Follow the Money Series
Blood Money in U.S. Healthcare
Financial Incentives: The Use of "Covered Countermeasures"

Summary Brief, Revised 15 October 2023

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Foreword

Founded in January 2021, TN Liberty Network is an independent Tennessee-based think tank comprised of 28 volunteer researchers who live within the state's borders. TN Liberty Network does not have a public membership, does not raise or accept funding, does not have a bank account, does not have a public-facing website, is not a registered 501-type organization, does not have a federal tax ID number, is not part of any another organization, and is not instructed by any organization or individual on what to research or what outcomes are produced. TN Liberty Network only follows money and evidence to factual and documented conclusions.

In January 2022, TN Liberty Network released its first white paper summary in our *Follow the Money Series* on ESSER funding and its effects on U.S. government schools. In late July 2022, a more detailed monograph titled *Blood Money and Trojan Horses: Federal ESSER Money in Public Schools* was released, further detailing how the federal government uses Covid relief money via Elementary and Secondary School Emergency Relief (ESSER) funds to coerce K-12 public school compliance with CDC-related requirements, Social Emotional Learning (SEL)/Critical Race Theory (CRT)-based requirements, and mental health requirements.

The next monograph in our *Follow the Money Series*, *Blood Money in U.S. Healthcare*, released in late summer 2022. This was the first of seven separate monographs TN Liberty Network plans for release to help readers better understand varying levels of fraud and corruption perpetrated on the American people by our government. Future monographs will include these topics:

- Centers for Medicare and Medicaid (CMS) Waivers: Destruction of Patient Rights and the Hippocratic Oath
- Public Health Emergency (PHE): Following Money and Power to Who is Responsible
- Public Readiness and Emergency Preparedness Act (PREP Act): How Immunity from Liability Works
- The CARES Act: How Legislation Weaponized Federal Agencies and Organizations During the Pandemic
- Vaccination Fraud: Lies Behind EUA-Approved Drugs and the Covid "Vaccinations"
- Medicare for All: The Future of Healthcare in America and How We Can Stop It

TN Liberty Network files Fair Use copyrights for each paper to be used in the public domain and encourages the public to include footnoted references as evidence. This is no longer anecdotal information. It is not the opinion of TN Liberty Network nor its members. Our mission is to equip the public with fact- and evidence-based information regarding what is occurring in U.S. healthcare and education systems.

One people—one fight for liberty.

AJ DePriest
TN Liberty Network
15 October 2023

Introduction

Hospitals have historically been the place we could count on to act in our best interest. If we were sick and needed care, hospitals and their staff were our trusted partners to help us get better. But something dark and insidious occurred in early 2020 when Covid-19 was labeled a "global pandemic." Covid signaled a new era of medical tyranny as Big Pharma, Big Med, Big Tech, and Fake News Media teamed up to become our fourth and most powerful branch of government.

In early 2020, trillions of dollars in Covid relief funds began pouring into states through the Coronavirus Aid, Relief, and Economic Security (CARES) Act,[1] $178B of which went immediately to healthcare providers for Phase 1 "relief funding." In June 2020, the second phase of emergency funding ($4B) went to healthcare providers. In October 2020, HHS announced the third phase of $20B in general distribution funds to providers. The Coronavirus Response and Relief Supplemental Appropriations (CRRSA) Act provided another $178B in relief funds to healthcare providers and hospitals.[2] More relief funds were siphoned to states from the American Rescue Plan (ARP) Act[3] beginning in March 2021, $8.5B of which went to healthcare providers. Phase four funds from the CARES Act delivered another round of provider relief funds of up to $25.5B.

Federal Covid relief funds flooding our hospitals are the carrot *and* the stick. Their blood-price is strict compliance to requirements and protocols dictated by the National Institutes of Health (NIH).[4]

American hospitals are making money off Covid diagnoses and deadly treatment protocols, *and* they are immune from liability if deadly protocols recommended by the Centers for Disease Control and Prevention (CDC) and the NIH are employed. Therefore, hospitals tell patients and their families there is *only one* treatment available for Covid. No other "off-label" treatments, despite effectiveness and safety, pay dividends for every patient. No other treatment offers immunity from liability in case of injury or death. Since early 2020, "covered countermeasures" are the hospitals' rule—no exceptions.

A final introductory note: On 1 March 2020, Centers for Medicare and Medicaid (CMS) were empowered to issue a series of devastating waivers ("1135 waivers"[5]) to be enacted until the end of the Covid-19 Public Health Emergency (PHE). The waivers allowed many of the horrific patient right violations witnessed from early 2020 until today, 15 October 2023. Verbal orders and reporting requirements for Covid deaths were waived. Patient rights, explicitly, were violated and waivers were provided to allow isolation of patients and denial of visitation from family, clergy, and advocates. Families were no longer allowed access to medical records or portals. Medical licensure requirements were waived for doctors and nurses. Advance directives were waived. Patients were allowed to be alone, without food, water, or personal care. Many of these waivers were terminated by June 2022.

CDC/NIH "Covered Countermeasures" for Inpatient Hospital Treatment of Covid-19

Specific medications and treatments within NIH Covid-19 Treatment Guidelines[6] for adults hospitalized for Covid-19 are considered "covered countermeasures":

- Baricitinib (Olumiant)
- Dexamethasone
- Heparin
- Remdesivir (Veklury)
- Sarilumab (Kevzara)
- Tocilizumab (Actemra)
- Tofacitinib (Xeljanz)

The Dangers of "Covered Countermeasures"

When patients enter hospitals and are suspected of having Covid, they become prisoners—medically kidnapped and isolated from families. Hospitals ignore powers of attorney and explicit written and verbal insistence from patients and families *not* to administer decision-altering sedatives and deadly Remdesivir and *not* to put patients on ventilators. Hospital staff sedate patients without consent and, with no personal advocate present, administer toxic doses of Remdesivir, leading to acute renal failure and pulmonary edema, followed by ventilators until death occurs.

Remdesivir

As of 23 Nov 2020, Remdesivir was the *only* FDA-approved treatment for hospitalized Covid-19 patients (adults and children weighing at least 88 lbs.)[7] The PINETREE trial claimed three consecutive days of IV Remdesivir resulted in an 87 percent relative reduction in risk of hospitalization or death compared to placebo.[8] A subsequent analysis of the FDA's safety database, however, revealed that Remdesivir caused kidney failure.[9] Independent, standalone trials (those not sponsored by a pharmaceutical company) proved Remdesivir harms patients. In Nov 2020, the WHO advised hospitals not to administer Remdesivir to hospitalized Covid patients.[10]

The Timing Dilemma. Remdesivir is not effective on Covid-19 patients when it is administered too late in the disease lifecycle. By the time a patient is admitted, he or she is well past Incubation phase and many are several days into the Symptomatic phase. By that time, viral replication is complete (**Figure 1**)[11] and there is a decrease in oxygenation due to massive lung inflammation. Covid patients begin Remdesivir immediately upon entering the hospital—often in the emergency room and often without patient consent.

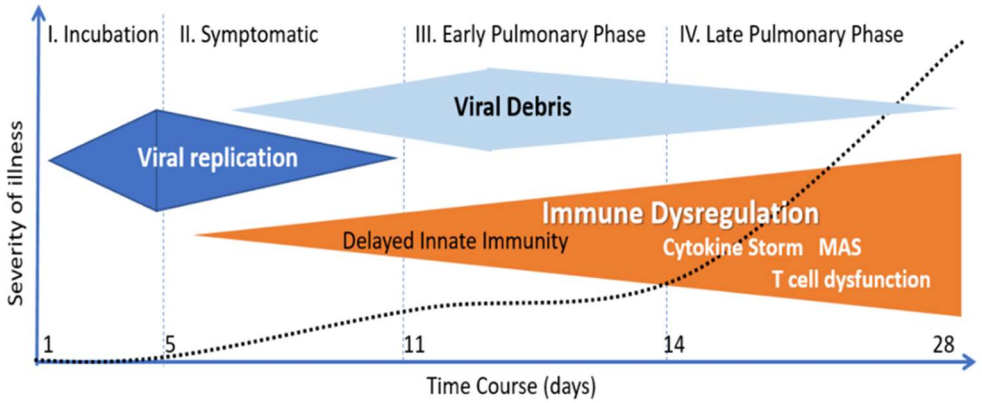


Figure 1. Covid Lifecycle. *Shows timeline of pulmonary symptoms.*

U.S. Federal Complicity

"Remdesivir, the first drug approved by licensing authorities in the US to treat Covid-19, is made by Gilead and has been shown to help people recover faster from the disease. The first 140,000 doses, supplied to drug trials around the world, have been used up. The Trump Administration has now bought more than 500,000 doses, which is all of Gilead's production for July and 90% of August and September.

