula's scheme. *See Mathew*, 916 F.3d 516. As in *Emordi*, if the victims had been aware that Akula and Canon were submitting billing for patients who were not hospice eligible or suffering from acute events such that they qualified for GIP, they would never have paid the claims. *See Emordi*, 959 F.3d at 647-48. Accordingly, the entire amounts Canon received from the victims should be counted toward Akula's restitution judgment. *See id.*

CONCLUSION

For the foregoing reasons, the draft presentence investigation report's calculation of the loss amount as totaling at least $84 million, *see* Rec. Doc. 390, ¶ 54, is correct. Additionally, the Court should order restitution in the amounts of $42,121,351.05 to Medicare and $219.00 to Blue Cross and Blue Shield of Louisiana.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on this 5th day of March, 2024, I electronically filed the foregoing with the Clerk of Court by using the CM/ECF system, which will send a notice of electronic filing to ECF-registered counsel of record

/s/ Kathryn M. McHugh
KATHRYN M. McHUGH
Assistant United States Attorney

Louisiana

December 8, 2023

United States Attorney Office
Eastern District of Louisiana
Sealed: Attention Victim-Witness Unit
650 Poydras Street, Suite 1600
New Orleans, LA 70130

Re: VICTIM IMPACT STATEMENT

Victim: Blue Cross and Blue Shield of Louisiana
Contact: Latisha Mire, Director
USAO Number: 2017R00040
Court Docket Number: 21-CR-00098

Dear Judge Africk:

Your Honor, my name is Latisha Mire, and I am the Director of Financial Investigations Department at Blue Cross and Blue Shield of Louisiana. Our Plan was a victim in the matter involving Dr. Shiva Akula, who is scheduled to be sentenced in your court on February 21, 2024.

Between January 1, 2014 and October 6, 2020, claims were submitted to Blue Cross and Blue Shield of Louisiana (BCBSLA) from Dr. Akula charging a total of $167,603.93 for services related to CPT codes 99233, 99236 and 99350 that were the focus of the government's case. Fortunately, our plan had taken steps to limit our exposure and only a total of $219.00 was paid for these codes.

The impact of Dr. Akula's actions may seem small when considered from an "actual dollars lost" perspective, but the impact to the individual members and the more global impact on the health care delivery system are greatly disturbing and cannot be ignored.

Blue Cross and Blue Shield of Louisiana respectively requests that Dr. Shiva Akula be sentenced to the maximum amount of time allowable by law. Thank you for your time, and for your consideration of this matter.

Sincerely,

Latisha Mire

Latisha Mire, CFE, AHFI
Director, Financial Investigations
Blue Cross and Blue Shield of Louisiana

GOVERNMENT EXHIBIT
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