IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Criminal Case No. 21-cr-00083-RM

UNITED STATES OF AMERICA,

Plaintiff,

v.

1. FRANCIS F. JOSEPH,

Defendant.

INDICTMENT
Count 1
18 U.S.C. § 669
Count 2
18 U.S.C. § 641
Count 3
18 U.S.C. § 1343
Count 4
18 U.S.C. § 152(3)
Forfeiture Allegation
18 U.S.C. §§ 981(a)(1)(C), 982(a)(2), and 982(a)(7) and 28 U.S.C. § 2461(c)

The Grand Jury charges:

GENERAL ALLEGATIONS

At all times relevant to this Indictment:

Defendant and Relevant Entities

1. FRANCIS F. JOSEPH was a resident of Douglas County, Colorado, within the District of Colorado. JOSEPH was a physician licensed to practice medicine in the State of Colorado.

2. Springs Medical Associates, P.C. a/k/a Springs Medical Associates, Inc. ("Springs Medical"), formed in or around August 2014 by FRANCIS F. JOSEPH, was a Colorado corporation that maintained its principal office in El Paso County, Colorado.

3. FRANCIS F. JOSEPH operated, managed, and controlled Springs Medical until on or about January 29, 2020, when he ceded management and control of Springs Medical as well as its finances, including its bank accounts, to Individual 1. Between January 29, 2020 and April 14, 2020, JOSEPH was employed by Springs Medical until he was terminated.

Relevant Financial Accounts

4. Springs Medical held business account x5191 at Bank 1 ("Official Springs Medical Account").

5. FRANCIS F. JOSEPH held account x6089 at Bank 1 in the name of a family member ("Family Member Account").

6. On or about March 27, 2020, unbeknownst to Springs Medical or Individual 1 and without authorization, FRANCIS F. JOSEPH opened account x0396 at Bank 2, in the name of Springs Medical with himself as the sole signatory ("Unofficial Springs Medical Account").

7. On or about October 29, 2020 and October 30, 2020, unbeknownst to Springs Medical or Individual 1 and without authorization, FRANCIS F. JOSEPH opened accounts x1462 and x7300, respectively, at Bank 3, in the name of Springs Medical with himself as the sole signatory ("Other Unofficial Springs Medical Accounts").

The Medicare Program

8. The Medicare Program ("Medicare") was a federally funded health care benefit program that provided free or below-cost health care benefits to certain individuals, primarily the elderly, blind, and disabled, and those who were 65 years of age or older. The Centers for Medicare and Medicaid Services ("CMS"), a Federal agency under the United States Department of Health and Human Services ("HHS"), administered Medicare.

9. The term "health care benefit program," under Title 18, United States Code, Section 24(b), was defined as "any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract."

10. Medicare was a "health care benefit program" pursuant to Title 18, United States Code, Section 24(b), and a "Federal health care program" pursuant to Title 42, United States Code, Section 1320a-7b(f).

11. Medicare was divided into multiple parts. Medicare Part A covered services provided by hospitals, skilled nursing facilities, hospices, among others. Medicare Part B covered services provided by physicians, medical clinics, laboratories, among others. Medicare Part C (or "Medicare Advantage") provided individuals with the option to receive their Medicare benefits through private insurers approved by Medicare, which may have entitled recipients to receive additional benefits. Medicare Part D provided prescription drug coverage to persons who were eligible for Medicare benefits under Parts A and B.

12. Health care providers, including physicians and clinics (collectively, "Providers") who wished to be eligible to participate in Medicare Part B were requested to periodically sign an enrollment application form, that is, CMS Form 855I for physicians and CMS Form 855B for clinics. The enrollment forms, which were required to be signed by an authorized representative of the Provider, contained a certification that stated:

> I agree to abide by the Medicare laws, regulations, and program instructions that apply to me or the organization listed in Section 4A of this Application. The Medicare laws, regulations, and program instructions are available through the fee-for-service contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the supplier's compliance with all applicable conditions of participation in Medicare.

13. Providers that enrolled in Medicare and received a "provider number" were able to file claims with Medicare, either in hardcopy or electronically, to obtain reimbursement for services provided ("Medicare Provider").

14. CMS contracted with private insurance companies under Part B to receive, adjudicate, and pay Medicare claims submitted by Medicare Providers. Once contracted to process Medicare Part B claims, these private insurance companies were known as Medicare Administrative Contractors ("MACs"). CMS contracted with Novitas Solutions ("Novitas") to process and pay Medicare Part B claims in the state of Colorado.

Accelerated and Advance Payment Program

15. On or about January 31, 2020, the Secretary of HHS declared that a public health emergency had existed in the United States since January 27, 2020 and continued to exist due to COVID-19. On April 21, 2020, July 23, 2020, October 2, 2020, and January

7, 2021, the Secretary of the HHS issued renewals of the existence of the public health emergency due to COVID-19.

16. In or around March 2020, in order to increase cash flow to Medicare Providers impacted by the pandemic, CMS expanded the existing Accelerated and Advance Payment Program to a broader group of Medicare Providers under both Medicare Part A and Part B.

17. The payments through the Accelerated and Advance Payment Program ("Advanced Payments") were intended to provide necessary funds due to a disruption in claims submission and/or claims processing. These Advanced Payments were offered in circumstances such as national emergencies or natural disasters in order to accelerate cash flow to the impacted Medicare Providers. CMS was authorized to provide Advanced Payments during the period of the COVID-19 public health emergency to any Medicare Provider who submitted a request to the appropriate MAC and met the required qualifications.

18. To qualify for Advanced Payments, the Medicare Provider was required to: (1) have billed Medicare for claims within 180 days immediately prior to the date of signature on the form requesting Advanced Payment ("Advance Payment Request Form"); (2) not be in bankruptcy; (3) not be under active medical review or program integrity investigation; and (4) not have any outstanding delinquent Medicare overpayments.

19. Medicare Providers would request a specific amount using an Advance Payment Request Form provided on each MAC's website. Most Medicare Providers were

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