How Billions in COVID Stimulus Funds Led Hospitals to Prioritize 'Treatments' That Killed, Rather Than Cured, Patients

How Billions in COVID Stimulus Funds Led Hospitals to Prioritize 'Treatments' That Killed, Rather Than Cured, Patients

> ***In the second half of an interview this month on Del Bigtree's "The Highwire" — "COVID-19: Following the Money" — policy analyst A.J. DePriest reported on the impact of billions in COVID stimulus funds, which, according to some doctors and lawyers, turned hospitals and medical staff into "bounty hunters," and COVID patients into "virtual prisoners."***

by **Children's Health Defense Team**, *The Defender*
January 24, 2022

As reported last week by The Defender, federal monies from the 2020 and 2021 COVID stimulus bills dramatically reshaped K-12 educational priorities, turning American school officials into lackeys for federal agencies more intent on masking and vaccinating every last child than on supporting meaningful education.

So, too, with the stimulus-induced reshaping of hospital priorities.

In the second half of a January interview on Del Bigtree's

"The Highwire" – "COVID-19: Following the Money" – policy analyst A.J. DePriest reported on the untoward consequences set into motion as a result of COVID funds provided to hospitals.

Managed by the U.S. Department of Health and Human Services (HHS), the federal government allocated a total of $186.5 billion to the Provider Relief Fund (PRF), with two-thirds ($121.3 billion) disbursed as of January 2022.

The first tranche of $50 billion for hospitals and other Medicare providers – "for healthcare-related expenses or lost revenues … attributable to COVID-19" – began flying out the door in April 2020.

Almost immediately, alert doctors and astute journalists warned the Medicare add-on payments built into the relief package created perverse incentives unfriendly to patients' interests.

As summarized by Dr. Scott Jensen – former Minnesota state senator and current gubernatorial candidate – "anytime healthcare intersects with dollars it gets awkward."

Nearly two years down the road, the "awkwardness" is increasingly difficult to hide.

In the view of DePriest and many others, HHS's stimulus slush fund has been every bit as dangerous for hospital patients as the U.S. Department of Education's handouts have been for the nation's schoolchildren.

Making out like bandits

Dr. Elizabeth Lee Vliet and Ali Shultz, J.D., who wrote a widely distributed op-ed in late 2021 for the Association of American Physicians and Surgeons (AAPS), summed up the disturbing situation prevailing in hospitals. The AAPS's professional calling card is its "dedication to the highest ethical standards of the Oath of Hippocrates."

Not mincing their words, the two argued that Centers for Medicare and Medicaid Services (CMS) payment directives turned hospitals and medical staff into "bounty hunters," and COVID patients into "virtual prisoners."

Highlighting the slew of CMS add-ons and other incentives established with the Coronavirus Aid, Relief and Economic Security (CARES) Act – and also the Paycheck Protection Program and Health Care Enhancement Act (PPPHCEA) – they emphasized the payments hinge on hospitals' willingness to slavishly follow the National Institutes of Health's (NIH's) guidelines "for all things related to COVID-19."

As itemized by Vliet and Shultz, compliant hospitals garner CMS payments for:

- Each completed diagnostic test (required in the emergency room or upon admission).
- Each COVID-19 diagnosis.
- Each COVID admission.
- Use of the intravenously administered Gilead drug remdesivir (brand name Veklury), which yields a 20% bonus payment on the entire hospital bill.
- Mechanical ventilation.
- COVID-19 listed as cause of death.

Citing a Becker's Hospital Review breakdown, published in April 2020, of CARES Act payments to different states, DePriest told Bigtree payments ranged from $166,000 per COVID patient in Tennessee hospitals, for example, to far higher payments in states such as North Dakota ($339,000), Nebraska ($379,000) and West Virginia ($471,000).

In addition, for hospitals ascertained to be in COVID "hotspots," HHS distributed special "high-impact" funds – $77,000 per admission initially, later downsized to $50,000 per admission.

HHS explained it used COVID admissions "as a proxy for the

extent to which each facility experienced lost revenue and increased expenses associated with directly treating a substantial number of COVID-19 inpatient admission [sic].