'President Trump has struck an amazing deal to ensure Americans have access to the first authorized therapeutic for Covid-19,' said the US health and human services secretary, Alex Azar. "To the extent possible, we want to ensure that any American patient who needs remdesivir can get it. The Trump Administration is doing everything in our power to learn more about life-saving therapeutics for Covid-19 and secure access to these options for the American people.'"

The Guardian, 30 Jun 2020.[12]

Ventilators

A *National Library of Medicine* (Jan 2021) report of 69 studies with more than 57,000 patients showed fatality rates of 45 percent among Covid-19 patients receiving invasive mechanical ventilation (ventilator). The fatality rate increased to 84 percent in older patients.[13] In New York hospitals, 88 percent of Covid patients on ventilators died.[14] **(SEE ENDNOTE FOR MORE INFORMATION ABOUT THIS SOURCE.)** In Texas, CMS data showed 84.9 percent of Covid patients died after 96 hours on a ventilator.[15]

Sedatives and Antibiotics

Prior to the 8 Jul 2022 update, NIH Guidelines expounded on the use of multiple, layered sedatives on hospitalized Covid patients. These were approved and used routinely to sedate patients, often beginning on arrival at emergency rooms and continued in greater degrees throughout patients' hospital stay. In some states like Tennessee, there are laws that prevent patients from leaving the hospital Against Medical Advice (AMA) once they receive a sedative.

- Midazolam (Versed)
- Fentanyl
- Lorazepam (Ativan)
- Dexmedetomidine hydrochloride (Precedex)
- Morphine
- Propofol (Diprivan)

As early as Apr 2020, medical publications were already reporting a shortage of these sedatives—shortages caused by a 51 percent increase in demand for sedating Covid patients.[16] By Oct 2020, 72.5 percent of these sedatives and related drugs were in dire short supply.[17] As of this edit, however, the NIH now includes only a short paragraph on Sedation Management in Adults with Covid-19.[18] Why the glaring and sudden removal of sedatives from current NIH Guidelines? By mid-2020, many families of hospitalized Covid patients knew how sedatives were hastening deaths of their loved ones. Midazolam use, for instance, increased 100 percent.[19] Patient records obtained from families of those lost to hospital Covid protocols tell the story of deadly overdose quantities of Midazolam and a layered host of sedatives listed above.

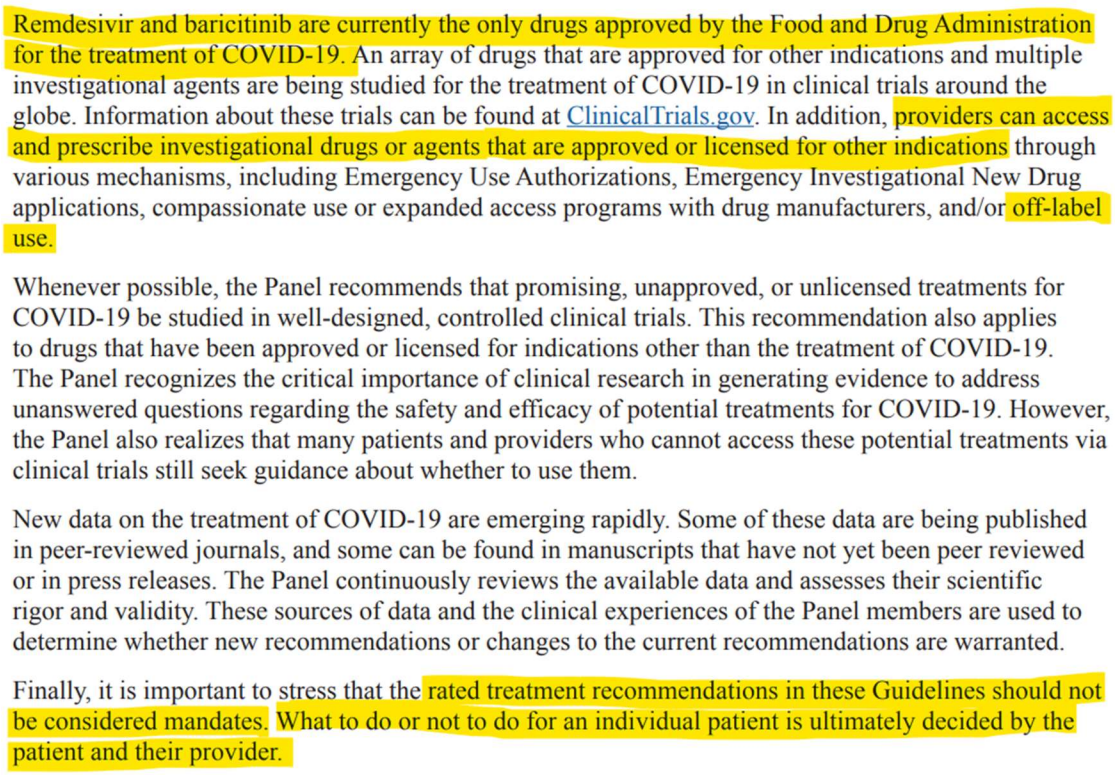
Despite negative respiratory side effects associated with sedatives and antibiotics, hospitals are administering at least one and often several of these drugs concurrently to Covid-19 patients. Examination of Medication Administration Records (MARs) and medical records of patients who died in U.S. hospitals show evidence that these sedatives were given to many patients without informed consent. When patients were isolated from family members or medical advocates, hospital staff administered sedatives that worsened Covid symptoms and advanced patient progression to ventilators.

Administering Investigational and/or Off-Label Covid-19 Treatments (e.g., Ivermectin, HCQ)

NIH Guidelines Introduction from 8 July 2022, states that providers can access and prescribe other investigational treatments and that rated treatment recommendations (Remdesivir) should not be considered *mandates*.[20] Compare the 5 Oct 2021 version of Evolving Knowledge (**Figure 2**) to the 8 August 2023 version (**Figure 3**):[21]

> Currently, remdesivir, an antiviral agent, is the only Food and Drug Administration-approved drug for the treatment of COVID-19. An array of drugs approved for other indications and multiple investigational agents are being studied for the treatment of COVID-19 in clinical trials around the globe. These trials can be accessed at ClinicalTrials.gov. In addition, providers can access and prescribe investigational drugs or agents that are approved or licensed for other indications through various mechanisms, including Emergency Use Authorizations (EUAs), Emergency Investigational New Drug (EIND) applications, compassionate use or expanded access programs with drug manufacturers, and/or off-label use.
>
> Whenever possible, the Panel recommends that promising, unapproved, or unlicensed treatments for COVID-19 be studied in well-designed, controlled clinical trials. This recommendation also applies to drugs that have been approved or licensed for indications other than the treatment of COVID-19. The Panel recognizes the critical importance of clinical research in generating evidence to address unanswered questions regarding the safety and efficacy of potential treatments for COVID-19. However, the Panel also realizes that many patients and providers who cannot access these potential treatments via clinical trials still seek guidance about whether to use them.
>
> A large volume of data and publications from randomized controlled trials, observational cohorts, and case series are emerging at a very rapid pace, some in peer-reviewed journals, others as manuscripts that have not yet been peer reviewed, and, in some cases, press releases. The Panel continuously reviews the available data and assesses their scientific rigor and validity. These sources of data and the clinical experiences of the Panel members are used to determine whether new recommendations or changes to the current recommendations are warranted.
>
> Finally, it is important to stress that the rated treatment recommendations in these Guidelines should not be considered mandates. The choice of what to do or not to do for an individual patient is ultimately decided by the patient and their provider.

