IN THE UNITED STATES DISTRICT COURT FOR THE
SOUTHERN DISTRICT OF TEXAS
Brownsville Division

UNITED STATES OF AMERICA	)	Case No. B-18-008
	)	
v.	)	Count 1: 18 U.S.C. § 1349
	)	(Conspiracy to Commit Health Care Fraud)
RODNEY MESQUIAS,	)	
	)	Counts 2-7: 18 U.S.C. §§ 1347 & 2
HENRY MCINNIS,	)	(Health Care Fraud)
	)	
JOSE GARZA,	)	Count 8: 18 U.S.C. § 1956(h)
	)	(Conspiracy to Commit Money Laundering)
FRANCISCO PENA,	)	
	)	Count 9: 18 U.S.C. §§ 1518 & 2
Defendants.	)	(Obstruction of Health Care Investigations)
	)	
	)	Count 10: 18 U.S.C. §§ 1001(a)(2) & 2
	)	(False Statement)
	)	
	)	Count 11: 18 U.S.C. §§ 1512(c)(2) & 2
	)	(Obstruction of Justice)
	)	
	)	Forfeiture Notice

INDICTMENT

THE GRAND JURY CHARGES THAT:

At all times relevant to this Indictment, unless otherwise stated:

INTRODUCTORY ALLEGATIONS

A. The Entities

1. The Merida Health Care Group, Inc., ("Merida Group"), was a corporation that purported to provide health care services throughout the State of Texas. The Merida Group's corporate headquarters was located at 1514 S. 77 Sunshine Strip, Suite 21-B, 78550, Harlingen, Texas, within the Southern District of Texas.

2. The Merida Group was affiliated with several entities ("Merida Group's affiliated entities") based throughout the State of Texas, including, but not limited to, Bee Caring Hospice Healthcare, Inc., ("Bee Caring"), in Harlingen; BRM Home Health, PLLC, ("BRM Home Health"), in Harlingen; Bee Caring Hospice, LLC ("Bee Caring Hospice"), in San Antonio; Professional Hospice Care ("Professional Hospice"), in Laredo; Merida Health Care Group of San Antonio, LLC ("Merida Group of San Antonio"), in San Antonio; Illumina, LLC ("Illumina") in Corpus Christi; Virtue Home Health, Inc. ("Virtue Home Health"), in Corpus Christi; Well-Care Home Health, Inc. ("Well-Care"), in Houston; and Excellent Homecare Provider Services ("Excellent Homecare"), in Sugar Land.

3. The Merida Group's affiliated entities were providers authorized by the Medicare health care benefit program ("Medicare") to file claims for reimbursement for covered health care services provided to qualified beneficiaries. The Merida Group's affiliated entities' primary business was purportedly providing hospice and home health services for beneficiaries of Medicare.

4. Between in or about 2009 through in or about the filing of this Indictment, the Merida Group's affiliated entities submitted claims to Medicare for hospice and home health services totaling approximately $153,111,986.40, which resulted in payments to the Merida Group's affiliated entities totaling approximately $120,390,290.18 on these claims.

B. The Conspirators

5. Defendant **RODNEY MESQUIAS ("RODNEY MESQUIAS")** owned and controlled the Merida Group and its affiliated entities. **RODNEY MESQUIAS** served as its President. **RODNEY MESQUIAS** supervised the overall management of the Merida Group and its affiliated entities. **RODNEY MESQUIAS** was a resident of Cameron County, Texas.

6. Defendant **HENRY MCINNIS ("HENRY MCINNIS")** was the Chief Executive Officer of the Merida Group. **HENRY MCINNIS** managed the day-to-day operations of the Merida Group and, in part, its affiliated entities. **HENRY MCINNIS** was a resident of Cameron County, Texas.

7. Defendant **JOSE GARZA ("JOSE GARZA")** was the operations manager of the Merida Group. **JOSE GARZA** assisted with the management of the day-to-day operations of the Merida Group and, in part, its affiliated entities. **JOSE GARZA** was a resident of Cameron County, Texas.

