Restructuring a Distressed Healthcare Business in a Post-Pandemic Economy

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Stimulus funds have run out, our population continues to age, the No Surprises Act has gone into effect, and CMS regulations are as byzantine as ever. What's a healthcare company to do? This session will provide insight into legal and financial challenges facing healthcare providers and servicers in a post-pandemic economy, and will also provide practical guidance for how troubled healthcare companies may best position themselves to weather financial headwinds. This panel also provides some guidance on the unique issues that arise in a healthcare business bankruptcy and the specific provisions of the Bankruptcy Code that govern issues particular to healthcare bankruptcy cases.

The healthcare industry in general is in very difficult financial times. These financial difficulties stem from systemic problems that have existed for decades, exacerbated by the difficulties coming out of the COVID 19 pandemic. Among the issues leading to general financial difficulties are: (a) greatly increased labor costs driven by a nursing shortage; (b) greatly increased costs driven by inflation and ongoing supply chain issues; (c) companies having relied extensively on COVID-related government funding which is now ended; (d) limited ability to pass through increased costs because government payors set their own rates and private payor contracts are inflexible; (e) for entities with investment portfolios, low returns on invested assets (S&P declined by ~20% in 2022); and (f) interest rate increases (the Federal Reserve raised rates seven times during 2022). The net result is a sharp increase in large healthcare bankruptcies in 2022, led by filings in the senior care and pharmaceutical sectors.[1]

Counsel handling healthcare business bankruptcies will encounter high-profile cases with difficult and unique issues that arise from the intersection of bankruptcy law, various federal and state statutes and regulations, and public interest and concern. Such cases frequently garner a great deal of high-profile publicity and public scrutiny, which may affect strategic management of the case. The unique legal issues arise, in part, from the fact that the healthcare industry is one of the most heavily regulated industries in the United States. Many of those regulations relate

[1] *See, e.g.*, Harriet Clarfelt, Debt woes mount for US healthcare sector as interest rates rise, Financial Times (Jan. 31, 2023), available at https://www.ft.com/content/b0679b82-baf2-495f-8684-8ac8d3d80a0f; Gibbins Advisors, Healthcare Sector Bankruptcy Filings Increased by 84% from 2021 to 2022 (Jan. 12, 2023), available at https://gibbinsadvisors.com/healthcare-sector-bankruptcy-filings-increased-by-84-from-2021-to-2022/;

only to care or services provided to Medicare or Medicaid patients. Healthcare businesses are governed by intricate statutes and regulations,[2] which vary in scope. Some relate only to care and services provided to Medicare or Medicaid patients;[3] others apply more broadly.

Dealing with the Federal and State Governments

Issues related to the resolution of disputes with the Centers for Medicare and Medicaid Services (CMS)[4] (which runs the Medicare program[5]) and the various state agencies that run the individual state Medicaid programs[6] can frequently be the most important issues in the case. This

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[2] Authors have described the intersection of the Medicare and Medicaid statutes and the Bankruptcy Code as an "accident scene." Robert G. Richardson, *Accident Scene—Medicare and Bankruptcy Code Collide*, AM. BANK. INST. J. 10 (Apr. 1995). This is in no small measure because the Medicare Act is very complex. *See, e.g.*, *Rehab. Assoc. of Va., Inc. v. Kozlowski*, 42 F.3d 1444, 1450 (4th Cir. 1994) (describing the Medicare Act as "among the most completely impenetrable texts within human experience"); *Brown v. Thompson*, 374 F.3d 253, 261 n.5 (4th Cir. 2004) (*quoting Beverly Cmty. Hosp. Ass'n v. B*elshe, 132 F.3d 1259, 1266 (9th Cir. 1997)) (noting that "any quality of crystal clarity is uniformly recognized as totally absent from the Medicaid and Medicare statutes").

[3] For example, Medicare pays for 22 percent of total national health expenditures, 26 percent of spending on hospital care, and 22 percent of spending on physician services. Ctrs. for Medicare & Medicaid Servs., Office of the Actuary, Nat'l Health Statistics Grp., Nat'l Health Expenditures Tables (Dec. 2014).

[4] CMS is an agency within the U.S. Department of Health and Human Services.

[5] Medicare is the federal program that provides health insurance to, primarily, people aged 65 or older, as well as younger people with disabilities, end-stage renal disease, and amyotrophic lateral sclerosis. Social Security Amendments of 1965, Pub. L. No. 89–97, 79 Stat. 286; 42 U.S.C. §§ 1395 *et seq.* More information is available at https://www.medicare.gov.

[6] Medicaid is a government insurance program, jointly funded and supervised by the federal and state governments, that provides insurance primarily for low-income adults, their children, and people with certain disabilities. Social Security Amendments of 1965, Pub. L. No. 89–97, 79 Stat. 286; 42 U.S.C. §§ 1396 *et seq.* More information is available at https://www.medicaid.gov.

is due to the relative importance in the healthcare industry of the federal and state governments, both as a payors and regulators.

The United States can be expected to argue that bankruptcy courts do not have jurisdiction over any dispute regarding Medicare payments or decisions unless and until the debtor exhausts its administrative remedies under the Medicare rules. Ordinarily, this means that a debtor must run the gauntlet of the Medicare program's multi-level review process, which can take years. C.F.R. § 404.900 (describing the administrative process).This has been a huge problem in healthcare bankruptcy cases because the Medicare program's appeal process was, for many years, broken. Staffed to handle approximately 70,000 appeals annually, at one point not all that long ago it had more than 700,000 appeals pending.[7] If the federal government's jurisdictional argument is followed by bankruptcy courts, it effectively denies meaningful bankruptcy protection to healthcare businesses forced into bankruptcy by a dispute with the Medicare program. This issue is usually litigated early in the bankruptcy case. A loss on this issue can eliminate the usefulness of the bankruptcy filing by effectively denying a healthcare debtor any bankruptcy relief.

