UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF KENTUCKY
SOUTHERN DIVISION
AT PIKEVILLE

ELECTRONICALLY FILED

UNITED STATES OF AMERICA PLAINTIFF

v. CRIMINAL ACTION NO. 7:12-CR-00011-ART

EMMANUEL ACOSTA, M.D., et al. DEFENDANTS

DR. EMMANUEL ACOSTA'S SENTENCING MEMORANDUM

More than two dozen people have submitted tributes to Dr. Emmanuel Acosta's character for the Court to consider at sentencing, and though the voices are many and diverse, they speak in unison of Dr. Acosta as a man who is "honest, hardworking, kind," "courteous, friendly, cheerful, compassionate, [and] helpful...." (Attachment, Letters of Support at pp. 6, 13.) And yet Dr. Acosta has confessed that he prescribed hydrocodone without legitimate medical purposes during the six-month period he treated patients at the Paintsville Auto and Accident Healthcare clinic, the sort of crime typically motivated by greed, excessive debt, or some other bad impulse, and committed without regard for the patients' health.

Close consideration shows Dr. Acosta to be the good man praised by friends and family, notwithstanding his crime. Unlike most colleagues who have worked for "pill mills," Dr. Acosta was not pressured

by want, or goaded by a desire for money or ease. He worked long hours and tried, often with success, to improve his patients' wellbeing, especially by weaning them from the highly addictive painkiller oxycodone. This does not excuse his crime, but his conduct was of a lesser order of culpability than that of the typical pill mill physician.

By the Presentence Report's analysis, the Sentencing Guidelines recommend a punishment of at least two years in prison for Dr. Acosta's crime. (PSR at pp. 9-10, ¶¶ 41-49, and pg. 15 ¶ 85.) The dominant factor in this calculation, though, is the assumption that every hydrocodone pill that Dr. Acosta prescribed at the Paintsville clinic – between 60 and 80 thousand pills – had no legitimate medical purpose. (*See id.* at pg. 9 ¶¶ 36, 41.) As explained below, this assumption is incorrect, and the inflated drug quantity skews the Guideline calculation so that it greatly overstates Dr. Acosta's culpability.

The following discussion also demonstrates why Dr. Acosta's many profoundly good qualities show him to be a man for whom a punishment of probation, not prison, will be "sufficient, but not greater than necessary" to satisfy the objectives of punishment under 18 U.S.C. § 3553.

1. Sentencing Guidelines

Dr. Acosta's crime consisted of intentionally prescribing hydrocodone pills without a legitimate medical purpose and outside the usual course of the practice of medicine. *United States v. Johnson*, 71 F.3d 539, 542 (6th Cir. 1995) *and United States v. Kirk*, 584 F.2d 773,

784 (6th Cir. 1978); *see also* 21 C.F.R. § 1306.04. There is no agreement between the parties regarding the number of pills that were prescribed illegally. (R. 357, Plea Agreement at Page ID # 2562.) The prosecution's evidence establishes that Dr. Acosta prescribed a *total* of between 60,000 to 80,000 hydrocodone pills in six months at the Paintsville clinic (*see* PSR at pg. 9 ¶ 36), but the government has not offered proof to show how many of the total were *illegally* prescribed.

The distinction is critical, because the facts stipulated in the plea agreement (R. 357, Page ID# 2560-2562) and those set out in the Presentence Report (*see* PSR at pp. 8-9 ¶¶ 31-36) establish that Dr. Acosta's hydrocodone prescriptions fell below the legal standard *sometimes, but not always.* For instance, in his first few months at the clinic, Dr. Acosta prescribed "*largely* the same amounts" (but not universally the same amounts) as his predecessor, Dr. Stephen Arny. (PSR at pg. 8 ¶ 32 (emphasis added).) Then, as Dr. Acosta became more comfortable with the practice, he "began to wean some of the patients off the Schedule II controlled substances" while maintaining the patients' prescriptions for hydrocodone. (*Ibid.*) Referrals for therapy or other rehabilitation efforts "were *generally not* made" – or, in other words, *occasionally were* made. (*Ibid.* (emphasis added).) Because his patient caseload had become so heavy by December 2011, Dr. Acosta "did not properly prescribe hydrocodone substances to *many* of the patients" (*id.* at ¶ 33 (emphasis added)) – but by the same token, he *did* properly prescribe the medication to *some* of the patients.

