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The Trump Administration Is Sending Taxpayer Dollars To Bail Out Large Health Care Companies That Have Recently Defrauded The Government

The Provider Relief Fund was designed to support American families, workers, and healthcare providers in the fight against the COVID-19 pandemic. The Trump administration's Department of Health & Human Services (HHS) was tasked with distributing the $175 billion to hospitals and healthcare providers on the front lines of the coronavirus response.

But, like many other efforts by the Trump administration, this fund has been mismanaged, poorly regulated and has not provided relief to those who need it most.

Recently, HHS quietly suspended quarterly reporting requirements for recipients of these taxpayer dollars, turning the Provider Relief Fund into what CMS Administrator Seema Verma described as "no strings attached" money that is being given away to fraudulent healthcare providers.

At least five recipients recently had to settle with the government for false claims, Medicare fraud, and other allegations, while non-Medicare providers continue to struggle to obtain funds. Places like mental health and addiction centers and hospitals that serve low-income patients have struggled to access funds while the biggest wealthiest hospital chains received billions in aid.

An investigation by Accountable.us found that at least five more recipients of the Trump administration's Provider Relief Fund recently had to settle with the government for false claims, Medicare Fraud, and other allegations.

For example, the publicly traded nursing home operator Diversicare received over $29 million in the taxpayer bailout funds through its state and local subsidiaries. The funds began to be disbursed just one month after the Department of Justice finally settled an 8-year investigation into the company's improper billing practices for $9.5 million.

As a result of the DOJ investigation, Diversicare suffered a $7.4 million net loss from continuing operations in 2018. That same year, the company's CEO was awarded a $56,000 raise from 2017 and then netted over $1 million in compensation in 2019. And just after, Diversicare subsidiaries received over $9.2 million in provider relief funds in April and May of 2020, Diversicare stock climbed 7.1%— its biggest weekly gain in 8 months.

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Over and over, the Trump administration has demonstrated that it has no interest in helping those who actually need aid to survive this pandemic. The administration has and continues to prioritize the wealthy and the well-connected while everyday American citizens suffer.

FEDERAL MONEY RECEIVED VS MONEY OWED		
COMPANIES RECEIVING "NO STRINGS ATTACHED" FUNDS	**MONEY RECEIVED FROM GOVERNMENT***	**MONEY PAID IN GOVERNMENT FINES**
Diversicare	$29,084,519.00	$9,500,000.00
Decatur Hospital Authority	$21,146,927.00	$431,138.00
Centra Health Inc. & Blue Ridge ENT	$18,613,274	$9,300,000.00
Cardiac Associates, P.C.	$556,028.00	$399,230
MedStar	$476,718	$35,000,000.00
Carewell Urgent Care Centers	$98,662	$2,000,000
The Medical Center Of Central Georgia	$14,379,335	$20,000,000.00
TOTAL	**$84,355,463.00**	**$76,630,368.00**

**Amounts up to date as of 06/22/20*

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After Sending Hundreds Of Millions Of Taxpayer Dollars To Health Care Providers Through Its "No Strings Attached" Provider Relief Fund, The Trump Administration Has Suspended Quarterly Reporting Requirements For Fund Recipients…

APRIL 2020: CMS ADMINISTRATOR SEEMA VERMA ON THE PROVIDER RELIEF FUND: "THERE ARE NO STRINGS ATTACHED."

April 2020: CMS Administrator Seema Verma On The Provider Relief Fund: "There Are No Strings Attached." "Without much fanfare, the Centers for Medicare & Medicaid Services (CMS) has begun doling out the first $30 billion chunk of approximately $100 billion set aside for health care providers in the coronavirus stimulus package passed last month. CMS administrator Seema Verma touted the flexibility that operators would be given once they received their shares of the COVID-19 stimulus cash. 'There are no strings attached, so the health care providers that are receiving these dollars can essentially spend that in any way that they see fit,' Verma said during a White House press conference last week." [Skilled Nursing News, 04/13/20;White House Press Briefing, 04/07/20]