The remdesivir ruse

The National Institute of Allergy and Infectious Diseases (NIAID) and the Centers for Disease Control and Prevention (CDC) spent $79 million developing remdesivir for Gilead, which itself dished out $2.45 million during the first quarter of 2020, to lobby for the drug's use with COVID patients.

On May 1, 2020, the U.S. Food and Drug Administration (FDA) authorized remdesivir for emergency use in individuals hospitalized with severe COVID illness, and members of an NIH expert panel (many with financial ties to Gilead) added the drug to the agency's treatment guidelines.

A scant five months later, FDA granted full approval to remdesivir for hospitalized COVID patients over age 12.

The World Health Organization (WHO), in contrast, advised against remdesivir, stating the drug has "no meaningful effect on mortality or on other important outcomes for patients."

Remdesivir sailed through regulatory hoops in the U.S. despite an abysmal track record of "adverse effects serious enough to kill" any individual hapless enough to take it.

Children's Health Defense Chairman Robert F. Kennedy, Jr. discusses remdesivir's toxicity in his best-selling book, The Real Anthony Fauci, outlining the lethal problems – multiple organ failure, acute kidney failure, septic shock, hypotension and death – experienced by participants in NIAID's clinical trial of remdesivir as an Ebola therapy.

When the trial, which compared remdesivir against three other drugs, killed more than half (54%) of the remdesivir recipients within 28 days – the highest mortality rate among the four groups – an oversight board forced the NIAID to end

the prong of the study focused on remdesivir.

As if remdesivir alone weren't bad enough, Vliet and Shultz estimate mechanical ventilation kills anywhere from 45% to 85% of COVID patients. Moreover, NIH's skimpy treatment guidelines prescribe dexamethasone concurrently with ventilators.

Dexamethasone, often described as a "double-edged sword," is a highly potent corticosteroid that suppresses the innate immune system.

Like remdesivir, dexamethasone's potentially significant adverse impacts include kidney damage. Additional side effects include interference with the normal function of other organ systems such as the cardiovascular, digestive, endocrine, musculoskeletal and nervous systems.

Ironically, dexamethasone can also increase the need for mechanical ventilation as well as for blood pressure intervention.

Therapies like these are a large part of why, as Vliet and Shultz note, the U.S. COVID mortality rate is so "shockingly high" compared to the rest of the world.

Remdesivir's trail of destruction could get worse – on Jan. 21, FDA expanded use of remdesivir to "high-risk" adult and pediatric outpatients (age 12 and older) "for the treatment of mid-to-moderate COVID-19 disease," permitting administration of the intravenous drug in various outpatient facilities.

FDA's side effects warnings include possible liver injury and allergic reactions such as "changes in blood pressure and heart rate, low blood oxygen level, fever, shortness of breath, wheezing, swelling …, rash, nausea, sweating or shivering."

Getting involved and bringing transparency

Referring to the 20% add-on payment that hospitals receive for

administering remdesivir to COVID patients, DePriest commented that a "bonus" is a "weird thing to call something when you're murdering people."

Journalist Jon Rappoport agreed, preferring to characterize hospitals' behavior toward COVID patients as "a federally incentivized protocol for murder" – or "cash for death."

All of the above parties concur that the best-case scenario is to treat COVID early at home and avoid hospitals – "because we know from experience what happens there."

In cases where hospitalization is unavoidable, DePriest encourages communities to get more involved:

"[W]hen you know these hospitals are doing that, the people of that community need to show up at that hospital en masse and start telling them that you, as a community, are going to be advocating for every single COVID patient that walks through those doors, and you are going to hold that hospital accountable – to their patient bill of rights, to their stated visitation policies – and if your state is not in a state of emergency anymore, there shouldn't be any reason why patients are medically kidnapped and separated from their families and isolated.

"There's absolutely no reason for it, but the communities have to get involved and they have to confront these hospitals and tell them, 'We're done, you're not killing any more of us.'"

Connect with Children's Health Defense