Figure 2. Evolving Knowledge on Treatments for Covid-19 (Oct 2021). *NIH protocols paying the most in financial reimbursements are explicitly followed. Clear guidelines on the use of off-label treatments and patient-physician treatment decisions are ignored.*



Remdesivir and baricitinib are currently the only drugs approved by the Food and Drug Administration for the treatment of COVID-19. An array of drugs that are approved for other indications and multiple investigational agents are being studied for the treatment of COVID-19 in clinical trials around the globe. Information about these trials can be found at ClinicalTrials.gov. In addition, providers can access and prescribe investigational drugs or agents that are approved or licensed for other indications through various mechanisms, including Emergency Use Authorizations, Emergency Investigational New Drug applications, compassionate use or expanded access programs with drug manufacturers, and/or off-label use.

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New data on the treatment of COVID-19 are emerging rapidly. Some of these data are being published in peer-reviewed journals, and some can be found in manuscripts that have not yet been peer reviewed or in press releases. The Panel continuously reviews the available data and assesses their scientific rigor and validity. These sources of data and the clinical experiences of the Panel members are used to determine whether new recommendations or changes to the current recommendations are warranted.

Finally, it is important to stress that the rated treatment recommendations in these Guidelines should not be considered mandates. What to do or not to do for an individual patient is ultimately decided by the patient and their provider.

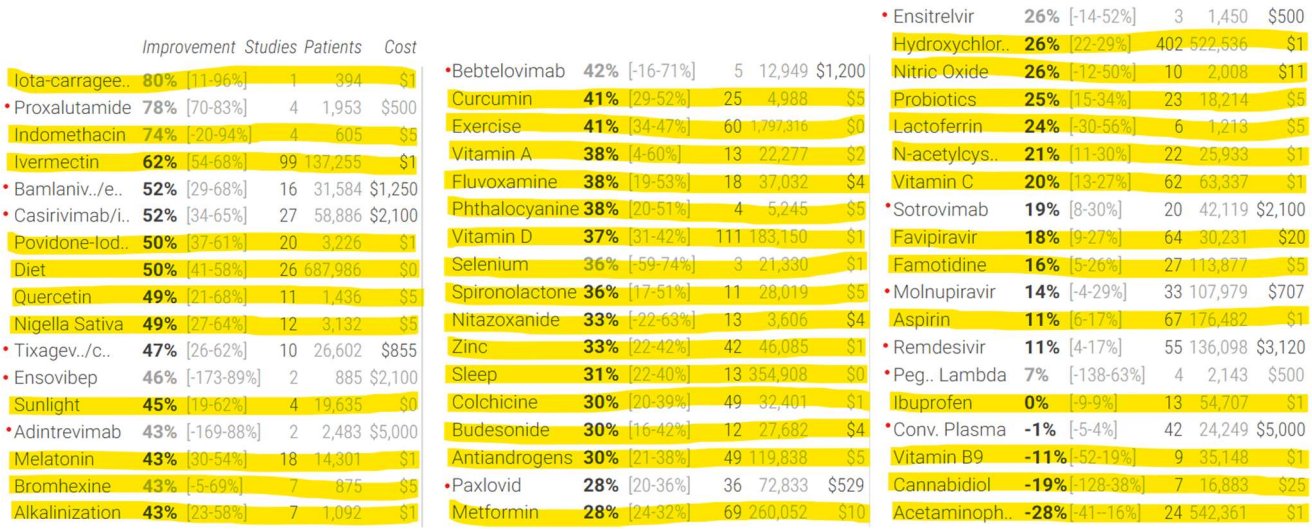
Figure 3. UPDATED Evolving Knowledge on Treatments for Covid-19 (Aug 2023). NIH protocols that bring the most in financial reimbursements are explicitly followed. Clear guidelines on the use of off-label treatments and patient-physician treatment decisions are ignored.

This section of the NIH Guidelines has been shared with many U.S. hospital administrators and Chief Medical Officers (CMOs) when trying to negotiate more effective treatments for Covid patients—to no avail. Even though hospitals tell patients and families they are bound to strict protocols dictated by the CDC and NIH, it seems they are only bound to those protocols that reimburse the most. From the beginning, patients had a right to other safer and more effective treatments, and their assigned hospitalists had a choice to access and prescribe such treatments.

NIH Protocol Medications Comparison to Off-Label and Investigational Treatments

Figure 4 shows studies for all known Covid-19 treatments.[22] Those marked with an asterisk are the only medications with FDA-granted Emergency Use Authorization (EUA is fast-track approval). Each authorized medication commands an exorbitant price and highest revenues for pharmaceutical companies, as well as the highest reimbursement to hospitals. Low-cost, effective drugs in boxes are not authorized for Covid treatment. The FDA also did not consult the Antimicrobial Drugs Advisory Committee when granting Remdesivir's EUA.[23]

This chart showing NIH treatments compared to elements of the I-CARE and MATH+ protocol[24] makes clear how certain drugs are granted FDA approval for Covid treatment while others are demonized in the press and social media and dismissed by special interest groups like the American Hospital Association (AHA) and our current DC swamp administration.



	Improvement	Studies	Patients	Cost
Iota-carragee..	80% [11-96%]	1	394	$1
• Proxalutamide	78% [70-83%]	4	1,953	$500
Indomethacin	74% [-20-94%]	4	605	$5
Ivermectin	62% [54-68%]	99	137,255	$1
• Bamlaniv../e..	52% [29-68%]	16	31,584	$1,250
• Casirivimab/i..	52% [34-65%]	27	58,886	$2,100
Povidone-Iod..	50% [37-61%]	20	3,226	$1
Diet	50% [41-58%]	26	687,986	$0
Quercetin	49% [21-68%]	11	1,436	$5
Nigella Sativa	49% [27-64%]	12	3,132	$5
• Tixagev../c..	47% [26-62%]	10	26,602	$855
• Ensovibep	46% [-173-89%]	2	885	$2,100
Sunlight	45% [19-62%]	4	19,635	$0
• Adintrevimab	43% [-169-88%]	2	2,483	$5,000
Melatonin	43% [30-54%]	18	14,301	$1
Bromhexine	43% [-5-69%]	7	875	$5
Alkalinization	43% [23-58%]	7	1,092	$1
• Bebtelovimab	42% [-16-71%]	5	12,949	$1,200
Curcumin	41% [29-52%]	25	4,988	$5
Exercise	41% [34-47%]	60	1,797,316	$0
Vitamin A	38% [4-60%]	13	22,277	$2
Fluvoxamine	38% [19-53%]	18	37,032	$4
Phthalocyanine	38% [20-51%]	4	5,245	$5
Vitamin D	37% [31-42%]	111	183,150	$1
Selenium	36% [-59-74%]	3	21,330	$1
Spironolactone	36% [17-51%]	11	28,019	$5
Nitazoxanide	33% [-22-63%]	13	3,606	$4
Zinc	33% [22-42%]	42	46,085	$1
Sleep	31% [22-40%]	13	354,908	$0
Colchicine	30% [20-39%]	49	32,401	$1
Budesonide	30% [16-42%]	12	27,682	$4
Antiandrogens	30% [21-38%]	49	119,838	$5
• Paxlovid	28% [20-36%]	36	72,833	$529
Metformin	28% [24-32%]	69	260,052	$10
• Ensitrelvir	26% [-14-52%]	3	1,450	$500
Hydroxychlor..	26% [22-29%]	402	522,536	$1
Nitric Oxide	26% [-12-50%]	10	2,008	$11
Probiotics	25% [15-34%]	23	18,214	$5
Lactoferrin	24% [-30-56%]	6	1,213	$5
N-acetylcys..	21% [11-30%]	22	25,933	$1
Vitamin C	20% [13-27%]	62	63,337	$1
• Sotrovimab	19% [8-30%]	20	42,119	$2,100
Favipiravir	18% [9-27%]	64	30,231	$20
Famotidine	16% [5-26%]	27	113,877	$5
• Molnupiravir	14% [-4-29%]	33	107,979	$707
Aspirin	11% [6-17%]	67	176,482	$1
• Remdesivir	11% [4-17%]	55	136,098	$3,120
• Peg.. Lambda	7% [-138-63%]	4	2,143	$500
Ibuprofen	0% [-9-9%]	13	54,707	$1
• Conv. Plasma	-1% [-5-4%]	42	24,249	$5,000
Vitamin B9	-11% [-52-19%]	9	35,148	$1
Cannabidiol	-19% [-128-38%]	7	16,883	$25
Acetaminoph..	-28% [-41--16%]	24	542,361	$1