8. Defendant **FRANCISCO PENA ("FRANCISCO PENA" or "MAYOR PENA")** was the Mayor of Rio Bravo, a city in Webb County, Texas, within the Southern District of Texas. **MAYOR PENA** was a licensed physician in the State of Texas and served as the Medical Director for the Merida Group's affiliated entities operating in and around Laredo, Texas. **MAYOR PENA** was a resident of Webb County, Texas.

C. The Medicare Program

9. The Medicare Program ("Medicare") was a federal government health care benefit program, affecting commerce, which provided benefits to individuals who were over the age of 65 or disabled. Medicare was administered by the Centers for Medicare and Medicaid Services ("CMS"), a federal agency under the United States Department of Health and Human Services. Medicare was a "health care benefit program" as defined by Title 18, United States Code, Section 24(b). Medicare was subdivided into multiple parts. Part A of Medicare covered hospice services.

10. Individuals who qualified for Medicare benefits were commonly referred to as "Medicare beneficiaries." Each Medicare beneficiary was given a Medicare identification number.

D. Hospice Care

11. Hospice care was a set of services meant to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient or the patient's family members. Hospice care was also known as palliative care, which meant care that was intended to alleviate suffering rather than to cure illness.

12. According to Medicare's regulations, to be eligible to elect hospice care under Medicare, the patient was required to be entitled to Part A of Medicare and be certified as being terminally ill. An individual was considered to be terminally ill if the medical prognosis was that the individual's life expectancy was six months or less if the illness ran its normal course. Medicare only covered care provided by (or under arrangements made by) a Medicare certified hospice.

13. A hospice company was permitted to admit a patient only on the recommendation of the hospice medical director in consultation with, or with input from, the patient's attending physician, if the patient had one. In determining whether to certify that a patient was terminally ill, the hospice medical director was required to consider at least the following information: (1) diagnosis of the terminal condition of the patient; (2) other health conditions, whether related or unrelated to the terminal condition; and (3) current clinically relevant information supporting all diagnoses.

14. The certification of terminal illness was required to be based on the clinical judgment of the hospice medical director or physician member of the interdisciplinary group and the patient's attending physician, if the patient had one, regarding the normal course of the patient's illness. The signed certification of terminal illness had to contain the following: (1) a prognosis for a life expectancy of six months or less if the terminal illness ran its normal course; (2) clinical

information and other documentation that supported the prognosis; and (3) a brief narrative explanation of the clinical findings that supported a life expectancy of six months or less.

15. A beneficiary could be certified in this manner for two ninety-day hospice benefit periods, or for about six months. Before a beneficiary could be further certified for additional hospice benefit periods, Medicare required that a licensed physician or nurse practitioner have a face-to-face encounter with the beneficiary to determine whether they were still hospice eligible. The physician or nurse practitioner was required to attest in writing that he or she had a face-to-face encounter with the patient, including the date of the visit. The narrative associated with this third benefit period, and every subsequent sixty-day recertification, needed to include an explanation of why the clinical findings of the face-to-face encounter supported a life expectancy of six months or less.

16. If the Medicare beneficiary (or the beneficiary's authorized representative) elected to receive hospice care, the Medicare beneficiary was required to file an election statement with a particular hospice company.

E. Home Health Care

17. Part B of the Medicare program covered certain eligible home health care costs for medical services. Those medical services were provided by a home health care agency to Medicare beneficiaries requiring home health services because of an illness or disability causing them to be homebound. The Medicare program paid for home health services only if the patient qualified for home health care benefits. A beneficiary qualified for home health care benefits only if: (1) the beneficiary was confined to the home, also referred to as homebound; (2) the beneficiary was under the care of a physician who specifically determined that there was a need for home healthcare and established a Plan of Care; and; (3) the determining physician signed a certification statement that

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