June 2020: HHS Suspended Provider Relief Fund Recipients Quarterly Reporting Requirements. "Since our last update, HHS has made a number of announcements and updates to its Relief Fund guidance, most of which are detailed in the agency's Frequently Asked Questions (FAQ) document that can be found here: https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/faqs/index.html. One of the most

notable recent program changes came with a June 13, 2020, update to the FAQ document, announcing the agency's temporary suspension of the recipient quarterly reporting requirement. Found in Section 15011 of the CARES Act and also referenced in the Relief Fund Terms and Conditions" [Butler Snow, 06/17/20]

… Meanwhile, Many Recipients Of The Provider Relief Fund Have Recently Defrauded The Government And Had To Settle Large Fines

Publicly Traded Nursing Home Operator, Diversicare Has So Far Received Over $29 Million In A Taxpayer Bailout—With Payments Starting Just ONE MONTH After Settling For $9.5 Million With The Feds For A Multi-Year Medicare Fraud

Diversicare Was The Subject Of A Long-Term DOJ Investigation Alleging That Between 2010 And December 2015, Corporate Policies And Practices Were Designed To Place As Many Beneficiaries In The Highest Level Of Medicare Reimbursement—Irrespective Of Medical Condition…

Department Of Justice: "The Government Alleged That From Jan. 1, 2010, Through Dec. 31, 2015, Diversicare's Corporate Policies And Practices Were Designed To Place As Many Beneficiaries In The Highest Level Of Medicare Reimbursement — Ultra High — Irrespective Of The Individual Clinical Needs Of The Patients." "The government alleged that from Jan. 1, 2010, through Dec. 31, 2015, Diversicare's corporate policies and practices were designed to place as many beneficiaries in the highest level of Medicare reimbursement — Ultra High — irrespective of the individual clinical needs of the patients. These profit-driven policies and practices resulted in the provision of unreasonable, unnecessary, and unskilled therapy to many beneficiaries in Diversicare's skilled nursing facilities." [Press Release, DOJ, 02/28/20]

DOJ: "The Government Also Alleged That Diversicare Submitted Forged, Photocopied, Or Pre-Signed Physician Signatures On Pre-Admission Evaluation Certifications Required In The Submission Of Claims To TennCare." "The government also alleged that Diversicare submitted forged, photocopied, or pre-signed physician signatures on pre-admission evaluation certifications required in the submission of claims to TennCare for nursing facility services rendered to TennCare beneficiaries at its associated Tennessee skilled nursing and rehabilitation facilities. TennCare is Tennessee's Medicaid program jointly funded by the state of Tennessee and the federal government." [Press Release, DOJ, 02/28/20]

2018: Diversicare CEO James McKnight Received A $56,000 Raise To His Base Salary, Even As Diversicare Sustained A Net $7.4 Million Loss Attributable To The DOJ Investigation Into Potential Violations Of The False Claims Act

2018: DIVERSICARE RECORDED A $7.4 MILLION NET LOSS FROM CONTINUING OPERATIONS, ATTRIBUTABLE TO THE DOJ INVESTIGATION…

2018: Diversicare Healthcare Services Recorded A Net Loss From Continuing Operations Of $7.4 Million, Attributed To The Department Of Justice Investigation Into Potential Violations Of The False Claims Act. "Diversicare Healthcare Services Inc. (Nasdaq: DVCR) recorded a net loss from continuing operations of $7.4 million, or $1.15 per share, in what president and CEO Jay McKnight described as 'a challenging quarter.' The loss was mainly attributable to a $6.4 million litigation contingency expense related to an open Department of Justice (DOJ) investigation into potential violations of the False Claims Act, related to the skilled nursing operator's therapy practices and other issues, McKnight said on the company's third quarter earnings call Thursday afternoon. Net loss from continuing operations in the third quarter of 2017 was $600,000." [Skilled Nursing News, 11/01/18]

… BUT, DESPITE THE COMPANY'S $7.4 MILLION NET LOSS IN 2018, CEO JAMES MCKNIGHT RECEIVED A $56,223 RAISE IN 2018 AND A TOTAL COMPENSATION OF OVER $1 MILLION IN 2019

2019: Diversicare CEO James R. McKnight, Jr. Received Over $1 Million In Total Compensation And Acquired 13,091 Shares In Company Stock.