Figure 4. Known Covid Treatments. *All studies (pooled effects, all stages). NIH-specific: red dot. Effective, inexpensive, at-home, early treatments (prescribed and over-the-counter) per I-CARE: highlighted.*

Financial Incentives to Hospitals to Administer "Covered Countermeasures"

Health Resources and Services Administration (HRSA) released Provider Relief Fund (PRF) Phase 4 of CARES Act distributions[25] in three batches to providers based on changes in operating revenues and expenses from 1 Jul 2020 to 31 Mar 2021. Payments focused on *equity*—reimbursing smaller providers for changes in operating revenues and expenses at a higher rate compared to larger providers and bonus payments based on number of services furnished to Medicaid and Medicare beneficiaries—$385,198,839 went to 1,920 Tennessee providers. Tennessee's Financial Stimulus Accountability Group recommended $3B in additional investments of federal relief funds.[26]

Hospitals are incentivized to vaccinate, test, diagnose, and admit Covid patients and report Covid-related deaths using add-on bonuses to push treatments such as Remdesivir, dialysis, ventilators, and new "covered countermeasures" approved for Covid. Patients, families, and former hospitalists confirm why hospitals and doctors are threatened and punished for using effective, off-label Covid treatments (despite what the NIH Guidelines Introduction states)—CMS will not pay bonuses for them, even though these treatments are known to save lives.

An Example. Remdesivir topped hospital drug spending in 2021. Gilead earned $4.2B in sales in the first nine months alone. Veklury's average in-hospital price is $2,400 to $3,200,[27] therefore, hospitals have a financial incentive to administer Remdesivir. CMS established various systems to provide layers of bonuses to each Covid patient's hospital bill[28] to encourage use of Remdesivir and other EUA-approved, high-cost, patented medications shown in **Figure 4**.

Investigation of CMS documents and Federal Register reveal CMS, authorized by the CARES Act in Mar 2020, established treatments and a coding system that financially incentivized hospitals to receive bonuses for using "covered countermeasures"[29] related to Covid.

Medical and Hospitalization

Tennessee and Florida medical and hospitalization cost data in **Figure 5** comes from more than 36 billion privately billed medical and dental procedures and 100 percent of Medicare Parts A, B, and D claims.[30]

Patient Type (TENNESSEE and FLORIDA)	TN Average Charge	FL Average Charge	TN Estimated Allowed	FL Estimated Allowed
Complex Covid Inpatient*	$292,566.00	$355,450.00	$84,512.00	$99,301.00
Noncomplex Covid Inpatient**	$58,281.00	$67,620.00	$21,781.00	$24,752.00
Covid Outpatient***	$2,473.00	$3,172.00	$925.00	$1,169.00

Figure 5. Average Covid Patient Costs. **Typical total costs for most serious cases (ICU, ventilator, room/board, increased complexity). **Typical total costs; does not require ventilation or ICU (room/board, lab, imaging, IV therapies). ***Typical total costs for patient; does not require hospitalization (lab, physician, urgent care visit). Estimated Allowed: Estimated total fee negotiated between insurance plan and provider for in-network service. Includes portion paid by plan member and portion paid by plan.*

Covid Hospital Admission Incentives

The U.S. Department of Health and Human Services (HHS) distributed the first phase of $100B emergency funding on 10 Apr 2020. However, $30B was distributed to hospitals based on Medicare revenue—*not number of Covid cases in each state*. **Figure 6** shows what states were paid *per Covid case admitted to hospitals*. Some states received as little as $12,000 per Covid case (e.g., New York). Some states received as much as $471,000 per Covid case (e.g., West Virginia).[31] Another $20B went to providers on 24 Apr 2020.[32]

State	Amount	State	Amount
Alabama	$158,000	Montana	$315,000
Alaska	$306,000	Nebraska	$379,000
Arizona	$23,000	Nevada	$98,000
Arkansas	$285,000	New Hampshire	$201,000
California	$145,000	New Jersey	$18,000
Colorado	$58,000	New Mexico	$171,000
Connecticut	$38,000	New York	$12,000
Delaware	$127,000	North Carolina	$252,000
District of Columbia	$56,000	North Dakota	$339,000
Florida	$132,000	Ohio	$180,000
Georgia	$73,000	Oklahoma	$291,000
Hawaii	$301,000	Oregon	$220,000
Idaho	$100,000	Pennsylvania	$68,000
Illinois	$73,000	Rhode Island	$52,000
Indiana	$105,000	South Carolina	$186,000
Iowa	$235,000	South Dakota	$241,000
Kansas	$291,000	Tennessee	$166,000
Kentucky	$297,000	Texas	$184,000
Louisiana	$26,000	Utah	$94,000
Maine	$260,000	Vermont	$87,000
Maryland	$120,000	Virginia	$201,000
Massachusetts	$44,000	Washington	$58,000
Michigan	$44,000	West Virginia	$471,000
Minnesota	$380,000	Wisconsin	$163,000
Mississippi	$166,000	Wyoming	$278,000
Missouri	$175,000		

Figure 6. Breakdown of Funding per Covid Case Each State Received. *From the first $30B in aid (CARES Act 2020), Kaiser Health News used a state breakdown provided to the House Ways and Means Committee by HHS, along with Covid cases tabulated by The New York Times for this analysis.*

Tennessee Examples. When the first $30B of CARES Act funding was allocated to hospitals, HHS determined how much hospitals would receive based on historical share of 2018 Medicare revenue—not on Covid burden.[33] House Ways and Means Committee breakdown and calculations of total Covid patients during the first CARES Act

distribution shows Tennessee hospitals received $166,000 for each positive Covid admission. Allocation methodology distributed relief to providers that bill Medicare Fee-For-Service (FFS) with a payment of 2 percent of provider's gross patient revenue—except Medicare beneficiaries' share in Medicare Advantage plans across the U.S. range from 1 percent to 40 percent.[34] Based on distribution adjustments, today's estimate: Tennessee receives $203,000 for every confirmed Covid admission.

How Payment Distributions Were Determined

Following Phase 1 distributions, provider payments were based on each provider's share of total Medicare FFS reimbursements in 2019. (Total FFS payments, approx. $484B.) Provider estimated approximate payment by multiplying 2019 Medicare FFS (not including Medicare Advantage) payments received by 6.19 percent ($30B divided by $484B).

- **Example 1:** A practice bills Medicare FFS $1M under a single TIN in 2019. This is how much they receive using equation: $1,000,000 x 6.19% = $61,900
- **Example 2:** A large practice bills Medicare FFS $25M under a single TIN in 2019. This is how much they receive using equation: $25,000,000 x 6.19% = $1,547,500[35]

Besides flat rates received for each "Covid" case, hospitals are incentivized to hold patients against their will, isolate them from family and advocates, and treat them with toxic drugs and ventilators.

Covid Testing

A Covid patient's journey starts in the emergency room with questionable PCR tests.[36] Healthcare providers and hospitals pocket between $20 and $1,419 for every test. Our government pays for the test, pays the hospital to administer the test, pays the hospital for every positive test, and then pays the hospital for every admission resulting from the test.