There is indeed substantial evidence that Dr. Acosta practiced medicine more carefully, and prescribed controlled drugs less frequently, than Dr. Arny had. For example, Dr. Acosta worked at the Paintsville clinic about half as long as Dr. Arny had, but prescribed only *four percent* as many units of controlled substances (60 kilograms on the pills-to-marijuana conversion scale for Dr. Acosta, almost 2000 kilograms for Dr. Arny). (*See* PSR at pg. 9 ¶ 36.) In every case where Dr. Acosta was weaning a patient off oxycodone, he was by definition acting *with* a legitimate medical purpose and *within* the usual course of the practice of medicine; a prescription for hydrocodone to such a patient could not be presumptively unlawful. The same could be said in every case where Dr. Acosta referred the patient for therapy or other specialized treatment: again, the level of individual attention paid to the patient belies the assumption that it was a crime to prescribe hydrocodone for the particular patient.

The government bears the burden of establishing, by a preponderance of the evidence, the quantity of drugs involved in the defendant's crime. *United States v. Gill*, 348 F.3d 147, 153-154 (6th Cir. 2003). The Sentencing Guidelines conceive drug quantity as a proxy for culpability, assuming that the greater the amount at issue, the more blameworthy the defendant is. *United States v. Goodwin*, 594 F.3d 1, 5 (D.C. Circ. 2010). In a case like ours, therefore – where the defendant's prescriptions *sometimes, but not always,* fell below the criminal threshold – the government must do much more than provide a grand total of

prescribed pills. *United States v. Chube*, 538 F.3d 693, 702, 705-706 (7th Cir. 2008). For prescribed pills to be counted toward drug quantity, the doctor's conduct with respect to the particular prescription "must be unlawful." *Id.* at 702. Therefore, the drug quantity measure cannot include prescriptions that were "the result of mistake or inadvertence," *id.* at 702, or those for which there was only "an absence of medical necessity," *id.* at 703: although such conduct may fall below the civil standard of care, they do not transgress the criminal standard. *Id.* at 702-703.

In *United States v. Chube*, the Seventh Circuit carefully analyzed the application of Sentencing Guideline § 2D1.1 to doctors who had prescribed OxyContin and other controlled substances illegally. *See id.*, 538 F.3d 696-696. The prosecution submitted medical files for ninety-eight patients who had been prescribed one of the controlled drugs, and successfully urged the district court to count "*any* prescription for a controlled substance found in *any* of the 98 patient files...." *Id.* at 696 (emphasis in original). The Seventh Circuit reversed, noting that "the burden in the sentencing proceedings was on the Government to show that a given prescription had no legitimate medical purpose and was not dispensed in the usual course of medical practice." *Id.* at 701. The prosecution could not meet this burden by demonstrating that "'numerous files' contained evidence suggesting illicit prescribing," or by providing expert testimony that "*many* files had red flags that were totally ignored," "diagnostic work-ups were present in *very few* charts," and

"when consultations were ordered, they were *rarely ever* followed up." *Id.* at 704 (emphasis in original). "Such statements are too imprecise and indefinite to establish the illegality of all the prescriptions in all of the files," the Seventh Circuit wrote. *Ibid.* On the other hand, records from nineteen patient files indicated that "the doctor was weaning the patient from OxyContin in an effort to avoid tolerance or addiction," which the Seventh Circuit characterized as "evidence tending to suggest a legitimate medical purpose for several prescriptions...." *Id.* at 705.

"Any legitimate prescriptions must be deducted from the pill totals before a final determination of relevant conduct is possible," the Seventh Circuit concluded in *Chube.* 538 F.3d at 705. When patient files and a "finite set of prescriptions" underlie the asserted drug quantity, the court warned, "[t]his is not a situation ... in which the district court may rely on sampling or extrapolation...." *Ibid.* "These are not defendants who, from a period of 'y' to 'z,' were dealing drugs on the street to an unclear number of people on an unknown number of occasions," the court said; rather, there was "a defined set of concrete data" available. *Ibid.* "For a prescription to be included in relevant conduct, the court must evaluate the facts surrounding that particular prescription and explain why those facts render it unlawful," the Seventh Circuit declared: "Generalizing from 'numerous' files will not suffice." *Ibid.* The task for the sentencing court, therefore, is to "make a reasoned determination whether or not the Government has carried its burden of establishing that each prescription

was dispensed outside the scope of medical practice and without a legitimate medical purpose." *Id.* at 706.