Summary Compensation Table

Name and Principal Position	Year	Salary ($)	Bonus($)(1)	Stock Awards($)(2)	Option Awards($)(2)	Non-Equity Incentive Plan Compensation($)(3)	All Other Compensation($)		Total ($)
James R. McKnight, Jr.	2019	450,000	80,000	255,450	—	225,000	40,582	(4)	1,051,032
President and Chief Executive	2018	386,748	—	101,750	—	342,000	36,314	(4)	866,812
Officer (4)	2017	330,525	—	124,750	—	594,945	32,438	(4)	1,082,658
Leslie D. Campbell	2019	375,000	—	78,600	—	187,500	38,363	(5)	679,463
Executive Vice President And Chief	2018	353,710	—	101,750	—	285,000	35,790	(5)	776,250
Operating Officer (5)	2017	339,966	—	124,750	—	611,939	32,314	(5)	1,108,969
Kerry D. Massey	2019	275,000	—	78,600	—	137,500	19,292	(6)	510,392
Executive Vice President and Chief	2018	79,327	—	—	—	64,132	2,996	(6)	146,455
Financial Officer (6)									

[Diversicare, SEC Schedule 14A Proxy Statement, 05/04/20]

Option Exercises and Stock Vested during 2019

	Stock awards			
Name	Number of shares acquired on vesting (#)(1)		Value realized on vesting ($)(2)	
James R. McKnight, Jr.	13,091	(3)	51,090	(3)
James R. McKnight, Jr.	4,523	(4)	(18,888)	(4)
Leslie D. Campbell	13,091	(5)	51,090	(5)
Leslie D. Campbell	7,402	(6)	(30,904)	(6)

[Diversicare, SEC Schedule 14A Proxy Statement, 05/04/20]

In March 2020, Diversicare Agreed To Pay A $9.5 Million Settlement To Resolve Improper Billing Allegations—Just A Month Before Its Subsidiaries Began Receiving Over $29 Million In Federal Funds, Followed By Diversicare Stock's Biggest Weekly Gain In 8 Months…

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MARCH 2020: DIVERSICARE FINALLY AGREED TO A 9.5 MILLION SETTLEMENT WITH THE DOJ—JUST OVER A MONTH BEFORE 47 OF ITS SUBSIDIARIES RECEIVED A COMBINED $9.2 MILLION IN FEDERAL PROVIDER RELIEF FUNDS…

March 2020: "Diversicare Health Services Agreed To Pay A $9.5 Million Settlement To Resolve Improper Billing Allegations For Medicare Rehabilitation Therapy Services." "Diversicare Health Services agreed to pay a $9.5 million settlement to resolve improper billing allegations for Medicare rehabilitation therapy services, according to the Department of Justice. The Brentwood, Tenn.-based nursing home chain submitted false claims to Medicare for services that weren't reasonable, necessary or skilled, according to investigators. Specifically, the federal government alleged that from 2010-15, the 74-facility chain followed corporate policies and practices that were designed to bill for the highest level of Medicare reimbursement — Ultra High — regardless of clinical needs. The policies led Diversicare to provide improper care to reach minute thresholds and extend patient lengths of stay, the investigators said. Diversicare also threatened employees who didn't meet budgets, goals and quotas, according to the DOJ." [Beckers Hospital Review, 03/02/20]

- **The Government Also Alleged That Diversicare "Submitted False Information To Tennessee's Medicaid Program, TennCare."** "Additionally, the government alleged Diversicare submitted false information to Tennessee's Medicaid program, TennCare. Under the settlement, Diversicare agreed to a five-year agreement with the HHS and the Office of Inspector General to conduct internal reviews and risk assessments. As the settlement was based on lawsuits filed under the qui tam provision of the False Claims Act, two plaintiffs will receive $1.4 million and $145,350 of the settlement." [Beckers Hospital Review, 03/02/20]