Health Care Staff Vaccinations

Covid "vaccines" are considered "covered countermeasures." Hospitals are paid by CMS for enforcing Biden's Covid shot mandates for hospital staff—and punished if they do not comply. Every facility had a process or plan in place for vaccinating all eligible staff and a process or plan for providing appropriate exemptions by 6 Dec 2021.[37] CMS's value-based compensation program for hospitals tracks data on how many healthcare workers get the shot and how many workers receive exemptions. The more shots, the more money the hospital makes. Enforcement is swift with regular recertification and compliance surveys.[38] Noncompliant facilities are cited, and if compliance is not restored, CMS uses civil monetary penalties, denies payments, and even terminates the facility from CMS programs.[39]

> *The Omnibus Covid-19 Health Care Staff Vaccination Interim Final Rule issued by CMS states "this regulation pre-empts any state law under the Supremacy Clause of the United States Constitution."*[40]

Patient Vaccinations

Originally, CMS set Medicare reimbursement rates for Covid shots at $28.39 for the first dose and $16.94 for subsequent doses.[41] Providers encouraged patients to come back for all boosters. The more shots, the more money providers made.

Bonus Money

CMS pays two types of bonuses to hospitals for treating Covid patients with "covered countermeasures": the Diagnosis-Related Group (DRG) add-on bonus and the Coronavirus Treatment Acceleration Program (CTAP) and New Covid-19 Treatments Add-On Payment (NCTAP).

Discharges on and after January 27, 2020, and on or before March 31, 2020	MS-DRG Assignment	FY 2020 Relative Weight[1]	Estimated MS-DRG Payment under the CARES Act[2]
Principal Diagnosis • J12.89 - Other viral pneumonia Secondary Diagnosis • B97.29 - Other coronavirus as the cause of diseases classified elsewhere • J96.01 - Acute respiratory failure with hypoxia (MCC)	MS-DRG 193 Simple Pneumonia and Pleurisy with MCC	1.3335	$9,275.77
Principal Diagnosis • J20.8 - Acute bronchitis due to other specified organisms Secondary Diagnosis • B97.29 - Other coronavirus as the cause of diseases classified elsewhere	MS-DRG 203 Bronchitis and Asthma without CC/MCC	0.6938	$4,826.04
Principal Diagnosis • J22 - Unspecified acute lower respiratory infection Secondary Diagnosis • B97.29 - Other coronavirus as the cause of diseases classified elsewhere	MS-DRG 206 Other Respiratory System Diagnoses without MCC	0.8725	$6,069.07
Principal Diagnosis • J80 - Acute respiratory distress syndrome Secondary Diagnosis • B97.29 - Other coronavirus as the cause of diseases classified elsewhere Procedures • 5A1955Z - Respiratory ventilation, greater than 96 consecutive hours	MS-DRG 207 Respiratory System Diagnosis with Ventilator Support >96 Hours	5.7356	$39,896.58
Principal Diagnosis • O98.513 - Other viral diseases complicating pregnancy, third trimester Secondary Diagnosis • J20.8 - Acute bronchitis due to other specified organisms • B97.29 - Other coronavirus as the cause of diseases classified elsewhere	MS-DRG 833 Other Antepartum Diagnoses without O.R. Procedure without CC/MCC	0.5321	$3,701.26
Principal Diagnosis • A41.89 - Other specified sepsis Secondary Diagnosis • B20 - Human immunodeficiency virus [HIV] disease (CC) • J12.89 - Other viral pneumonia (MCC) • B97.29 - Other coronavirus as the cause of diseases classified elsewhere Procedures • 5A1955Z - Respiratory ventilation, greater than 96 consecutive hours	MS-DRG 974 HIV with Major Related Condition with MCC	2.6739	$18,599.53

Medicare Diagnosis-Related Group (DRG) Add-On Bonuses

During the Public Health Emergency (PHE), the CARES Act approved a *20 percent add-on bonus* from CMS on DRG rates for Covid patients treated in rural and urban hospitals.[42] The DRG determines hospital payments under the Medicare Inpatient Prospective Payment System (IPPS). Beginning 27 Jan 2020, when the PHE was announced by the U.S. Health Secretary, 20 percent Medicare add-on bonus payments for Covid cases automatically started applying to claims.[43] These payments depend on PHE continuance and proof of positive Covid tests. If there is no test, CMS recoups this 20 percent add-on payment.

NOTE: To determine relative weight for a particular DRG, visit the CMS website,[44] scroll down to 3. Table 5 (Final Rule and Correction Notice). Or click to download.[45] Open the file with information as an Excel file. Column labeled "weights" shows relative weight for each DRG. See Figures below of actual MS-DRG assignment and estimated payments under the CARES Act.

DRG and add-on bonus only require proof of positive Covid test, according to the fourth Interim Final Rule with Comment period.[46] Hospitals must make a connection to the Medicare bonus for Covid inpatients by documenting a positive test and include correct ICD-10-CM codes.

In Oct 2020, CMS announced Medicare would pay hospitals extra through IPPS when Covid *inpatients* were treated with "covered countermeasures," specific FDA-approved drugs, biologicals and medical devices.[47] Additional payments are linked to the 20 percent bonus hospitals already receive for Covid-related MS-DRGs.

Figure 7. Increase in IPPS Operating MS-DRG Payments (ICD-10-CM diagnosis code B97.29). *If discharged on and after 27 Jan 2020 until on or before 31 Mar 2020.*

Inpatient Covid Treatment Costs Per MS-DRGs

DRGs are much like the code car mechanics see when a car is attached to a computer to run diagnostics. The computer tells the mechanic what likely repairs are needed, along with specific parts needed, and gives an overall cost for the repairs and parts based on that code. To save money, DRGs are one-size-fits-all prescriptions, leaving no room for personalized service.

There are hundreds of Covid-related DRGs. A few standard estimated MS-DRG payments by CMS under IPPS (including adjustment provided by Section 3710 CARES Act) for patients diagnosed with Covid (discharged on and after 27 Jan 2020 until on or before 31 Mar 2020[48]) are shown in **Figure 7 (previous page)**.

- $9,275.77 – Standard treatment, simple Covid-related pneumonia
- $4,826.04 – Covid-related bronchitis/asthma
- $6,069.07 – "Other" Covid-related respiratory system illness
- $39,896.58 – Covid treatment, ventilator ("covered countermeasure") >96 hrs
- $3,701.26 – Acute Respiratory Distress Syndrome (ARDS)
- $18,599.53 – Covid-related treatment, HIV/AIDS

A few of the estimated MS-DRG payments under IPPS (including adjustment provided by Section 3710 of the CARES Act) for patients diagnosed with Covid and discharged on and after 1 Apr 2020 until end of declared PHE period[49] are shown in **Figure 8**.

- $13,155.10 – Covid-related respiratory infections, acute respiratory failure/hypoxia
- $8,648.34 – Covid-related respiratory infections, acute kidney failure
- $6,024.55 – Covid-related respiratory infections, acute bronchitis
- $39,896.58 – Covid treatment, ventilator ("covered countermeasure") >96 hrs
- $7,502.00 – ARDS
- $18,599.53 – Covid-related, HIV/AIDS