The prosecution's evidence in our case falls far short of that which would allow the Court to make the "reasoned determination" described in the Seventh Circuit opinion. The significance of this to the Sentencing Guidelines calculation cannot be overstated; indeed, for all intents and purposes, drug quantity *is* the Sentencing Guidelines calculation. If even half of all the hydrocodone pills were prescribed by Dr. Acosta "outside the scope of medical practice and without a legitimate medical purpose" – and this proportion is almost certainly an exaggeration – the resulting quantity for § 2D1.1 purposes would be 30,000 to 40,000 pills (offense level 16), which would yield a final guideline range of 12 to 18 months in Zone C (offense level 13). That range is still too high, but it is certainly a better approximation of Dr. Acosta's culpability in this case.

2. Variance pursuant to 18 U.S.C. § 3553

As the attached letters from family and friends eloquently attest, Dr. Acosta's personal qualities are many and profound: he is the type of man whose continued presence in society would be a positive good. Moreover, as a result of this prosecution, Dr. Acosta has had to surrender his license and can no longer practice medicine; this disability is a guarantee against future offenses by him and, more importantly, a severe deterrent to any medical professionals who might be tempted to violate the law. Lastly, a sort of statistical reassurance can be taken from United States Sentencing Commission data showing that

Dr. Acosta's age, lack of criminal history, education, and other factors all put him in the category of offenders who pose the least risk of harm to the community. Dr. Acosta is, in sum, one for whom a probated sentence will be sufficient, but not greater than necessary, to satisfy the objectives of criminal punishment.

Dr. Acosta is "Manny" to friends and relatives, and is "Tito Manny" to his step-son Richard, who explains that "Tito" is "a Filipino cultural title that is given to an older man whom one respects." (Letters at pg. 7.) "He earned my respect," writes Richard, "because he accepted not only my mother" – Leticia, whom Dr. Acosta married in 2000 – "but my entire family as one of his own." (*Ibid.*) "[H]e is compassionate, loves unconditionally, and is always concerned about others' well being," Richard attests. (*Ibid.*) Dr. Acosta's niece Angela puts it simply: "He is the uncle that remembers our birthdays." (*Id.* at pg. 11.)

The many testimonials show that Dr. Acosta was a natural fit for a caregiving profession. "[H]e has been very kind and generous with his time, love, [and] support (both emotional and at times financial)," writes his nephew Eric, a Filipino immigrant who calls Dr. Acosta "my father here in the US." (Letters at pg. 4.) Dr. Acosta "is a boy scout at heart," writes a family friend: "Whenever he is around, nobody gets hungry." (*Id.* at pg. 13.) Step-daughter Lerissa echoes this, calling Dr. Acosta "the most gentle and kind hearted man I know in my life," someone who "always acts to put others' well being first." (*Id.* at pg. 8.) Dr. Acosta's son Elliot offers an example of this characteristic: "On the day of his visit,

my father was unaware that my wife and I were scheduled to participate in a service project," but his immediate response was "gleefully join[ing] us, assisting us with the daylong event." (*Id.* at pg. 20.) He "has a heart for service," says a fellow doctor. (*Id.* at pg. 31.)

Dr. Acosta's failures at the Paintsville clinic were not typical of the standard of care he tried to maintain during his career. He "saved people's lives by working in the emergency room," writes his son Erwin. (Letters at pg. 12.) Leticia, a registered nurse who works with drug addicts, says that her husband is attuned to working with drug-dependent people and "knows how to ... wean them effectively from drug abuse." (*Id.* at pg. 2.) A longtime friend writes that "it was [Dr. Acosta's] approach to pain treatment that encouraged me to seek alternative modalities of healing, only prescribing medication as a last resort." (*Id.* at pg. 10.) "His general concern for the welfare of others and desire to keep his patients living with quality of life have ... been noteworthy," his pastor writes. (*Id.* at pg. 22.) "He was a very hard working physician who was passionate about his patients," says a business associate. (*Id.* at pg. 25.)