… AND AS OF JUNE 2020, DIVERSICARE SUBSIDIARIES RECEIVED OVER $29 MILLION COMBINED FROM THE FEDERAL PROVIDER RELIEF FUND

PROVIDER NAME	STATE	CITY	AMOUNT*
Diversicare Of Arab LLC	AL	ARAB	$405,127.00
Diversicare Of Bessemer LLC	AL	BESSEMER	$760,852.00
Diversicare Of Riverchase LLC	AL	BIRMINGHAM	$592,736.00
Diversicare Of Boaz LLC	AL	BOAZ	$462,189.00
Diversicare Of Foley LLC	AL	FOLEY	$656,016.00
Diversicare Hartford, LLC	AL	HARTFORD	$349,810.00
Diversicare Of Hueytown LLC	AL	HUEYTOWN	$236,129.00
Diversicare Of Big Springs LLC	AL	HUNTSVILLE	$646,270.00
Diversicare Windsor House, LLC	AL	HUNTSVILLE	$508,274.00
Diversicare Of Lanett LLC	AL	LANETT	$380,640.00
Diversicare Of Montgomery LLC	AL	MONTGOMERY	$589,028.00
Diversicare Of Oneonta LLC	AL	ONEONTA	$513,291.00
Diversicare Of Oxford LLC	AL	OXFORD	$715,052.00

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Diversicare Of Pell City LLC	AL	PELL CITY	$409,364.00
Diversicare Of Selma LLC	AL	SELMA	$489,398.00
Diversicare Of Winfield LLC	AL	WINFIELD	$531,730.00
Diversicare Of Chanute LLC	KS	CHANUTE	$355,323.00
Diversicare Of Council Grove, LLC	KS	COUNCIL GROVE	$321,186.00
Diversicare Of Haysville LLC	KS	HAYSVILLE	$522,930.00
Diversicare Of Hutchinson LLC	KS	HUTCHINSON	$345,732.00
Diversicare Of Larned, LLC	KS	LARNED	$278,539.00
Diversicare Of Sedgwick LLC	KS	SEDGWICK	$298,695.00
Diversicare Leasing Corp.	KY	ASHLAND	$5,445,410.00
Diversicare Of Riverside LLC	MO	SAINT JOSEPH	$408,547.00
Diversicare Of St. Joseph LLC	MO	SAINT JOSEPH	$629,423.00
Diversicare Of Chateau LLC	MO	ST JOSEPH	$294,627.00
Diversicare Of Amory LLC	MS	AMORY	$639,688.00
Diversicare Of Batesville LLC	MS	BATESVILLE	$555,645.00
Diversicare Of Brookhaven LLC	MS	BROOKHAVEN	$305,388.00
Diversicare Of Eupora LLC	MS	EUPORA	$525,339.00
Diversicare Of Meridian LLC	MS	MERIDIAN	$492,421.00
Diversicare Of Ripley LLC	MS	RIPLEY	$610,319.00
Diversicare Of Southaven LLC	MS	SOUTHAVEN	$638,994.00
Diversicare Of Tupelo LLC	MS	TUPELO	$539,984.00
Diversicare Of Tylertown LLC	MS	TYLERTOWN	$266,283.00
Diversicare Of St Theresa LLC	OH	CINCINNATI	$453,692.00
Diversicare Of Siena Woods LLC	OH	DAYTON	$493,027.00
Diversicare Of Bradford Place LLC	OH	HAMILTON	$444,412.00
Diversicare Briarcliff, LLC	TN	OAK RIDGE	$519,610.00
Diversicare Ballinger LLC	TX	BALLINGER	$402,518.00
Diversicare Doctors LLC	TX	DALLAS	$1,042,115.00
Diversicare Treemont LLC	TX	DALLAS	$504,574.00
Diversicare Estates LLC	TX	FORT WORTH	$426,534.00
Diversicare Afton Oaks, LLC	TX	HOUSTON	$678,456.00
Diversicare Katy LLC	TX	KATY	$537,591.00
Diversicare Chisolm, LLC	TX	LOCKHART	$377,773.00
Diversicare Paris, LLC	TX	PARIS	$463,271.00
Diversicare Normandy Terrace LLC	TX	SAN ANTONIO	$1,020,567.00
TOTAL*			**$29,084,519.00**