Discharges on or after April 1, 2020, through the duration of the COVID-19 public health emergency period	MS-DRG Assignment	FY 2020 Relative Weight[1]	Estimated MS-DRG Payment under the CARES Act[2]
Principal Diagnosis • U07.1 - COVID-19 Secondary Diagnosis • J12.89 - Other viral pneumonia (MCC) • J96.01 - Acute respiratory failure with hypoxia (MCC)	MS-DRG 177 Respiratory Infections and Inflammations with MCC	1.8912	$13,155.10
Principal Diagnosis • U07.1 - COVID-19 Secondary Diagnosis • J22 - Unspecified acute lower respiratory infection • N17.9 - Acute kidney failure, unspecified (CC)	MS-DRG 178 Respiratory Infections and Inflammations with CC	1.2433	$8,648.34
Principal Diagnosis • U07.1 - COVID-19 Secondary Diagnosis • J20.8 - Acute bronchitis due to other specified organisms	MS-DRG 179 Respiratory Infections and Inflammations without CC/MCC	0.8661	$6,024. 55
Principal Diagnosis • U07.1 - COVID-19 Secondary Diagnosis • J80 - Acute respiratory distress syndrome (MCC) Procedures • 5A1955Z - Respiratory ventilation, greater than 96 consecutive hours	MS-DRG 207 Respiratory System Diagnosis with Ventilator Support >96 Hours	5.7356	$39,896.58
Principal Diagnosis • O98.513 - Other viral diseases complicating pregnancy, third trimester Secondary Diagnosis • U07.1 - COVID-19 (MCC) • J20.8 - Acute bronchitis due to other specified organisms	MS-DRG 831 Other Antepartum Diagnoses without O.R. Procedure with MCC	1.0785	$7,502.00
Principal Diagnosis • A41.89 Secondary Diagnosis • B20 - Human immunodeficiency virus [HIV] disease (CC) • U07.1 - COVID-19 (MCC) • J12.89 - Other viral pneumonia (MCC) Procedures • 5A1955Z - Respiratory ventilation, greater than 96 consecutive hours	MS-DRG 974 HIV with Major Related Condition with MCC	2.6739	$18,599.53

Figure 8. Increase in IPPS Operating MS-DRG Payments (ICD-10-CM diagnosis code U07.1). *Discharged on and after 1 Apr 2020 until end of declared PHE.*

Coronavirus Treatment Acceleration Program/ New Covid Treatments Add-On Payment

The FDA program for potential Covid therapies, Coronavirus Treatment Acceleration Program (CTAP), includes EUAs issued during the PHE[50] for five Covid drugs and biologicals. Only Remdesivir and convalescent plasma are eligible for IPPS add-on payment.

Through the New Covid-19 Treatments Add-on Payment (NCTAP), Medicare provides enhanced payment for eligible inpatient cases using certain *new* Covid products ("covered countermeasures") with current FDA approval or EUA. *Note correlation of products in **Figure 4** showing known treatments.* Products include:

- 23 Aug 2020. FDA issued (reissued 30 Nov 2020, revised 9 Mar 2021) an EUA for use of convalescent plasma[51] for hospitalized patients

- 22 Oct 2020. Most recently, FDA approved Remdesivir (Veklury)52 for hospitalized adults and pediatric patients (see Emergency Use Authorizations for all EUAs for Remdesivir)
- 19 Nov 2020. FDA issued (amended 20 Dec 2021) an EUA for use of Baricitinib (Olumiant)[53] for treating suspected or lab-confirmed Covid in certain hospitalized patients
- 22 Dec 2021. FDA issued an EUA for Molnupiravir for treating mild-to-moderate Covid in certain adults at high risk for progression to severe Covid, including hospitalization or death
- 23 Dec 2021. FDA issued an EUA for Nirmatrelvir (Paxlovid) for treating mild-to-moderate Covid in certain adults and pediatric patients at high risk for progression to severe Covid, including hospitalization or death

CMS issued an Interim Final Rule with Comment Period[54] that established NCTAP of 20 percent under Medicare IPPS. This new bonus under IPPS (effective 2 Nov 2020 until end of PHE), according to Medicare PHE Waiver Questions,[55] mitigates potential financial disincentives for hospitals to provide new Covid treatments during the PHE.

NOTE: This 20 percent NCTAP bonus is separate from the 20 percent add-on bonus from CMS on DRG rates. A report on CMS compliance explains for hospitals that treat with approved emergency therapeutics ("covered countermeasures"), they are eligible for the 20 percent DRG bonus, and eligibility triggers access to the NCTAP bonus under IPPS for Covid cases that meet certain criteria.[56] Not only do hospitals get extra for Remdesivir, but they receive thousands for treating an individual patient for his or her entire hospital stay. *Hospitals must be eligible for the 20 percent DRG add-on to get the new therapeutic 20 percent add-on.*

Eligibility Criteria for IPPS NCTAP for Remainder of the PHE[57]

Under Medicare, hospitals are generally reimbursed a fixed payment amount for services they provide during an inpatient stay, even if costs exceed that amount. Under current rules, hospitals may qualify for additional "outlier payment," but only when costs for a particular patient exceed a certain threshold.

NCTAP allows hospitals to qualify for additional payments when they treat patients with certain new products approved or authorized to treat Covid. Enhanced payment is equal to the lesser of: (1) 65 percent of operating outlier threshold for the claim; or (2) 65 percent of cost of a Covid stay beyond operating Medicare payment (including 20 percent add-on payment under section 3710 of the CARES Act) for eligible cases.

As drugs or biological products become available and are FDA-authorized or -approved for inpatient Covid treatment, HRSA believes it is appropriate to increase current IPPS payment amounts *to mitigate any potential financial disincentives for hospitals to provide these new treatments* during the PHE. Therefore, effective for discharges occurring on or after effective date of this rule and until the end of the PHE, CMS uses exceptions and adjustment authority under section 1886(d)(5)(I) of the CARES Act to create NCTAP under the IPPS for Covid cases that meet certain criteria.[58]

Determination of IPPS NCTAP Amount for Remainder of PHE

The goal of NCTAP is to mitigate potential financial disincentives for hospitals to provide new Covid treatments.[59] These financial disincentives are already mitigated in part by the IPPS outlier payment, but costs of a case must exceed payments by the "outlier threshold" or "fixed-loss" amount before outlier payments are made. For FY 2021, outlier threshold is approximately $30,000 and is adjusted to account for local cost variation in determining whether an individual claim is eligible for outlier payments.

To further mitigate potential financial disincentives for hospitals to provide new Covid treatments, NCTAP functions to partially offset costs exceeding Medicare payment but are less than outlier threshold.

An Example. Normally, Medicare outlier payments, which are extra payments for cases with extraordinarily high costs, only kick in after the hospital incurs $30,000 in costs above MS-DRG payment. Under standard outlier rules, a hospital only receives 80 percent of costs exceeding $30,000 of IPPS payment (hospitals eat the first $30,000 in losses). Under the Interim Final Code (IFC), when hospitals provide Remdesivir or Covid convalescent plasma and the patient

has a positive Covid test, Medicare shares in 65 percent of the first dollar losses exceeding MS-DRG reimbursement up to $30,000 outlier threshold. The hospital is reimbursed for 65 percent of initial cost as well. No wonder hospitals are in such a rush to treat patients with Remdesivir as soon as possible.

How much difference could this make per patient? For a hospital system that treats 5,000 Covid patients over the course of the pandemic, Remdesivir alone could deliver close to $100M in federal reimbursements[60] or $20,000 per patient. Thanks to the PREP Act, patients and families cannot sue Gilead (maker of Remdesivir) for money damages in court for death or organ failure caused by the drug.[61] The federal government, however, can and *did* sue Gilead for patent infringement.[62] NOTE: Our government can sue a drug company for interfering with the government's efforts to profit from pharmaceuticals; but citizens cannot sue drug companies when their pharmaceuticals maim or kill humans.

Outpatient "Covered Countermeasures"

Most drugs and biological products authorized for use to treat Covid in outpatient settings are paid separately under standard Outpatient Prospective Payment System (OPPS) payment policies. Medicare established payment rates for vaccines in the IFC. If they require two or more doses, Medicare now pays more for subsequent doses as an incentive to providers who administer the first dose to encourage patients back for subsequent doses.[63]

Additional Financial Incentives for New EUA-Approved Covid Medications[64]

As of 8 Aug 2023, NIH Treatment Guidelines listed preferred therapies for non-hospitalized adults in order of preference:

- Ritonavir-boosted Nirmatrelvir aka Paxlovid (Pfizer; $530 - $700 per treatment)
- *Remdesivir aka Veklury (Gilead Sciences; outpatient Remdesivir is considered "off-label". Note: Inpatient Remdesivir is $9 a vial to produce and $3,120 per treatment. [65]

Alternative therapy for use when neither preferred therapies above are available:

- Molnupiravir (Merck; $700 per treatment)[66]

*The FDA expanded Remdesivir for *outpatient* Covid treatment on 21 Jan 2022. CMS reimburses $5.512 per outpatient treatment under Medicare Part B. This form of Remdesivir is a gateway drug to further hospitalizations. It is as dangerous for outpatient use as it is for inpatient use if it is not administered within the first seven days of symptoms onset.[67] Most people do not experience symptoms and seek treatment until after day seven. See EUA section below for more information about Paxlovid, Veklury, and Molnupiravir.