To support its position, the federal government relies on 42 U.S.C. § 405(h) ("Section 405(h)"), which expressly states that federal courts may take jurisdiction over Medicare disputes only after a party exhausts applicable appeal processes within the Medicare system. A complete discussion of this issue would be too lengthy to include here. It should be noted, however, that there is currently a split among the circuits regarding whether bankruptcy courts are barred by this provision from adjudicating disputes with CMS.[8] In short, the controversy is based on the

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[7] *See Am. Hosp. Ass'n v. Burwell*, 812 F.3d 183 (D.C. Cir. 2016) (discussing delays in the Medicare appeals process and concluding, among other things, that the delays in Medicare appeals "are having a real impact on 'human health and welfare'").

[8] *Compare Florida Agency For Health Care Admin., et al v. Bayou Shores, SNF, LLC (In re Bayou Shores, SNF, LLC)*, 828 F.3d 1297, 1331 (11th Cir. 2016) ("The bankruptcy court was without § 1334 jurisdiction under the § 405(h) bar to issue orders enjoining the termination of the provider agreements and to further order the assumption of the provider agreements.") *with In re Benjamin*, 924 F.3d 180, 184-88 (5th Cir. 2019) (Section 405(h) "strips federal jurisdiction under only the listed statutory provisions—§§ 1331 and 1346—not under unlisted ones, such as

plain language of Section 405(h). This provision expressly restricts courts from taking jurisdiction under sections 1331 and 1336 of title 28 of the U.S. Code. It does not expressly refer to 28 U.S.C. § 1334 ("Section 1334"), which grants federal bankruptcy court jurisdiction. The plain language of the statute[9] supports the argument that the debtor need not exhaust its administrative remedies before a bankruptcy court may take jurisdiction in order to rule on non-Medicare-specific classic bankruptcy issues. For purposes of this discussion, such determinations specifically include whether the debtor can assume and assign an executory contract under section 365 of the Bankruptcy Code and/or sell debtor assets free and clear of liens, claims, and interests under § 363 of the Bankruptcy Code. (As discussed later herein, these are two essential issues for healthcare business bankruptcy cases.). Nevertheless, the government has argued with

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bankruptcy jurisdiction under 28 U.S.C. § 1334."); *Do Sung Uhm v. Humana, Inc.*, 620 F.3d 1134, 1140 n.11 (9th Cir. 2010) (noting the "special status" of bankruptcy court jurisdiction over bankruptcy issues); *University Medical Center, Inc. v. Sullivan (In re Univ. Med. Ctr.),* 973 F.2d 1065, 1072 (3d Cir. 1992) ("Because we agree . . . that the Bankruptcy Code supplies an independent basis for jurisdiction in this case, we reject the Secretary's arguments and find that the district and bankruptcy courts properly had jurisdiction. . . ."); *and Sullivan v. Town & Country Home Nursing Servs., Inc. (In re Town & Country Home Nursing Services, Inc.)*, 963 F.2d 1146, 1155 (9th Cir. 1992) ("Section 405(h) only bars actions under 28 U.S.C. §§ 1331 and 1346; it in no way prohibits an assertion of jurisdiction under section 1334."); *and Nurse's Registry & Home Health Corp. v. Burwell (In re Nurses' Registry & Home Health Corp.),* 533 B.R. 590, 593 (Bankr. E.D. Ky. 2015) (Court holds that "the statutory bar on federal jurisdiction over unexhausted Medicare Act disputes .. did not apply to bankruptcy jurisdiction".); *see also* Samuel R. Maizel & Michael B. Potere, *Killing the Patient to Cure the Disease: Medicare's Jurisdictional Bar Does Not Apply to Bankruptcy Courts*, 32 EMORY BANKR. DEV. J. 1 (2015).

[9] *United States v. Ron Pair Enters., Inc*., 489 U.S. 235, 241 (1989) (stating that statutory interpretation begins "with the language of the statute itself," and that "is also where the inquiry should end," if "the statute's language is plain").

some success that the absence of a reference to Section 1334 is a "scriveners error," and therefore, the statute should be read as if a reference to Section 1334 were expressly included.[10]

The Provider Agreement as a License or Contract?

The relationship between the Medicare or Medicaid programs and the providers of healthcare goods and services is captured in a document commonly referred to as a "provider agreement." The treatment of provider agreements in a bankruptcy proceeding is often vital to the success of a bankruptcy case involving a sale of assets, but it can present difficult legal issues. Inside of bankruptcy proceedings, the government takes the position that the provider agreement is an executory contract that must be assumed by the debtor and assigned to the buyer under § 365 of the Bankruptcy Code. If the provider agreement is an executory contract, the debtor must cure existing defaults in the Medicare relationship (i.e., pay any existing prepetition obligations). Moreover, the buyer must take successor liability for the debtor's prior overpayments from Medicare and perhaps even for damages resulting from federal False Claims Act lawsuits.[11] What makes this issue controversial is that, outside of bankruptcy proceedings, the federal government argues, with success, that the Medicare provider agreement is not a contract.[12] The

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[10] *See, e.g.*, *Bayou Shores*, 828 F.3d at 1304 ("we conclude that the lack of reference to section 1334 in section 405(h) is the result of a codification error").

[11] Outside of bankruptcy, courts have held that parties that take a provider agreement take it with liability for their predecessors, i.e., with successor liability. *See, e.g.*, *United States v. Vernon Home Health, Inc.*, 21 F.3d 693 (5th Cir. 1994), *cert. denied*, 513 U.S. 1015 (1994).

[12] *PAMC, Ltd. v. Sebelius*, 747 F.3d 1214, 1221 (9th Cir. 2014) ("We have, on occasion, stated that providers and others have contracts with the government in this area, but our decisions have turned on the regulatory regime rather than on contract principles. . . . As the Eleventh Circuit Court of Appeals held when hospitals complained of legislative impairment of their contract rights in this area because they had agreements with the Secretary: 'Upon joining the Medicare program, however, the hospitals received a statutory entitlement, not a contract right.'") (*quoting Mem'l Hosp. v. Heckler*, 706 F.2d 1130, 1136 (11th Cir. 1983)); *Germantown Hosp. & Med. Ctr. v. Heckler*, 590 F. Supp. 24, 30–31 (E.D. Pa. 1983), *aff'd*, 738 F.2d 631 (3d Cir. 1984) ("There is no contractual obligation requiring HHS to provide Medicare reimbursement."); *In re BDK Health Mgmt., Inc*., Case Nos. 98-609-B1, Order Authorizing Sale

government does this to avoid giving Medicare providers contract-based rights and remedies. The Bankruptcy Code does not define the word *contract*. Instead, applicable non-bankruptcy law defines the nature of the debtor's property and contract rights.[13] Therefore, it is hard to fathom why the filing of a bankruptcy case would change the essential character of a document from a noncontract to a contract.