[HHS Provider Relief Fund, General Distribution, HHS ASPA Data, accessed, 06/22/20]

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*Amount is up to date as of 06/22/20

May 22, 2020: Diversicare Stock Climbed 7.1%— The Company's Biggest Weekly Gain In 8 Months

May 22, 2020, Diversicare Stock Climbed 7.1% Over The Past Week— Its Biggest Weekly Gain In 8 Months. "Diversicare Healthcare Services, Inc. (OTCQX:DVCR), has climbed 10.0c (or 7.1%) in the past week to close at USD1.50. In the past week the shares have climbed 7.1%, the biggest weekly gain since October 18, 2019. Compared with the NASDAQ-100 Index which rose 261.4 points (or 2.9%) in the week, this represented a relative price increase of 4.3%. The volume was 0.2 times average trading per week of 13,280 shares. In the past week the market cap has risen USD667,893." [News Bites Finance, 05/22/20]

… And At Least Five More Recipients Of The Trump Administration's Provider Relief Fund Recently Had To Settle With The Government For False Claims, Medicare Fraud, And Other Allegations, While Non-Medicare Providers Struggle To Get Funds

The Billions Of Dollars In Provider Relief Funds That Have Been Allocated By HHS Have Been Weighted Towards Hospitals And Doctors That Regularly Bill Medicare—Disadvantaging Providers That Largely Treat Patients Who Are Covered By Medicaid…

June 2, 2020: HHS Created The Provider Relief Fund In March 2020 And Set Aside $175 Billion In Aid For Hospitals And Doctors—As Of June 2020, HHS Has Allocated Only About $77 Billion Of That Total… "Congress created the provider relief fund in late March as part of its $2 trillion CARES Act, setting aside $100 billion in aid for hospitals and doctors and adding another $75 billion on top of that a few weeks afterward. But HHS has allocated only about $77 billion of that total to date, according to its own disclosures — a process slowed recently by difficulties figuring out how to get money to the providers still waiting for emergency payouts." [Politico, 06/02/20]

… The Approach For Allocating The Funds Has Disadvantaged Providers That Largely Treat Patients Who Are Covered By Medicaid, Or That Don't Participate In The Medicare Program. "Much of the funds that HHS has allocated so far have been weighted toward hospitals and doctors that regularly bill Medicare — in large part because the health department already has extensive data on participants in that federal program, making it easier to rapidly ship out the funding. But that approach has disadvantaged providers that largely — or even exclusively — treat patients who are covered by Medicaid, or that don't participate in the Medicare program. HHS does not maintain similarly detailed databases for Medicaid, the low-income health program run by individual states, making it far more challenging to identify and quickly get bailout money to that wide swath of the industry." [Politico, 06/02/20]

Decatur Hospital Authority—Which Has Received More Than $21 Million From The Taxpayer Funded Program, Recently Settled Allegations Of Fraudulent Billing

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DECATUR HOSPITAL AUTHORITY RECEIVED MORE THAN $21 MILLION FROM THE HHS MANAGED PROVIDER RELIEF FUND THE SAME MONTH IT SETTLED FOR $431,138 AROUND ALLEGATIONS THAT IT FRAUDULENTLY BILLED MEDICARE

May 6, 2020: Decatur Hospital Authority Agreed To Settle Allegations That It Violated The False Claims Act By "Billing Medicare For Medically Unreasonable Or Unnecessary Genetic Testing For Surgical Patients." "Decatur Hospital Authority, which is doing business as Wise Health System in Decatur, Texas, agreed to settle allegations that it violated the False Claims Act, the Department of Justice said May 3. According to the allegations, from 2016-18, Wise Health System billed Medicare for medically unreasonable or unnecessary genetic testing for surgical patients. The health system would submit the unnecessary samples from surgical patients to Total Diagnostic labs in Tennessee, then file false claims with Medicare, according to the Justice Department." [Becker's Hospital Review, 05/06/20]