Emergency Use Authorizations and the Pharmaceutical Profit Pipeline

If the public allows our government to continue renewing the PHE, alphabet agencies will not stop bringing new, dangerous, and profitable pharmaceuticals to bear on the American people. With each new "variant" of a virus and each new "virus," endless coercive actions will force us under the needle. The first stop for all drugs is EUA approval. The FDA website says: "EUA authority allows FDA to help strengthen the nation's public health protections against chemical, biological, radiological, and nuclear (CBRN) threats including infectious diseases, by facilitating availability and use of Medical Countermeasures (MCMs)[68] needed *during public health emergencies*.

Note: A determination under section 319 of the Public Health Service Act that *a public health emergency exists, such as the one issued on 31 Jan 2020, does not enable FDA to issue EUAs. On 4 Feb 2020, the HHS Secretary determined that there is a public health emergency with significant potential to affect national security or health and security of U.S. citizens living abroad, and that involves the virus that causes COVID.* Subsequent HHS declarations supporting use of EUAs and based on this determination are described … below."[69]

The "Covid-19 PHE" expired on May 11, 2023. The FDA states, however, that "The ending of the COVID-19 PHE will not impact FDA's ability to authorize medical countermeasures for emergency use. Existing COVID-19 EUAs will remain in effect, and the agency may continue to issue new EUAs if the situation meets criteria to do so."[70]

New and *revoked* EUAs[71] for Covid treatment include:

Vaccines (EUA):

- Pfizer-BioNTech Covid-19 vaccine. Issued 11 Dec 2020.[72]
- Moderna Covid-19 vaccine. Issued 18 Dec 2020.[73]
- Novavax Covid-19 vaccine. Issued 13 Jul 2022.[74]
- Janssen COVID-19 Vaccine. Issued 27 Feb 2021; revoked 1 Jun 2023.[75]

Vaccines (Licensed):

- Pfizer-BioNTech (Comirnaty). LICENSED 23 Aug 2021.[76] (Name and marketing licensed only; not actual product. See Following the Money Through Misleading Covid Vaccine Licensing below.)
- Moderna (Spikevax). LICENSED 31 Jan 2022.[77]

Sedation Medications for Use in Conjunction with Ventilators:

- Fresenius Kabi Propoven 2%. Issued 8 May 2020; revoked 10 May 2022.[78]
- Propofol-Lipuro 1%. Issued 12 Mar 2021; revoked 12 Apr 2023.[79]

Monoclonal Antibodies:

- Bamlanivimab. Issued 9 Nov 2020; revoked 16 Apr 2021.[80] [81]
- Sotrovimab (Xevudy). Issued 26 May 2021; limits use 25 Mar 2022; revoked 5 Apr 2022. **SEE ENDNOTE FOR MORE INFORMATION.**[82]

NOTE: On 25 March 2022, FDA limited the use of Sotrovimab to treat Covid-19, and on 5 April 2022, revoked its use entirely. It claimed other therapies were available and expected to be effective against the BA.2 sub-variant. The other therapies are Paxlovid, Veklury (remdesivir), and Molnupiravir[83]—all treatments with Big Pharma reimbursements, NCTAP bonus potential, and were highly toxic gateway drugs that guided patients back into hospitals.

Remdesivir:[84] [85] [86]

- EUA issued 1 May 2020 for inpatient treatment of adults and children 12+ (weighing at least 12kg).
- EUA re-issued 28 Aug 2020 to expand authorized use by no longer limiting it to use for treatment of patients with severe disease.
- EUA re-issued 1 Oct 2020 to incorporate revisions to scope and conditions of authorization designating Gilead Sciences, Inc. and its authorized distributors as responsible parties for distribution of Remdesivir.
- EUA re-issued 16 Oct 2020 with revisions to clarify Alternate Care Site (ACS) meeting certain criteria is considered an "inpatient hospital setting" for purposes of EUA scope.
- EUA re-issued 22 Oct 2020 to include inpatient use for children and infants (weighing 3.5kg - 40kg).
- EUA re-issued 21 Jan 2021.
- EUA revoked 25 Apr 2022, as it was approved as a supplemental New Drug Application (NDA) 214787, which expanded approved use for hospitalized (Remdesivir) and non-hospitalized (Veklury) patients.[87]

- Chloroquine (CQ) and Hydroxychloroquine (HCQ). EUA issued 28 Mar 2020; revoked 15 Jun 2020. FDA determined CQ and HCQ "unlikely to be effective in treating COVID for authorized uses in EUA."[88] [89]

The Truth Behind More Than One Million Covid Deaths in the U.S.

More than one million people have allegedly died "from Covid" in the United States—more than any other developed nation on earth. But most of these victims did not die from Covid. They died in U.S. hospitals, victims of the NIH/CDC Covid treatment protocols.[90]

Alphabet agencies (HHS, CDC, and NIH, as well as Anthony Fauci) claim Covid deaths hit high-risk populations the hardest—Medicare and Medicaid patients with multiple comorbidities such as heart disease, obesity, diabetes. These are the highest risk patients who went to hospitals, were given Remdesivir, and put on ventilators. These are the patients held hostage by hospitals, separated from their families, sedated and intubated without informed consent.

But we know one million people in America *did not* die *from Covid*, because those same high-risk populations survive Covid when treated effectively with safe, inexpensive protocols at home under the care of ethical direct primary care physicians. During the early months of Covid, high-ranking government officials knew ivermectin and HCQ were safe and effective but willfully made these life-saving medications unavailable to patients as they lay dying on ventilators in hospitals.[91] As noted in the section above, the FDA deliberately revoked HCQ's EUA for Covid patients on 15 Jun 2020.

Following the Money Through U.S. Hospital Systems

TN Liberty Network is collecting annual audit information on random U.S. hospitals to determine if institutions profited from Covid relief funding (from the CARES Act). Information is also being collected on hospitals that strictly adhered to NIH protocols and, if so, how much they profited and what they are doing with the windfall.

Example: Arizona

Arizona hospitals were already showing slight profit increases prior to Covid and experienced a 35 percent increase in 2020 totaling $1.5B in net operating profits. Arizona hospitals lost hundreds of medical staff due to the Covid shot mandates, while also accepting Covid relief money. The Medicaid rate enhancement program implemented in Oct 2020 increased Medicaid payments.[92]

Example: Florida

The *Miami Herald* fulfilled its journalistic duty of stoking fears among the Florida population, reporting Covid updates to show Covid deaths, hospitalizations, and new cases.[93] *People* joined the fearmongering frenzy by reporting that Florida hospitals were running out of morgue space due to "Covid" deaths.[94] Healthcare systems in Collier and Lee counties halted all elective procedures in early 2020, by order of Gov. Ron DeSantis.[95] It is impossible to determine how many vials of Remdesivir went to Florida hospitals, but based on archived articles, the number could be more than 50,000.[96]

Example: North Carolina

Seven of North Carolina's largest hospital systems made a combined $5.2B net profit in 2021, in addition to receiving $1.5B in Covid relief funds. The hospital system treasurer claims they will use profits to lower costs for patients, but the hospital also claims they faced "immense struggles and challenges …" including workforce shortages, skyrocketing costs for supplies, equipment, and drugs.[97] Their workforce shortages were caused by forcing Covid shot mandates on medical staff, while the high cost of drugs could have been alleviated if they had administered safe, effective, low-cost treatments outside NIH protocols.