Are provider agreements executory contracts, or licenses?[14] The impact of this determination on a healthcare bankruptcy case is profound. A detailed discussion is beyond the scope of this

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of Assets out of the Ordinary Course of Business, 1998 Bankr. LEXIS 2031 (Bankr. M.D. Fla., Nov. 16, 1998). *But see In re Univ. Med. Ctr*., 973 F.2d 1065, 1075 n.13, 1076 (3d Cir. 1992) (reasoning that the "complexity of the Medicare scheme" does not exclude a provider agreement from the ambit of section 365, and that "a Medicare provider agreement easily fits" within the judicial definition of an executory contract). Lower courts in the Third Circuit have concluded that the decision in *University Medical Center* on this issue is limited. *See, e.g.*, *Health Care Fin. Admin. v. Sun Healthcare Grp., Inc. (In re Sun Healthcare Grp., Inc.)*, 2002 U.S. Dist. LEXIS 17868 (D. Del. 2002) (holding that "although the Medicare provider agreement may not be a license in the strictest sense of the word, it is clearly similar to a license for section 525 purposes").

[13] *See Mission Products Holdings, Inc. v. Tempnology, LLC*, 587 U.S. ___ , 139 S. Ct. 1652, 203 L. Ed. 2d 876 (2019) (A term which "is neither a defined nor a specialized bankruptcy term … means in the [Bankruptcy] Code what it means in contract law outside bankruptcy."); *Field v. Mans*, 516 U. S. 59, 69 (1995) (The Bankruptcy Code "incorporate[s] the established meaning" of "terms that have accumulated settled meaning.").

[14] Oddly, the United States, when pressed, generally agrees that the provider agreement is not a contract. For example, the United States responded in a non-bankruptcy case to a provider's citation to a bankruptcy case holding that the Medicare Provider Agreement was an executory contract by saying: "[I]n neither context, bankruptcy nor federal court, are Medicare Provider Agreements enforceable as contracts." United States Sur-Reply to Tenant's Reply to Its Motion for Summary Adjudication (Statute of Limitations), at 3, *United States v. Tenant Healthcare Corp*., 2005 WL 3784642 (C.D. Cal. Dec. 22, 2005).

chapter;[15] however, several implications are clear. A license becomes property of the bankruptcy estate[16] and can be sold under § 363 of the Bankruptcy Code, without successor liability passing to the buyer. An executory contract is also property of the estate,[17] but it must be transferred under § 365 of the Bankruptcy Code, and the buyer must assume the contract *cum onere*.[18] Such a transfer could result in the party taking the assignment of the Medicare provider agreement subject to successor liability.[19] Thus, an assignment of the provider agreement under § 365 of the Bankruptcy Code is likely to generate significantly less value than a sale of the provider agreement under § 363 of the Bankruptcy Code as a license.

If the provider agreement is governed by § 363 of the Bankruptcy Code rather than § 365 of the Bankruptcy Code, then § 363(f) of the Bankruptcy Code allows the debtor to sell the provider agreement "free and clear of *any interest* in such property," including any successor liability. The Second, Third, Fourth and Seventh Circuits, and many lower courts, have interpreted "any interest" expansively to include not only *in rem* interests in property, but also other obligations that may "arise from the property being sold."[20] Allowing a debtor to transfer a Medicare

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15 For a more detailed discussion of this issue, see Samuel R. Maizel & Jody A. Bedenbaugh, *The Medicare Provider Agreement: Is It a Contract or Not? And Why Does Anyone Care*?, 71 BUS. LAW. 4 (Fall 2016).

16 *See, e.g.*, *In re Re Tak Commc'ns*, 985 F.2d 916 (7th Cir. 1993). This is consistent with the general rule that all of a debtor's property, including all legal and equitable interests, becomes property of the bankruptcy estate. *See, e.g.*, 11 U.S.C. § 541; *Taylor v. Freeland & Kronz,* 503 U.S. 638, 642 (1992); *United States v. Whiting Pools, Inc*., 462 U.S. 198, 203–05 (1983).

17 *See, e.g.*, *In re Palace Quality Servs. Indus., Inc*., 283 B.R. 868, 892–98 (Bankr. E.D. Mich. 2002) (discussing impact of section 541(a)(1) on whether contract rights become property of the estate).

18 *See, e.g.*, *In re Monroeville Dodge, Ltd*., 166 B.R. 264 (E.D. Pa. 1994).

19 *See, e.g.*, *Cinicola v. Scharffenberger*, 248 F.3d 110 (3d Cir. 2001) (discussing the interrelationship between assumption under section 365 and a sale under section 363).

