United States Department of Justice
United States Attorney's Office
District of Minnesota

B. Todd Jones,
United States Attorney

Jeanne F. Cooney
Director of Community Relations
(612) 664-5611
email: jeanne.cooney@usdoj.gov

News Release

FOR IMMEDIATE RELEASE
Thursday, April 14, 2011
WWW.JUSTICE.GOV/USAO/MN

Multiple Health Care Fraud Cases Filed in the District of Minnesota

U.S. Attorney pledges that prosecutions will continue

Federal health care fraud investigations have been growing. In fiscal year 2010 alone, the United States Justice Department opened more than 1,100 new criminal health care fraud investigations and nearly 1,000 civil health care fraud investigations. In that same time period, the Justice Department filed criminal charges in 488 health care fraud cases, and gained convictions of more than 700 defendants.

This week in the District of Minnesota, five individuals were charged in four separate cases for health care fraud crimes. In announcing the efforts of the U.S. Attorney's Office in this area, U.S. Attorney B. Todd Jones said, "Nearly every Minnesotan, whether covered by Medicare, Medicaid, or one of the many private insurers victimized by health care fraud, is affected by this crime. Fraudulent billing, stealing personal medical information, making bogus Medicaid claims, and all the other ways fraudsters have tapped into our money costs taxpayers billions of dollars every year. We need everyone's help in stopping this insidious crime. Working with our state partners and private citizens, the U.S. Department of Justice is making every effort to find and prosecute thieves who steal from the health care system."

Lamont Pugh, III, Special Agent in Charge of the U.S. Department of Health and Human Services, Office of Inspector General, Chicago Regional Office, added, "The Office of Inspector General is committed to aggressively fighting health care fraud and protecting the Medicare and Medicaid programs. Working in concert with our law enforcement partners, we will continue to identify those who choose to attack these programs and ensure that they are held accountable."

On April 12, 2011, the owners of two home health care agencies were indicted for

conspiring to defraud Medicaid and obtaining money by submitting false claims for Medicaid payments. Samuel Akoto Danso, age 41, of Woodbury, and Harry Kwabena Ossei, age 51, of Oakdale, were charged with one count of conspiracy to commit health care fraud and one count of conspiracy to commit money laundering. In addition, Danso and Ossei were charged with 15 counts of health care fraud and 8 counts of aggravated identity theft in relation to health care fraud. Danso made his initial appearance earlier today in federal court, while Ossei remains a fugitive.

Between 1995 and 2001, Ossei owned two health care agencies, Midwest Home Health Care Systems, Inc., and Midwest Health Care Systems, Inc., both of which operated in Minnesota. Between 2000 and 2007, Danso owned Metwest Health Care Services; and between 2005 and 2007, Danso was the half-owner of a second health care agency, Minnesota Home Health Care Services. Both of those agencies also operated in Minnesota.

In 2003, Ossei pled guilty to one count of health care fraud and one count of willfully filing a false tax return in the District of Minnesota. The convictions arose out of Ossei's operation of Midwest Home Health Care. According to federal law, anyone who is convicted of certain offenses, including health care fraud, is excluded from participating in federal health care programs. Therefore, Ossei was excluded from participating in Medicare, Medicaid, and all other federal health care programs for 15 years.

The current indictment alleges that the defendants agreed that Ossei would participate in the Medicaid program, despite his exclusion, and that the income Ossei derived from such participation would be hidden. In addition, the defendants allegedly submitted to the Minnesota Department of Human Services ("DHS") false reimbursement claims for Personal Care Assistant ("PCA") services. PCAs, whose services are paid for by Medicaid, provide medical care and services to low-income people who meet certain income and eligibility requirements.

The indictment alleges that the defendants provided payments to personal care assistants as well as Medicaid recipients in exchange for their participation in the phony PCA service arrangements. The defendants, on many occasions, allegedly used without lawful authority the identification of others in connection with the fraud.