Decatur Hospital Authority Settled With The Justice Department For $431,138 "Under the settlement, Wise Health agreed to resolve the allegations for $431,183." [Becker's Hospital Review, 05/06/20]

As Of June 22, 2020, Decatur Hospital Authority Received $21,146,927 From The Federal Government's Provider Relief Fund. [HHS Provider Relief Fund, General Distribution, HHS ASPA Data, accessed, 06/22/20]

The Medical Center Of Central Georgia— Which Had To Settle Two Separate Allegations Of Fraudulent Billing In The Past 5 Years, Recently Received $14,379,335 Through The Provider Relief Fund

BETWEEN 2015 & 2017, THE MEDICAL CENTER OF CENTRAL GEORGIA HAS HAD TWO SEPARATE SETTLEMENTS TOTALING OVER $22.5 MILLION FOR FRAUDULENT MEDICARE AND MEDICAID BILLING…

2015: "The Medical Center Of Central Georgia Has Agreed To Pay $20 Million To Settle Allegations That The Hospital Violated The False Claims Act By Billing Medicare For More Expensive Inpatient Services That Should Have Been Billed As Less Costly Outpatient Or Observation Services." "The Medical Center of Central Georgia (MCCG) has agreed to pay $20 million to settle allegations that the hospital violated the False Claims Act by billing Medicare for more expensive inpatient services that should have been billed as less costly outpatient or observation services, the Justice Department announced today. MCCG is located in Macon, Georgia, and is the second largest hospital in the state. 'Charging the government for higher cost inpatient services when the patient care received was outpatient or observation services causes Medicare to pay more than it should,' said Principal Deputy Assistant Attorney General Benjamin C. Mizer of the Justice Department's Civil Division. 'This department will continue its work to stop abuses of the nation's health care resources and to ensure patients receive the most appropriate care.'" [Press Release, 04/27/15]

2017: The Medical Center Of Central Georgia (D/B/A The Medical Center, Navicent Health) Agreed To Pay $2,549,742 To The U.S. And State Of Georgia To Resolve Allegations That It Violated The False Claims Act And The Georgia False Medicaid Claims Act By

Submitting Inflated And Medically Unnecessary Bills For Ambulance Transports. "G.F. 'Pete' Peterman, III, United States Attorney for the Middle District of Georgia, and Georgia Attorney General Christopher M. Carr announced today a civil settlement with The Medical Center of Central Georgia, Inc., d/b/a The Medical Center, Navicent Health ('Navicent'). Navicent agreed to pay to the United States and the State of Georgia $2,549,742 to resolve allegations that it violated the False Claims Act and the Georgia False Medicaid Claims Act by submitting bills for ambulance transports that were either inflated or medically unnecessary. Additionally, Navicent's current Corporate Integrity Agreement (CIA) will be heightened and extended to cover the newly resolved conduct. A CIA is an agreement between a private provider of services and the United States whereby the provider, at its own expense, institutes and maintains a program, overseen by the OIG with reviews by an independent review organization, to insure compliance with the laws and regulations regarding participation in federally funded programs." [Press Release, Department of Justice, Middle District of Georgia, 08/03/17]

… APRIL 2020: THE MEDICAL CENTER OF CENTRAL GEORGIA RECEIVED $14,379,335 FROM THE FEDERAL GOVERNMENT'S PROVIDER RELIEF FUND

As Of May 14, 2020 The Medical Center Of Central Georgia Received $14,379,335 From The Federal Government's Provider Relief Fund. [HHS Provider Relief Fund, General Distribution, HHS ASPA Data, accessed, 06/22/20]

Centra Health Inc. & Blue Ridge ENT Both Recently Settled Allegations Of Fraud And Received A Combined $18.6 Million From The Taxpayer Funded Program