20 *See In re Grumman Olson Indus. Inc*., 467 B.R. 694, 702–03 (S.D.N.Y 2012); *see also United Mine Workers of Am. 1992 Benefit Plan v. Leckie Smokeless Coal Co. (In re Leckie*

provider agreement without subjecting the buyer to the risk of successor liability fosters the Bankruptcy Code's goal of maximizing recovery for creditors.[21]

This issue was litigated in 2019 in the context of the transfer of a Medicaid provider agreement in the chapter 11 case of *In re Verity Health System of California, Inc*. ("Verity"). In Verity the bankruptcy court held, in a comprehensive opinion, that the Medicaid provider agreement at issue there (i) was in nature of a statutory entitlement, and not a contract, and did not need to be assumed to be transferred, (ii) could be sold, outside the ordinary course of debtors' business, in same fashion as other estate assets; and (iii) could be transferred to purchaser of a debtor's assets free and clear of all liabilities which the state alleged had attached thereto.[22]

Smokeless Coal Co.), 99 F.3d 573 (4th Cir. 1996) (holding that coal mine operators could sell their assets free and clear of their obligations to a benefits plan and fund under the Coal Act); *PBBPC, Inc. v. OPK Biotech, LLC (In re PBBPC, Inc.)*, 484 B.R. 860 (1st Cir. B.A.P. 2013) (holding that debtor's assets could be sold free and clear of Commonwealth of Massachusetts's right to treat a purchaser of substantially all of the assets of chapter 11 debtor as a "successor employer" to which debtor's experience rating could be imputed to determine purchaser's unemployment insurance contribution); *In re Tougher Indus*., 2013 WL 1276501 (Bankr. N.D.N.Y. Mar. 27, 2013) (holding that debtor's assets could be sold free and clear of New York State Department of Labor's right to use the debtor's experience rating to access the buyer's tax liability as successor to the debtor); *WBO P'ship v. Va. Dep't of Med. Assistance Servs. (In re WBO P'ship)*, 189 B.R. 97, 104–05 (Bankr. E.D. Va. 1995) (holding that Commonwealth of Virginia's right to recapture depreciation is an "interest" as used in section 363(f)).

[21] This is not to suggest that the buyer need not be subject to change of ownership rules related to the transfer of the provider agreement other than pecuniary interests. Medicare considers certain business transactions, including sales, to constitute a "change of ownership." 42 C.F.R. § 489.18. When a change of ownership occurs, the provider agreement is automatically assigned to the new owner. 42 C.F.R. § 489.18(c).

[22] *In re Verity Health System of California, Inc*., 606 B.R. 843 (2019). Although this opinion was vacated when the parties settled, it is well reasoned and persuasive.

Setoff and Recoupment by the Government

Outside of bankruptcy, the federal government and its contractors routinely withhold Medicare and Medicaid payments when they determine that a healthcare provider has been overpaid.[23] Section 362 of the Bankruptcy Code automatically stays creditors' efforts to exercise control over property of the estate or collect on the debtor's prepetition obligations.[24]

Medicare and Medicaid withholdings might be characterized either as setoff or recoupment. Simply stated, *recoupment* is the assertion against the debtor of a claim or defense that arises from the same contract (or transaction or relationship), whereas *setoff* is the assertion of a claim that arises between the same parties but under a different contract (or transaction or relationship). Outside of bankruptcy, the distinction may be insignificant; inside of bankruptcy it can be key. The Bankruptcy Code strictly limits creditors' setoff rights but does not restrict creditors' recoupment rights.[25] For example, the Bankruptcy Code allows setoff only with respect to mutual prepetition obligations; however, precedent uniformly holds that recoupment is not so limited.[26] Additionally, while setoff is subject to the automatic stay and requires a creditor to obtain court approval, recoupment is not subject to the automatic stay and does not require court approval.[27] Consequently, in bankruptcy cases the government argues that its withholding of Medicare payments to recover prior overpayments constitutes recoupment. While a complete

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23 42 U.S.C. § 1395(g)(a).

24 11 U.S.C. § 362(a)(7).

25 *See, e.g., In re Gardens Regional Hosp. and Medical Ctr., Inc.*, 975 F.3d 926, 932-36 (9th Cir. 2020) (discussing origins and differences between setoff and recoupment in bankruptcy); *University Med. Ctr.*, 973 F.2d at 1079-80 (discussing the differences between setoff and recoupment in bankruptcy).

26 11 U.S.C. § 553(a); *see, e.g.*, *In re Holford*, 896 F.2d 176, 179 (5th Cir. 1990).

27 *See, e.g.*, *In re Visiting Nurse Ass'n of Tampa Bay, Inc.*, 121 B.R. 114, 119 (M.D. Fla. 1990).

discussion of this issue is beyond the scope of this chapter,[28] it should be noted that there is a split in the circuits on whether the withholding is recoupment or setoff.[29]

The same arguments that apply to federal Medicare recoupments/setoffs also generally apply to state governments' efforts to recover prior Medicaid overpayments from ongoing Medicaid programs. There are, however, differences arising from the different approaches states have applied to the provider agreements. As with Medicare, courts are split on the issue.[30] More recently, cases have been reported that deal with state's efforts to offset payments owed to a debtor in bankruptcy arising out of patient care payments against payments owed to the debtor for other reasons, frequently Hospital Quality Assurance Fee program payments. The two appellate courts to review this issue agree that the payments and claims do not arise out of the same transaction or occurrence.[31]

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[28] For a more detailed discussion of this issue, see Samuel R. Maizel, *An Issue That Just Won't Go Away*, 16(6) AM. BANKR. INST. J. 34 (Jul/Aug. 2004); Samuel R. Maizel, *Medicare's Recoupment Rights Get More Confusing*, 16(7) AM. BANKR. INST. J. (Sept. 1997).

[29] *Compare Univ. Med. Ctr*., 973 F.2d at 1081-82 (holding that Medicare could only recoup overpayments within the same cost report year as the ongoing payments) *with United States v. Consumer Health Servs. of Am., Inc*., 108 F.3d 390 (D.C. Cir. 1997) (holding that Medicare adjustments were recoupment); *and Sims v. United States Dep't of Health & Human Servs. (In re TLC Hosps., Inc.*), 224 F.3d 1008 (9th Cir. 2000) (same); *and Holyoke Nursing Home, Inc. v. Health Care Fin. Admin. (In re Holyoke Nursing Home, Inc.)*, 372 F.3d 1 (1st Cir. 2004) (same).

[30] *Compare In re Doctors Hosp. of Hyde Park*, 2002 WL 1770528 (N.D. Ill. 2002) (allowing recoupment of Medicaid payments) *with In re Dartmouth House Nursing Home, Inc*., 24 B.R. 256 (Bankr. D. Mass. 1982) (denying Medicaid's recoupment arguments), *appeal dismissed*, 30 B.R. 56 (1st Cir. BAP 1983), *aff'd on other grounds*, 726 F.2d 26 (1st Cir. 1984).