If convicted, the defendants face a potential maximum penalty of ten years in prison on each health care fraud count, 20 years for money laundering, ten years on the conspiracy count, and a mandatory minimum penalty of two years for aggravated identity theft. All sentences will be determined by a federal district court judge. This case is the result of an investigation by the U.S. Department of Health and Human Services, the IRS, and the FBI. It is being prosecuted by Assistant U.S. Attorney David M. Genrich.

The indictment returned against Danso and Ossei builds upon the 2010 conviction of Henry Asante-Tawiah for his participation in the same conspiracy. Asante-Tawiah, who appeared before U.S. District Court Judge Ann D. Montgomery, pleaded guilty to conspiracy to commit health care fraud based upon the same allegations found in the Danso and Ossei indictment; namely that Medicaid was defrauded through submission of false claims and by hiding Ossei's participation in the program after he had been excluded from it. Asante-Tawiah is awaiting sentence.

***

In a second case charged on April 12, 2011, another owner of a home health care agency was indicted for allegedly defrauding Medicaid and obtaining more than $400,000 through false billing practices. John Alemoh Momoh, age 51, of Brooklyn Park, was charged with 23 counts of health care fraud and 18 counts of aggravated identity theft in relation to health care fraud. Momoh has made his initial appearance in federal court.

Momoh owned Hopecare Services, Inc., located in Brooklyn Park. In March of 2007, DHS opened an investigation into Hopecare's billing practices after it billed Medicaid for more service than was actually reported. DHS met with Momoh about the audit and advised him how to fix the problem. Momoh repaid the unsupported claims. After that, DHS received additional complaints about Hopecare's billing practices, and a second audit was conducted in August of 2007. At that time, DHS found that Momoh had continued to bill Medicaid for unsupported claims.

Momoh's indictment alleges that from May of 2007 through March of 2008, he submitted to Medicaid false claims for PCA services. Moreover, on numerous occasions, Momoh allegedly used without authority the means of identification of others in connection with the fraud.

If convicted, Momoh faces a potential maximum penalty of ten years in prison on each health care fraud count and a mandatory minimum penalty of two years for aggravated identity theft. All sentences will be determined by a federal district court judge. This case is the result of an investigation by the U.S. Department of Health and Human Services-Office of Inspector General, the FBI and the Medicaid Fraud Control Unit in the Minnesota Attorney General's Office. It is also being prosecuted by Assistant U.S. Attorney Genrich.

***

The home health care fraud indictments returned this week are part of a larger effort involving federal and state law enforcement. At the district level, the U.S. Attorney's Office participates in a task force with the Medicaid Fraud Control Unit at the Minnesota Attorney General's Office that focuses on home health care fraud trends. The task force includes the U.S. Department of Health and Human Services–Office of Inspector General, the Federal Bureau of Investigation, the Internal Revenue Service, and other federal, state, and local law enforcement partners.

Those efforts have produced results. For example, Patrick Osei recently was sentenced to 63 months in federal prison for defrauding Medicaid, paying illegal kickbacks, and making false statements in connection with his operation of a home health care agency. Osei, through his home health care business, fraudulently billed Medicaid for hundreds of thousands of dollars. The 63-month sentence was higher than the sentencing guidelines' range, and Osei was also ordered to pay more than $520,000 in restitution. In that case, two personal care assistants employed by Osei's business were also convicted of defrauding Medicaid through unlawful billing.

In pronouncing sentence against Osei, U.S. District Court Judge Joan N. Ericksen emphasized the seriousness of health care fraud schemes, particularly those targeting programs

like Medicaid. Judge Ericksen said, “This sort of fraud is extremely dangerous and extremely hurtful to the most vulnerable members of society–people who can’t see, people who can’t bathe themselves, people who have children who are seriously challenged mentally and physically, people who have twins who are blind and need to depend on this kind of money. This money is supposed to go to help people who have no other means of support. Fraud in the provision of health care services makes it easier for politicians to cut the funding to those services. It reduces public confidence in important government programs.”