THE SAME MONTH THAT CENTRA HEALTH AND BLUE RIDGE ENT BOTH HAD TO SETTLE ALLEGATIONS THAT THEY VIOLATED THE FALSE CLAIMS ACT & STATE FRAUD LAWS THROUGH A KICKBACK SCHEME, THEY RECEIVED A COMBINED $18.6 MILLION FROM THE PROVIDER RELIEF FUND

April 2020: Centra Health And Blue Ridge Ear, Nose, Throat And Plastic Surgery Agreed To Pay $9.3. Million Dollars To Settle Allegations That They Violated The False Claims Act And State Fraud Laws. "Centra Health and Blue Ridge Ear, Nose, Throat and Plastic Surgery, both in Lynchburg, Va., agreed to pay $9.3 million to settle allegations that they violated the False Claims Act and state fraud laws, the Department of Justice said April 22. Federal investigators accused the organizations of improper financial relationships. According to the Justice Department, Blue Ridge ENT allegedly had a financial referral relationship with Centra to guarantee income to one of its physicians. Centra agreed to reimburse Blue Ridge ENT for actual additional incremental costs attributed to the physician, according to the allegations. However, Blue Ridge ENT knowingly claimed and received more reimbursement than would be allowed under Stark Law and the Anti-Kickback Statute. Centra self-disclosed the violations of the False Claims Act and worked with federal officials to resolve the issue." [Becker's Hospital Review, 04/27/20]

As Of June 22, 2020 Centra, Health Inc. Received $18,541,272 From The Federal Government's Provider Relief Fund. [HHS Provider Relief Fund, General Distribution, HHS ASPA Data, accessed, 06/22/20]

As Of June 22, 2020, Blue Ridge Ear, Nose And Throat, Inc., Received $72,002 From The Federal Government's Provider Relief Fund. [HHS Provider Relief Fund, General Distribution, HHS ASPA Data, accessed, 06/22/20]

Cardiac Associates, P.C.—Which Recently Paid Hundreds Of Thousands Of Dollars To Settle Allegations Of False Medicare Claims, Received $556,028 From The Taxpayer Funded Program

APRIL 2019: CARDIAC ASSOCIATES IN MARYLAND AGREED TO PAY HUNDREDS OF THOUSANDS OF DOLLARS TO SETTLE ALLEGATIONS OF SENDING FALSE CLAIMS TO MEDICARE…

April 2019: Cardiac Associates In Maryland Agreed To Pay Hundreds Of Thousands Of Dollars To Settle Allegations Of Sending False Claims To Medicare. "Cardiac Associates, a medical group with four offices in Maryland, has agreed to pay $399,230 to settle false billing allegations, according to the Department of Justice. The settlement resolves allegations that Cardiac Associates submitted claims to Medicare for services that weren't actually rendered between January 2012 and December 2016. The government alleged that the medical group billed Medicare for two similar procedures on the same date for the same patients, when only one of the procedures was actually performed. Specifically, the government alleged Cardiac Associates billed Medicare under CPT 93970 for tests administered to patients to assess the venous sufficiency in their legs. The group also allegedly billed for an additional test using CPT 93965, which references older technology that has generally been replaced by CPT 93970. Billing for both codes led to the submission of false claims to Medicare, according to the Justice Department." [Becker's Hospital Review, 04/16/19]

… APRIL 2020: CARDIAC ASSOCIATES IN MARYLAND RECEIVED $556,028 FROM THE FEDERAL GOVERNMENT'S PROVIDER RELIEF FUND

As Of May 14, 2020, Cardiac Associates, P.C., Received $556,028 From The Federal Government's Provider Relief Fund. [HHS Provider Relief Fund, General Distribution, HHS ASPA Data, accessed, 06/22/20]

One Year After Medstar Health And Two Of Its Hospitals Had To Pay $35 Million To Resolve Allegations Of Illegal Kickbacks & Medicare Fraud, One Of The Same Hospitals Received $476,718 From The Provider Relief Fund