[31] *In re Gardens Regional Hosp. and Medical Ctr., Inc., 975 F.3d 926 (9th Cir. 2020); In re Saint Catherine Hosp. of Ind., LLC*, 511 B.R. 117, 127 (S.D. Ind. 2014), *rev'd on other grounds, Saint Catherine Hosp. of Ind., LLC v. Ind. Family & Soc. Servs. Admin*., 800 F.3d 312 (7th Cir. 2015).

Impact of Healthcare Business Bankruptcy on Healthcare Fraud Cases

One of the most omnipresent issues facing healthcare providers is the federal False Claims Act[32] (the "FCA"), and frequently the issues raised by litigation asserting a violation of the FCA are existential in nature and size.[33] The federal government, acting through the United States Department of Justice (the "US DOJ"), asserts FCA liabilities against all industries, but healthcare industry cases represent a majority of the cases and recoveries. In 2021 the US DOJ "obtained more than $5.6 billion in settlements and judgments from civil cases involving fraud and false claims against the government … Settlement and judgments since 1986 … now total more than $70 billion." Of that $5.6 billion, more than $5 billion "relates to matters that involved the health care industry, including drug and medical device manufacturers, managed care providers, hospitals, pharmacies, hospice organizations, laboratories and physicians."[34] Given the slim operating margins for most healthcare providers,[35] and the fact that liabilities under the FCA can result in treble damages,[36] a significant liability from the FCA can represent a

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[32] 31 U.S.C. §§ 3729-3733. Many states have similar state false claims act statutes.

[33] United States Department of Justice, Office of Public Affairs, *Justice Department's False Claims Act Settlements and Judgments Exceed $5.6 Billion in Fiscal Year 2021*, available at https://www.justice.gov/opa/pr/justice-department-s-false-claims-act-settlements-and-judgments-exceed-56-billion-fiscal-year (last visited on April 6, 2022).

[34] Id.

[35] Alia Paavola, Margins remain narrow for US hospitals, Beckers Hospital Review (Apr. 26, 2021), available at https://www.beckershospitalreview.com/finance/margins-remain-narrow-for-us-hospitals.html#:~:text=Not%20including%20federal%20relief%20aid,operating%20margin%20was%202%20percent (last visited on Apr. 10, 2022); Alex Kacik, Operating margins stabilize, but not-for-profit hospitals still vulnerable, Modern Healthcare, available at https://www.modernhealthcare.com/providers/operating-margins-stabilize-not-profit-hospitals-still-vulnerable (last visited on Apr. 10, 2022).

[36] US Department of Justice, The False Claims Act, available at https://www.justice.gov/civil/false-claims-act (last visited on Apr. 10, 2022).

crushing blow for healthcare providers, and frequently place them in a position where they must evaluate whether a bankruptcy filing can assist in dealing with the issue.

First, False Claims Act lawsuits are usually filed under seal by *qui tam* relators.[37] While the case is still under seal, the United States can decide whether to intervene. During this process, the debtor/defendant is not aware that a lawsuit is pending against it. Nevertheless, if the United States wants to recover in the bankruptcy case any damages that might be awarded in the False Claims Act case, the government must file a proof of claim by the applicable bar date. This requirement provides the debtor with knowledge of and the ability to address what may have been unknown litigation prepetition. Moreover, the United States may be required to defend that claim in the bankruptcy court, which it may view as a less favorable forum than the district court. The time for doing so may be much shorter than the time allowed outside of bankruptcy. Finally, § 502(c) of the Bankruptcy Code permits a bankruptcy court to estimate claims for the purposes of (1) allowance of the claim as to amount, (2) voting on a plan, (3) feasibility of a plan, and (4) distributions under a plan.[38] The court may also estimate a claim in order to determine the amount to be paid as "cure" when the Medicare and or Medicaid Provider Agreements are assumed by a debtor and/or assigned to a buyer.[39] The key question in determining whether a court should estimate a claim otherwise pending in another forum is "whether the liquidation of that claim" outside of bankruptcy "would unduly delay the . . . reorganization."[40] If so, a debtor could employ a bankruptcy case estimation proceeding to compel the government to assert claims otherwise pending in a False Claims Act case. This strategy has the potential benefit of forcing a resolution much more quickly than could be obtained outside of bankruptcy.

Generally the purchaser of Medicare Provider Agreements is not responsible for FCA civil penalties and any related overpayments under the "fraud exception" to successor liability under applicable law. Under the government's interpretation of 42 C.F.R. § 489.18, contained in

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37 The False Claims Act permits a private person, known as a qui tam relator, to bring a lawsuit on behalf of the United States, based on information possessed by the relator without regard to whether damages are suffered by the relator. *See, e.g.*, 31 U.S.C. § 3730.

38 *In re Trident Shipworks, Inc.*, 247 B.R. 513 (Bankr. M.D. Fla. 2000).

39 *In re Ground Round, Inc.*, 2004 WL 1732007 (Bankr. D. Mass. July 12, 2004).

40 *In re Apex Oil Co.*, 107 B.R. 189 (Bankr. E.D. Mo. 1989).

chapter 3 of the Medicare Financial Management Manual, "the new owner assumes all penalties under the Medicare program, including the repayment of any accrued overpayments, regardless of who had ownership of the Medicare agreement at the time the overpayment was discovered *unless fraud was involved*."[41] The Manual further states the following exception to its rule that the new owner has responsibility for outstanding and future overpayments: *If any of the overpayments determined for a fiscal year when the previous owner had assignment were discovered due to fraud, the responsibility for the repayment of the overpayments does not shift to the new provider. It stays with the old provider.*[42] The Manual does not expressly state that the exception applies to penalties and treble damages under the FCA, but the language broadly encompasses all fraud-related penalties and overpayments. An agency's interpretation of its own regulations in the Manual is entitled to deference from the court unless it is clearly erroneous or conflicts with the regulation.[43]

Is a Skilled Nursing Facility Residential Real Property

Many courts have grappled with the issue of whether a skilled nursing facility ("SNF") is residential real property or non-residential real property.[44] The typical resident in a SNF is a person who is chronically ill or recuperating from an illness or surgery and needs regular nursing care and other health related services. The average length of stay in skilled nursing is between 20-38 days. The issue in bankruptcy cases is significant, because the deadline for assuming or rejecting non-residential real property is only 210 days from the filing of the bankruptcy petition (120 days plus a single 90-day extension) pursuant to § 365(d)(4) of the Bankruptcy Code. Courts have usually looked at the fact that residents in SNFs can be there for sometimes long

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41 Medicare Financial Management Manual, ch. 3, § 130 (emphasis added).