Example: Tennessee

HCA, the largest U.S. for-profit hospital system, received approximately $1B in CARES Act relief funds. By comparison, Tenet, Community Health Services, and United Health Services received $517M, $420M, and $239M, respectively.[98] HCA owns and operates 187 hospitals in 2,000 sites in 20 states and in the United Kingdom.[99] HCA reported $4B in profit in 2020.[100] Then, HCA reported $2.26B in net income in the third quarter of 2021, following

an intense surge in Covid cases. Revenues in 2021 were $15.2B compared with $13B in 2020.[101] Tennessee's billionaire Frist family doubled their wealth between Mar 2020 and 2021 ($7.5B to $15.6B).[102]

TN Liberty Network's Covid advocacy organization, The Adam Group, fought 17 battles against HCA to rescue Covid patients who were well enough to leave the hospital but were held against their will while families were refused access. Many patients were given Remdesivir without informed consent and died on ventilators after patients and families clearly stated, "No ventilator!"

The Adam Group helped nearly three dozen families with Covid patients in ***Tennova*** hospitals around Tennessee, nearly all of whom died on ventilators after being administered Remdesivir against their will and being restrained and left alone with no food or water for up to two days. Tennova's North Knoxville Medical Center announced plans for a $67.5M construction expansion in May 2020, including a 98,000sf patient tower, 28 ICU beds, 28 acute beds, a new emergency room, meeting space, pharmacy, and lab. Tennova CEO, Colin McRae, stated, "Our community is thriving … growth horizon is bright … (we) began planning this project mid-2020 … a collaboration of many people … thankful for all that helped to make this happen, many of whom are in attendance today. … when people in our communities need health care, Tennova is always going to be there for them."[103]

Why does a hospital begin planning a $68M expansion in mid-2020 after international scientists determined Covid would infect 60 percent of the world's population and kill one in 100 of those infected (approximately 50 million people)?[104] Seems very risky. If Tennova wished to thank the people responsible for their ability to pursue a $68M expansion, they should visit their local cemeteries.

Cookevi[105]lle Regional Medical Center (CRMC) was the site of many Covid deaths in the surrounding communities of Cookeville, Crossville, and Monterey. The hospital released its 2020-2021 audit, which shows, "despite Covid-19, financial health is in good standing." CRMC reported a net loss in 2019 of $5,842,948 but reported a net income in 2020 of $9,554,777 and a net income in 2021 of $4,380,554. The hospital claims they are using the net income to reinvest in equipment and services to better serve patients.[106] From our experiences trying to save Covid patients at CRMC, better service to patients is not consistent with life.

Williamson Medical Center (WMC) killed many Covid patients in their Franklin, TN, hospital. Despite "labor challenges" (caused by firing medical staff who exercised their right to reject an experimental covid shot), WMC claimed, "profits soar amid pandemic." WMC reported a net income in Nov 2021 of $822,707 and a year-to-date net income of $4.1M—a more than 104 percent increase compared to Nov 2020.

WMC CFO, Michael Jennessee, spoke at a Williamson County commission meeting in Nov 2021, stating he is proud of the hospital's earnings. Commissioner Barbara Sturgeon asked Jennessee what services WMC was providing that led to such an increase in revenue and asked if the hospital was getting paid extra for Covid diagnoses and Covid patients on ventilators, to which Jennessee replied, "We're getting the same money that anybody would be getting."[107] Jennessee spoke the truth in that WMC is reimbursed the same as all U.S. hospitals that strictly adhere to NIH Covid protocols. The Adam Group had many conversations with WMC administrators as patients lay dying on ventilators—patients that could have been saved if WMC had worked with patients and their families on safe, effective, inexpensive Covid treatment protocols. Just because WMC makes the same as "anybody" does not justify the number of Covid deaths in their hospital.

Following the Money Through Misleading Covid Vaccine Licensing

On 11 December 2020, the FDA issued an EUA for the Pfizer-BioNTech vaccine. That EUA was reissued on:

- 23 December 2020
- 25 February 2021
- 10 May 2021
- 25 June 2021
- 12 August 2021

21 U.S. Code § 360bbb–3a2[108] says:

(2) Approval status of product

An authorization under paragraph (1) may authorize an emergency use of a product that—

(A) is not approved, licensed, or cleared for commercial distribution under section...

(B) is approved, conditionally approved under section 360ccc of this title, licensed, or cleared under such a provision, but which use is not under such provision an approved, conditionally approved under section 360ccc of this title, licensed, or cleared use of the product (referred to in this section as an "unapproved use of an approved product")."

Approval and *licensing* are different actions. Under an EUA, a product can be conditionally licensed, but that does not mean it is approved. A product may also be approved (i.e., EUA) but not licensed. The Pfizer-BioNTech Covid-19 vaccine was ONLY given permission to be manufactured and marketed under the new name Comirnaty in specific packaging. The vaccine's letter of authorization dated 23 August 2021 says:

"This product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 12 years of age and older."[109]

On 23 August 2021, an FDA press release read:

"Today, the U.S. Food and Drug Administration approved the first COVID-19 vaccine. The vaccine has been known as the Pfizer-BioNTech COVID-19 Vaccine, and will now be marketed as Comirnaty (koe-mir'-na-tee), for the prevention of COVID-19 disease in individuals 16 years of age and older."[110]

What does 'Comirnaty' mean? Does this press release mean the drug treatment is FDA approved? FDA licensed? Answers lie in the approval letter:

"You may label your product with the proprietary name, COMIRNATY, and market it in 2.0 mL glass vials, in packages of 25 and 195 vials."[111]

Searching the web for 'Comirnaty' from August 2010 to August 2021 does not provide a single result. Fiercephrama.com, however, defines it as, "Comirnaty. It's a name we'll all know soon. The new brand name for Pfizer and BioNTech's COVID-19 vaccine, Comirnaty mashes up community, immunity, mRNA and COVID... ."[112]

FDA approval was granted for a new name for marketing the Pfizer Covid shot (Comirnaty) and packaging instructions (2.0 mL glass vials, in packages of 25 and 195 vials). The FDA did not approve or license the vaccine product itself.

The Press Release continues:

"The vaccine also continues to be available under emergency use authorization (EUA), including for individuals 12 through 15 years of age."[113]

The key word here is 'including.' It does not exclude individuals over the age of 15.

On the EUA document, it specifically references that the company is licensed to *produce* the vaccine,[114] but not that the drug itself is FDA approved or licensed.

Subsequently, the FDA reissued the EUA for the Pfizer-BioNTech vaccine (not Comirnaty) on:

- 22 September 2021
- 20 October 2021
- 29 October 2021
- 19 November 2021
- 9 December 2021
- 16 December 2021

- 3 January 2022
- 29 March 2022
- 17 May 2022
- 17 June 2022.
- 8 July 2022 (a supplement to BLA approved and EUA reissued)
- 31 August 2022
- 12 October 2022
- 8 December 2022
- 14 March 2023
- 18 April 2023
- 28 April 2023[115]

On 11 September 2023, FDA finally approved Comirnaty, the product (2023-2024 Formula): [116]

- Multiple dose vials with yellow caps and labels with yellow borders (each 0.3 mL dose containing 3 mcg of modRNA) for use in individuals 6 months through 4 years of age …;
- Single dose vials with blue caps and labels in blue borders (each 0.3 mL dose containing 10 mcg of modRNA) for use in individuals 5 through 11 years …"

It was concluded in the EUA letter that the Pfizer-BioNTech Covid-19 Vaccine met the criteria for issuance of an EUA because:

a) Covid was "life threatening;"
b) "totality of scientific evidence" showed the Pfizer-BioNTech vaccine was an effective treatment for Covid, and potential benefits outweighed known and potential risks; and
c) NO ADEQUATE, APPROVED, AND AVAILABLE ALTERNATIVE to the vaccine was available.

The EUAs for all Covid vaccines were issued under false pretenses. The "totality of scientific evidence" was lacking. Worse, there were many adequate, approved, available, safe, and inexpensive alternatives to the vaccine. All were demonized by pharmaceutical companies, the press, social media, and our government.

BOTTOM LINE: The investigational Covid "vaccine product" by Pfizer-BioNTech was never approved nor licensed by the FDA until 11 September 2023. All other Covid "vaccines" to date remain EUA only.

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