MARCH 2019: MEDSTAR HEALTH AND ITS AFFILIATED UNION MEMORIAL HOSPITAL HAD TO PAY $35 MILLION TO RESOLVE ALLEGATIONS OF ILLEGAL KICKBACKS AND RECEIVING MEDICARE PAYMENTS FOR MEDICALLY UNNECESSARY STENTS…

March 2019: Medstar Health And Two Of Its Hospitals, Including Union Memorial Hospital In Baltimore, Agreed To Pay $35 Million To Resolve Allegations That They Paid Illegal Kickbacks To A Cardiology Group And Received Medicare Payments For Medically Unnecessary Stents. "Columbia, Md.-based MedStar Health and two of its hospitals have agreed to pay $35 million to resolve allegations that they paid illegal kickbacks to a cardiology

group, according to the Department of Justice. The settlement resolves allegations that MedStar paid kickbacks to Pikesville, Md.-based MidAtlantic Cardiovascular Associates in exchange for referring patients to MedStar Union Memorial Hospital in Baltimore for cardiovascular procedures. Those kickbacks were allegedly paid between Jan. 1, 2006, and July 31, 2011. MedStar also settled allegations that it received Medicare payments for medically unnecessary stents performed by a physician who was employed by MidAtlantic Cardiovascular Associates and later worked at MedStar. The settlement resolves two whistleblower lawsuits — one filed in 2010 by cardiac surgeons and another filed in 2012 by former MedStar patients." [Becker's Hospital Review, 03/22/19]

… APRIL 2020: MEDSTAR, UNION MEMORIAL RECEIVED $476,718 FROM THE FEDERAL GOVERNMENT'S PROVIDER RELIEF FUND

As Of May 14, 2020 Medstar, Union Memorial Physicians LLC Received $476,718 From The Federal Government's Provider Relief Fund. [HHS Provider Relief Fund, General Distribution, HHS ASPA Data, accessed, 06/22/20]

One Year After Carewell Urgent Care Had To Pay $2 Million To Resolve Allegations That It Submitted False Claims To The Government, Its Rhode Island And Massachusetts Locations Received A Combined $98,662 From The Provider Relief Fund

APRIL 2019: CAREWELL URGENT CARE HAD TO PAY $2 MILLION TO RESOLVE ALLEGATIONS THAT IT SUBMITTED FALSE CLAIMS TO GOVERNMENT INSURERS…

April 2019: "Carewell Urgent Care, A Chain Of Walk-In Clinics In Massachusetts And Rhode Island, Will Pay $2 Million To Resolve Allegations That It Submitted False Claims To Government Insurers." "CareWell Urgent Care, a chain of walk-in clinics in Massachusetts and Rhode Island, will pay $2 million to resolve allegations that it submitted false claims to government insurers, according to the U.S. Justice Department. The Justice Department, Massachusetts and Rhode Island allege CareWell violated the False Claims Act by sending inflated and upcoded claims to Medicare, Massachusetts Medicaid, the Massachusetts Group Insurance Commission and Rhode Island Medicaid. They allege that between March 1, 2013, and August 31, 2018, CareWell inflated the level of evaluation and management services performed and failed to properly identify the providers of services. The governments said CareWell 'accomplished its fraud in several ways, including mandating that medical personnel examine and document at least 13 body systems during medical history inquiries, and at least nine body systems during physical examinations, even if patients' specific medical complaints or symptoms did not justify such a comprehensive inquiry or examination.'" [Becker's Hospital Review, 04/01/19]

… MAY 2020: CAREWELL RECEIVED A COMBINED $98,662 FROM THE FEDERAL GOVERNMENT'S PROVIDER RELIEF FUND

As Of May 14, 2020 Carewell, Urgent Care Centers Of MA Received $ $91,932 From The Federal Government's Provider Relief Fund. [HHS Provider Relief Fund, General Distribution, HHS ASPA Data, accessed, 06/22/20]

As Of May 14, 2020 Carewell Urgent Care Of Rhode Island, Received $6,730 From The Federal Government's Provider Relief Fund. [HHS Provider Relief Fund, General Distribution, HHS ASPA Data, accessed, 06/22/20]

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