42 Id. (emphasis added).

43 *See Triad at Jeffersonville I LLC v. Leavitt*, 563 F. Supp. 2d 1, 19 (D.D.C. 2008) (internal citations omitted); *see also St. Mary's Hosp. of Troy v. Blue Cross & Blue Shield Ass'n*, 788 F.2d 888, 890 (2d Cir. 1986) (explaining that CMS manuals are "interpretive" sources entitled to persuasive weight); *Battle Creek Health Sys. v. Leavitt*, 498 F.3d 401, 409 (6th Cir. 2007) (analyzing CMS's Provider Reimbursement Manual and determining that CMS properly relied upon that manual in reaching the at-issue decision).

periods, which makes it seem like they are residents. However, it seems obvious that the living arrangements in a SNF are only incidental to the medical care being provided. The average rent in the United States is only $1,718 per month for an average size apartment of 896 sq. ft. By comparison, the average monthly cost of a private room in a SNF nationally is over $10,000. This difference results from a SNF being required to provide 24-hour skilled nursing care, as well as related or rehabilitative services. The difference makes clear what is really being "sold" in a SNF setting is not a place to live but medical care, making a SNF more akin to a hospital than to an apartment building.

Not-for-Profit Healthcare Business Rules

Many healthcare businesses are not -for-profit entities.[45] Three provisions of the Bankruptcy Code address the sale of not-for-profit assets. Section 363 of the Bankruptcy Code requires the trustee to comply with all applicable non-bankruptcy laws governing the transfer, sale, or lease of not-for-profit entities' property.[46] Under § 1129(a)(16) of the Bankruptcy Code, the court

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[44] *Compare In re Passage Midland Meadows Operations, LLC*, 578 B.R. 367 (Bankr. S.D. W. Va. 2017); *In re Summit Ventures*, No. 90-00213, 1991 WL 133412, at *2 (Bankr. D. Vt. Mar. 4, 1991); *and In re Sonora Convalescent Hosp., Inc*., 69 B.R. 134 (Bankr. E.D. Cal. 1986) (all holding SNFs are non-residential real estate) *with In the Matter of Memory Lane of Bremen LLC*, 535 B.R. 901 (Bankr. N.D. Ga. 2015); *In re Care Givers, Inc*., 113 B.R. 263, 267 (Bankr. N.D. Tex. 1989); *In re Independence Village, Inc*., 52 B.R. 715 (Bankr. E.D. Mich. 1985); *In re Texas Health Enterprises, Inc.*, 255 B.R. 181 (Bankr. E.D. Tex. 2000); *and PNW Healthcare Holdings, LLC*, Case No. 19-43754 (Bankr. W.D. Wash. 2019) (all holding SNFs are residential real estate).

[45] For example, 59 percent of all community hospitals in the United States are nongovernment, not-for-profit community hospitals. American Hosp. Ass'n, Fast Facts on US Hospitals, http://www.aha.org/research/rc/stat-studies/fast-facts.shtml (last updated Jan. 2017).

[46] *See In re Gardens Reg. Hosp. and Med. Ctr., Inc*., 567 B.R. 820 (Bankr. C.D. Cal. 2017) (discussing sale of not for profit hospital under California statutes); see also Samuel R. Maizel & Khoi Ta, *Not So Fast: Bankruptcy Court Reject Attorney General's Review of Sale of Assets of a Closed Hospital*, Cal. Health Law News, Vol. XXXVI, Issue 1 (Fall 2017/Winter 2018); Samuel

cannot confirm a plan of reorganization without a finding that all transfers of not-for-profit assets comply with applicable non-bankruptcy law. Similarly, § 541(f) of the Bankruptcy Code allows a not-for-profit healthcare business to transfer property to a for-profit entity, but only under the same conditions that would apply if the debtor were not in bankruptcy.

It is important to note two statutory provisions related to these codified sections that were not codified into the U.S. Code but that are still binding and relate to the sale of not-for-profit assets in bankruptcy.[47] First, § 1221(d) of the Bankruptcy Abuse Prevention and Consumer Protection Act ("BAPCPA") of 2005 states that "the court shall not confirm a plan . . . without considering whether this section[48] would substantially affect the rights of a party in interest. . . . The parties who may appear and be heard in a proceeding under this section include the attorney general of the State in which the debtor is incorporated, was formed, or does business." Second, BAPCPA § 1221(e) states that "[n]othing in this section [which is now section 363(d)(1)] shall be construed to require the [bankruptcy] court in which a case under [the Bankruptcy Code] is pending to remand or refer any proceeding, issue, or controversy to any other court or to require the approval of any other court for the transfer of property." These provisions make clear both that the state Attorney General has standing to appear on issues related to the sale of not-for-profit

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R. Maizel, Khoi Ta & Matt Weiss, *Extent of State's Power at Issue in Nonprofit Hospital's Asset Sale,* J. of Corporate Renewal, Vol. 30 (Mar. 2017).

[47] The Code of Laws of the United States of America (also known as United States Code (U.S.C.)) is the official consolidation and codification of the general and permanent federal statutes of the United States. It is published every six years by the Office of the Law Revision Counsel of the House of Representatives. Cumulative supplements are published annually. Portions of some congressional acts, such as these two from BAPCPA, however, are not codified. Library of Congress, Researching Federal Statutes, https://www.loc.gov/law/help/statutes.php (last updated June 9, 2015). These statutes may be found by referring to the acts as published in "slip law" and "session law" form. The official version of those laws not codified in the U.S. Code can be found in United States Statutes at Large. 2 U.S.C. § 285.