Dr. Acosta's pastor also excludes greed as a possible motivation for the offense in this case. "During difficult financial times," he writes, "Manny and I would meet for spiritual counseling," and in these sessions Dr. Acosta "never demonstrated the hallmarks of greed: panic and machination." (Letters at pg. 22.) "I never saw greed or love of money and things in Manny's reasoning," he continues, "only a constant

motivation to keep his family fed, educated and safe." (*Id.* at pg. 23.) "I cannot debate" that Dr. Acosta committed a crime, he concludes, "but I firmly attest that whatever wrong choices he made were not motivated by greed...." (*Ibid.*)

Mrs. Acosta's letter reflects on the financial loss caused by Dr. Acosta's inability to practice medicine. "We have lost about everything," she writes, and at age 65 she has put her retirement on hold so that she can earn money to "pay for bills, educational loans, etc. just to maintain a simple, decent life." (Letters at pp. 2-3.) The cost has been great in emotional terms, too. Someone "familiar with the Filipino culture" would not be surprised, says Dr. Acosta's brother Eduardo, by the fact that "[t]his event in his life is devastating" and is a source of acute shame. (*Id.* at pg. 16.) "[T]he emotional stress of the present situation on his family is sure to be a sufficient deterrent from repeating the mistakes which have led to this day," his pastor adds. (*Id.* at pg. 23.)

Important objective characteristics classify Dr. Acosta as one who is an excellent candidate for probation. He has no criminal history points, a factor indicating a low recidivism risk: only 11.8% of all such offenders commit another offense, half the rate of defendants generally. U.S. Sentencing Comm'n, *Measuring Recidivism* at pg. 23 (May 2004).[1] (Surprisingly, even defendants with just a single point in their criminal

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[1] Available at http://www.ussc.gov/sites/default/files/pdf/research-and-publications/research-publications/2004/200405_Recidivism_Criminal_History.pdf.

history re-offend twice as often as people in Dr. Acosta's category. *Ibid.*) Older age is another factor closely associated with low recidivism rates: at the age of 63, Dr. Acosta is part of a group whose risk of recidivism is 6.2%. *Id.* at pg. 28. Higher educational attainment is yet another significant consideration: the recidivism rate for college graduates in criminal history Category I is just 7.1%. (*Id.* at pg. 29.)

First offenders are perhaps the most favored of all persons eligible for probation. Congress has expressly directed the Sentencing Commission to "insure that the guidelines reflect the general appropriateness of imposing a sentence other than imprisonment in cases in which the defendant is a first offender who has not been convicted of a crime of violence or an otherwise serious offense...." 28 U.S.C. § 994(j). Sentencing Commission statistics indicate that almost one-third of all defendants with no criminal history points and no prior arrests receive a fully-probated sentence; fewer than one-half in this category are given a sentence of prison only. Sentencing Comm'n, *Recidivism and the First Offender*, pp. 10, 25 (May 2004).[2] The dramatic difference between the costs of probation and imprisonment strongly encourage the resort to probation in cases like Dr. Acosta's: probation costs $3,162.00 per year, some or all of which Dr. Acosta could pay; prison costs $29,000.00 per year, almost all of which the taxpayers would bear. (*See* PSR at pg. 17 ¶ 93.)

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[2] Available at http://www.ussc.gov/sites/default/files/pdf/research-and-publications/research-publications/2004/200405_Recidivism_First_Offender.pdf.

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"Dr. Emmanuel Acosta is a very good man with so many things to offer to all the people around him and to society," writes a friend. (Letters at pg. 9.) He is eligible by statute for probation; the Sentencing Guidelines, properly calculated, would allow a fully-probated sentence or something very close to that. A sentence of probation would be sufficient in this case; the defense urges the Court to impose such a punishment.

Respectfully submitted,

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CERTIFICATE OF SERVICE

On July 6, 2015, I electronically filed this document through the ECF system, which will send a notice of electronic filing to all counsel of record.

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