***

In another indictment unsealed earlier today, a former employee of a health care provider in Rochester was charged with wrongfully obtaining the personal medical information of a patient and using that information to cause malicious harm to that patient. The indictment, which was filed on April 12, 2011, charges Autumn Lee Wright, age 33, of Rochester, with one count of wrongfully obtaining individually identifiable health information and one count of wrongfully disclosing individually identifiable health information. The indictment was unsealed earlier today following Wright’s initial appearance in federal court.

The indictment alleges that on August 31, 2009, Wright obtained the patient’s demographic information, medical history, and information relating to the patient’s past and present physical and mental health. In addition, it alleges that on August 31 and September 23, 2009, Wright disclosed that information to an adult male.

If convicted, Wright faces a potential maximum penalty of ten years in prison on each count. All sentences will be determined by a federal district court judge. This case is the result of an investigation by the Federal Bureau of Investigation and the Rochester Police Department. It is also being prosecuted by Assistant U.S. Attorney Genrich.

***

In a fourth case, a care provider at a senior assisted living facility in Burnsville was charged with allegedly taking narcotics from patients. Margaret Alice Mammen, age 54, no known address, was charged via an Information with one count of obtaining a controlled substance by fraud. The Information alleges that from September 22 through October 8, 2009, Mammen took Oxycontin from patient rooms for her personal use. Mammen allegedly replaced the Oxycontin with ibuprofen.

If convicted, Mammen faces a potential maximum penalty of four years in prison. All sentences will be determined by a federal district court judge. This case is the result of an investigation by the U.S. Food and Drug Administration-Criminal Investigation Division, the Burnsville Police Department and the Minnesota Department of Health. It is being prosecuted by Assistant U.S. Attorney Kimberly A. Svendsen.

A number of other prosecutions have resulted in convictions of medical personnel for stealing controlled substances meant for patients. In several other instances, employees have been convicted of embezzling health care funds for their own benefit.

***

The U.S. Attorney's Office also has been active in health care fraud cases other than those that involve home health care services. For example, the office secured criminal convictions against the Guidant Corporation for violations relating to its interactions with the Food and Drug Administration ("FDA"). Guidant admitted withholding information from the FDA regarding catastrophic failures in some of its lifesaving devices. The convictions resulted in $296 in criminal fines and forfeitures and the ongoing supervision of the company by federal authorities, including unannounced compliance inspections of Guidant's records.

***

To tackle health care fraud nationwide, the U.S. Department of Justice has formed a senior-level task force. The Health Care Fraud Prevention and Enforcement Action Team, represented by the Department of Justice and the Department of Health and Human Services, will review how to share more effectively real-time intelligence data on health care fraud patterns as well as other critical information regarding health care services, pharmaceuticals, and medical devices.

As a result of federal convictions for health care fraud, defendants are excluded from participating in federal health benefit programs, including Medicare and Medicaid. Exclusion determinations are made by the U.S. Department of Health and Human Services. Nationwide, more than 3,000 individuals were excluded from program participation in Fiscal Year 2010 based upon criminal convictions or patient abuse or neglect, license revocations, or other factors.

****

The Civil Frauds Unit in the Civil Division in the U.S. Attorney's Office has been active in addressing health care fraud as well. Acting in concert with the office's Criminal Division, the Civil Frauds Unit restrains assets of providers accused of health care fraud pending resolution of the charges against them. At the successful conclusion of criminal litigation, those ill-gotten gains are then returned to the state and federal health care programs that were victimized. During 2010, more than $1 million in provider funds were restrained. In the Osei matter alone, $300,000 was returned to health care programs.

In addition to working with the Criminal Division, the Civil Frauds Unit litigates civil cases against health care providers. Using the False Claims Act, nearly $93 million has been recovered from providers since 1996, $20 million within the past four years alone. Nationwide, recoveries exceeded $4 billion in FY 2010. Civil recoveries have totaled over $15 billion since 1996. This represents $6.80 recovered for every dollar spent on recovery efforts.

###

An indictment is a determination by a grand jury that there is probable cause to believe that offenses have been committed by a defendant. A defendant, of course, is presumed innocent until he or she pleads guilty or is proven guilty at trial.