[48] Section 1221 of the BAPCPA, which deals with transfers made by nonprofit charitable corporations.

assets and that the bankruptcy court need not defer to a state court to decide issues related to the transfer of assets.

Definition of Healthcare Business

Section 101 of the Bankruptcy Code defines a *healthcare business*. Under this definition, a healthcare business:

> (A) means any public or private entity . . . that is primarily engaged in offering to the general public facilities and services for (i) the diagnosis or treatment of an injury, deformity, or disease; and (ii) surgical, drug treatment, psychiatric, or obstetric care; and
>
> (B) includes (I) general or specialized hospital; (II) ancillary ambulatory emergency, or surgical treatment facility; (III) hospice; (IV) home health agency; and (IV) other health care institution that is similar to an entity referred to in subclause (I), (II), (III), or (IV); and (ii) any long-term care facility, including any (I) skilled nursing facility; (II) intermediate care facility; (III) assisted living facility; (IV) home for the aged; (V) domiciliary care facility; and (VI) health care institution that is related to a facility referred to in subclause (I), (II), (III), (IV), or (V), if that institution is primarily engaged in offering room, board, laundry, or personal assistance with activities of daily living and incidentals to activities of daily living.[49]

The Bankruptcy Code also has definitions of *patient* (§ 101(40A) of the Bankruptcy Code) and *patient record* (§ 101(40B) of the Bankruptcy Code). A patient means "any individual who obtains or receives services from a health care business." A patient record means any written or electronic record relating to a patient. These definitions are rarely discussed and never litigated. In contrast, the parties not infrequently dispute whether an entity is a healthcare business.

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[49] 11 U.S.C. § 101(27A).

Exclusion from Participation in the Medicare Program

Outside of bankruptcy, the Office of Inspector General[50] may exclude an individual or entity from future participation in all federal healthcare programs and all state healthcare programs. Section 362(b)(28) of the Bankruptcy Code provides that the automatic stay does not apply to "the exclusion by the Secretary of Health and Human Services of the debtor from participation in the Medicare program or any other Federal health care program." This provision is not as broad as it may seem, in part because the conditions for exclusion are limited.[51] Counsel should be careful to draw a distinction between suspension and exclusion with regard to the Medicare program. While § 362(b)(28) of the Bankruptcy Code expressly exempts exclusion from the automatic stay, it does not expressly exempt suspensions. The courts are split concerning whether the automatic stay bars suspension.[52] Additionally, having payments suspended are not the same as having the provider suspended. Courts generally agree that suspension of payments to a provider are subject to the automatic stay.[53]

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[50] The Office of Inspector General, which is part of the U.S. Department of Health and Human Services (HHS), is responsible for protecting the integrity of HHS programs.

[51] For a more in-depth discussion of this issue, see Samuel R. Maizel & Rachel Caplan, *Chicken Little Comes to Roost in Bankruptcy*, 25(6) AM. BANKR. INST. J. (July/Aug. 2006).

[52] *Compare In re First Am. Health Care of Ga., Inc*., 208 B.R. 985 (Bankr. S.D. Ga. 1996) (holding that suspension violates the stay and enjoining future suspensions notwithstanding criminal conviction of nursing home operators), *and In re Medicar Ambulance Co*., 166 B.R. 918, 926–27 (Bankr. N.D. Cal. 1994) (holding that suspension for fraud violates the stay), *with In re Orthotic Ctr., Inc*., 193 B.R. 832 (N.D. Ohio 1996) (reversing bankruptcy court and holding that suspension for fraud does not violate the stay).

[53] *See, e.g., True Health Diagnostics LLC v. Azar (In re THG Holdings LLC)*, 604 B.R. 154 (Bankr. D. Del. 2019) ("[T]he Court finds that the Defendants' withholding of post-petition reimbursement payments is a violation of the automatic stay as it does not fall within the police power exception."); *In re Medicar Ambulance Co., Inc*., 166 B.R. 918 (Bankr. N.D. Cal. 1994) (Fiscal intermediary ordered to discontinue its suspension of Medicare payments and to turn over to the debtor all amounts placed in the suspense account.).

Patient Care Ombudsman

The Bankruptcy Code, through § 333 of the Bankruptcy Code, which requires the appointment of a patient care ombudsman (PCO). The PCO represents the interests of patients and serves as the "eyes and ears" of the bankruptcy court to ensure that the healthcare business maintains appropriate levels of patient care. Section 333 of the Bankruptcy Code requires the bankruptcy court to order the appointment of a PCO, within 30 days after the commencement of a bankruptcy case, unless the court reviews and facts and determines that the appointment is not necessary for the protection of the patients. If the court orders the appointment of a PCO, the U.S. Trustee must appoint a disinterested person (which can include a corporation) as the PCO. If the healthcare business provides long-term care services, the U.S. Trustee may appoint the state long-term care ombudsman as the PCO.

The PCO is required to monitor the quality of patient care and report on it to the court within 60 days of being appointed. Reports are required every 60 days thereafter. The PCO is authorized to file a motion or written report (other than the regular report) if it observes that the quality of patient care is declining significantly or otherwise being materially compromised. The PCO will almost certainly have to review medical records in the course of monitoring patient care. The PCO must comply with applicable nonbankruptcy law, including federal law that strictly controls access to medical records.[54] Usually, PCOs obtain express authorization to review patient records as well.

While the requirement for a PCO was the subject of much discussion when enacted in 2005, in practice it has been fairly inconsequential. In fact, the appointment of a PCO is found unnecessary in many, if not most, cases.

Disposal of Medical Records

The Bankruptcy Code, through § 351, contains a provision dealing with the destruction of medical records. This provision was necessary because federal and state regulations require most medical records to be stored for years and for some medical records to be stored for more

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[54] *See, e.g.*, Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936.

than 20 years.[55] This storage can be very expensive. Section 351 of the Bankruptcy Code preempts such non-bankruptcy rules and provides a mechanism by which a debtor or trustee who does not have sufficient funds to comply with non-bankruptcy storage standards may destroy medical records rather than pay for storing them. It requires the trustee to publish notice in appropriate newspapers, stating that patient records will be destroyed if they are not claimed by the patient or an insurance provider within 365 days of publication of the notice. In the 180 days after publication, the trustee must promptly attempt to notify each patient with patient records being held, and any appropriate insurance carrier, of how and when they may obtain the medical records. If records remain unclaimed after the 365-day period expires, § 351 of the Bankruptcy Code requires the trustee to mail a request to an "appropriate" federal agency before destroying the records. No such agency is identified, however, and it is not clear that any such agency exists. Oddly, there are state agencies that are available to take on the storage of medical records, but the statute makes no mention of contacting the appropriate state agency. If no federal agency accepts the request to take on storage of the records, the trustee is authorized to destroy the records by shredding or burning paper records, or by "otherwise" destroying magnetic, optical, or electronic records.[56]

Duty of a Trustee to Transfer Patients

The Bankruptcy Code, through § 704(a)(12) of the Bankruptcy Code, has rules applicable to the transfer of patients when a healthcare business is closing. The trustee must transfer patients to a facility that (1) is in the vicinity of the healthcare business being closed, (2) provides the

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[55] The Medicare program requires that Medicare beneficiaries' patient records be retained for five years. 42 C.F.R. § 482.24(b). Medicaid requirements vary state by state. *See* State Medical Records Laws: Minimum Medical Record Retention Periods for Records Held by Medicaid Doctors and Hospitals tbl. A-7, available at https://www.healthit.gov. The American Health Information Management Association usually has current information on the state-by-state retention of medical records requirements.

[56] For a detailed discussion of some issues with the text of section 351, *see* Samuel R. Maizel & Michael Maizel, *Revising § 351: Dealing with Unwanted Medical Records,* Problems in the Code column, AM. BANKR. INST. J. (May 2017).

patient with services that are substantially similar to those provided by the healthcare business that is being closed, and (3) maintains a reasonable quality of care.

Costs of Closing a Healthcare Facility

The Bankruptcy Code, through § 503(b)(8), provides that the costs and expenses a trustee, federal agency, or state or local government department incurs in closing a healthcare business are administrative expenses. These expenses include but are not limited to those related to disposing of patient records (but not storing patient records) or the transfer of patients as necessary.[57]

Discrimination against Healthcare Business by Governmental Entities

The Bankruptcy Code prohibits the government from refusing to enter into a new provider agreement with a healthcare business based solely upon the fact that a healthcare business did not repay monies owed to the government because the healthcare business is or was in bankruptcy. Section 525 of the Bankruptcy Code expressly states that a governmental unit may not "deny, revoke, suspend, or refuse to renew a charter, franchise, or other similar grant to, condition such grant to discriminate with respect to such grant against . . . a person that is or has been a debtor under the Bankruptcy Code or a person associated with a debtor." Courts have held that this applies to contractual relationships as well, even though contracts are not expressly listed.[58] Consequently, it should apply regardless of whether the Medicare provider agreement is deemed to be a contract or a license.[59] Courts have also held that § 525 of the Bankruptcy Code

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[57] While this provision is not frequently litigated, an interesting issue related to state asserted administrative expenses in a healthcare bankruptcy has recently been litigated as to whether state imposed hospital quality assurance fees are a tax under section 503(b)(1)(B)(i). *See In re Gardens Reg. Hosp. and Med. Ctr., Inc*., 573 B.R. 811 (Bankr. C.D. Cal. 2017).

[58] *In re Exquisito Servs., Inc*., 823 F.2d 151 (5th Cir. 1987); *see generally Toth v. Mich. State Hous. Auth.*, 136 F.3d 477, 480 (6th Cir. 1998) (holding that section 525(a) prohibits governmental conduct where the "government's role [is] as a gatekeeper in determining who may pursue certain livelihoods").

[59] At least some commentators disagree. *See* EH Sperow, *Section 525(a) of the Bankruptcy Code Plainly Does Not Apply to Medicare Provider Agreements*, 34 J. HEALTH LAW 487 (2001).

protects purchasers of assets from a bankruptcy estate.[60] Nonetheless, states have continued to push the limits on these protections. For example, in *In re Gardens Regional Medical Center and Hospital, Inc.*, the California Attorney General imposed a condition of the sale of a not-for-profit that required the debtor or the purchaser of its assets to pay approximately $2.4 million that the debtor owed to the state. The state threatened to deny the purchaser the right to continue to participate in the state's Hospital Quality Assurance Fee program if the amount was not paid, which would have resulted in the purchaser forfeiting millions of dollars. The matter was not litigated, and it is thus unclear how this condition would have been resolved.[61]

Conclusion

Some, or all, of the issues discussed in this chapter arise in most bankruptcy cases involving a healthcare business. Any one of them may be complex and case dispositive. Healthcare bankruptcy cases almost always involve interactions with federal and state governments, in which the government entities act as both creditors and regulators. The cases also almost always involve the intersection of bankruptcy law and federal healthcare statutes and regulations. Most importantly, many of the issues are disposed of differently in different jurisdictions. For all these reasons, healthcare bankruptcy cases are particularly challenging.

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60 *Compare In re Betty Owen Sch.,* 195 B.R. 23 (Bankr. S.D.N.Y. 1996) (holding that purchaser of a bankrupt school's assets qualifies as an entity "associated" with the debtor under section 525(a)) *with In re Draughon Training Inst., Inc*., 119 B.R. 927 (Bankr. W.D. La. 1990) (holding that state agency does not violate section 525(a) when it denies purchaser of schools the transfer of a license).

61 For a more detailed discussion of this issue, *see* Samuel R. Maizel, Khoi Ta & Matt Weiss, *Extent of State's Power at Issue in Nonprofit Hospital's Asset Sale*, J. of Corporate Renewal (Vol. 30), Mar. 2017.