AMERICAN COLLEGE of BANKRUPTCY

Just What The Doctor Ordered: Developments and Opportunities in Healthcare Restructuring

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Introduction

- Why Should You Care?
  - Hospitals and health systems are facing significant financial distress due to the international pandemic caused by COVID-19. The pandemic has caused additional expenses at the same time that revenue is declining due to cessation of non-emergent care and reduction in emergency cases. The American Hospital Association estimates declines in hospital revenue of between $53 billion and $122 billion in 2021.
  - Commercial Chapter 11 filings were up 29% in 2020.
  - The healthcare industry is huge. Industry annual revenue is over $1.6 trillion. The United States spends more on health care per capita ($8,608), and more on health care as a percentage of its GDP (19%), than any other nation.
  - The Medicare program itself processes over a billion claims for payment annually. In 2019, Medicare Part A and B payments were over $400 billion, and there were over 1.1 million providers enrolled.

Stress Between Government Regulations and Bankruptcy Code

Who has jurisdiction?

- Bankruptcy
  - Jurisdiction granted by 28 U.S.C. § 1334. Absent statutory limits, Bankruptcy Code provides broad powers as to debtors and creditors, and to resolve disputes.
- Medicare
  - Channels all claims arising under the Medicare Act through the administrative process before a court has jurisdiction. 42 U.S.C. §§ 405(h), 1395ii statutorily bars premature judicial review of claims.

Does the Bankruptcy Court have jurisdiction?

- 42 U.S.C. § 405(h) as it applies to Medicare reads:
  - Finality of [Secretary's] decision: The findings and decision of the [Secretary] after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decisions of the [Secretary] shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the [Secretary] or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.
- This section is made applicable to the Medicare Act via operation of 42 U.S.C. § 1395ii.
- This section does not explicitly apply to actions brought under section 1334 of Title 28, the section governing referral of bankruptcy cases by the district court to the bankruptcy court.

Does § 405(h) apply in bankruptcy and diversity actions?

- Courts are split on this issue:
  - **YES** (3rd, 7th, 8th, and 11th Circuit Courts of Appeal) based on a detailed review of legislative history and the lack of any indication Congress was making a fundamental change to reverse decades of Medicare policy and Congress' statement in the statute itself that the amendment should not be interpreted as making any substantive change in the law.
    - "[W]e align ourselves with the Seventh, Eighth, and Third Circuits and hold that § 405(h) bars § 1334 jurisdiction over claims that 'arise under [the Medicare Act].'" *In re Bayou Shores SNF*, 828 F.3d 1297 (11th Cir. 2016); *Midland Psychiatric Assocs., Inc. v. U.S.*, 145 F.3d 1000 (8th Cir. 1998); *Bodimetric Health Servs., Inc. v. Aetna Life & Cas.*, 903 F.2d 480 (7th Cir. 1990); *In re Hodges*, 364 B.R. 304 (Bankr. N.D. Ill. 2007); *In re Hosp. Staffing Servs.*, 258 B.R. 53 (S.D. Fla. 2000); *In re St. Mary Hosp.*, 123 B.R. 14 (E.D. Penn. 1991).
  - These authorities represent a quarter-century of analyses.

- **NO** (5th, 9th Circuits) – the statutory bar on federal jurisdiction over unexhausted Medicare disputes does not apply to bankruptcy court jurisdiction under 28 U.S.C. § 1334.
  - "With respect to the majority of our sister circuits, we join the Ninth Circuit in applying the third sentence's plain meaning—a meaning that . . . does not bar § 1334 jurisdiction." *In re Benjamin*, 932 F.3d 293 (5th Cir. 2019).
  - "The BAP . . . found 'the better reasoned position' to be that 'where there is an independent basis for bankruptcy court jurisdiction, exhaustion of administrative remedies pursuant to other jurisdictional statutes is not required.' . . . We agree." *In re Town & Country Home Nursing Servs., Inc.*, 963 F.2d 1146 (9th Cir. 1992).

Application of Jurisdiction-Stripping to Medicaid

- Does the jurisdiction-stripping provision of 42 U.S.C. § 405(h) apply to the Medicaid statute, which does not contain a similar provision?
- Some courts have interpreted the Medicare jurisdictional-stripping provision to also cover decisions revoking a provider's approval under Medicaid when a provider operates under both because the decision to revoke Medicaid automatically revokes Medicare. *See Cathedral Rock of North Coll. Hill, Inc. v. Shalala*, 223 F.3d 354, 357-66 (6th Cir. 2000); *In re Bayou Shores*, 828 F.3d 1297 (11th Cir. 2016); *but see Maine Dep't of Health and Human Servs. v. The Getchell Agency*, No. 17-CV-00252 (D. Me. Apr. 17, 2018) (holding that bankruptcy court would not extend jurisdiction-stripping to case in which provider only operated under Medicaid).

Ability to Transfer Agreements

Provider Agreement: Like an Executory Contract?

- **NO:** "We have, on occasion, stated that providers . . . have contracts with the government . . . '[u]pon joining the Medicare program, however, the hospitals received a statutory entitlement, not a contractual right.'" *PAMC, Ltd. v. Sebelius*, 747 F.3d 1214 (9th Cir. 2014) (citations omitted).
- **YES**: "[M]ajority of bankruptcy courts considering the Medicare-provider relationship conclude that the Medicare provider agreement, with its attendant benefits and burdens is an executory contract." *In re Vitalsigns Homecare, Inc.*, 396 B.R. 232, 239 (Bankr. D. Mass. 2008).
  - "A Medicare provider agreement easily fits within [the] definition [of executory contract]." *In re Univ. Med. Ctr.*, 973 F.2d 1065, 1075 n.13 (3d Cir. 1992); *U.S. v. Consumer Health Servs.*, 108 F.3d 390, 394 (D.C. Cir. 1997).
- Nearly 40 years ago, one court dismissed the attempt to characterize the provider agreement as something other than an executory contract as "interesting reading . . . that . . . in no way reflects the reality of the relationship" between DHHS and the provider. *In re Monsour Med. Ctr.*, 11 B.R. 1014, 1018 (W.D. Penn. 1981); *In re Adv. Professional Home Care, Inc.*, 94 B.R. 95 (E.D. Mich. 1988).

- *In re Verity Health Systems of California, Inc.*, 606 B.R. 843 (Bankr. C.D. Cal. 2019)
  - Debtors were hospitals operating in California, pursuant to provider agreements between the Debtors and the California Department of Health Care Services ("DHCS").
    - Debtors moved to sell substantially all assets of four of their hospitals (including provider agreements) to a purchaser. Debtors took the position that the provider agreements were "statutory entitlements" (or licenses) that were property of the estate and could be sold like any other property of the estate, pursuant to section 363(f).
  - The issue presented to the court was whether provider agreements were executory contracts pursuant to section 365—such that any defaults under them would have to be cured in connection with any assumption and assignment or purchaser—or assets that could be sold to the purchaser free and clear of all interests under section 363(f)(5).

- The economic value of this legal issue was significant: The Debtors owed DCHS $30 million for past due quarterly fees and had received another $25 million in overpayments.
  - If the provider agreements were considered executory contracts, the Debtors would have to cure the outstanding balance of $55 million in connection with assumption and assignment.
  - If, however, the provider agreements were simply assets that could be sold free and clear.
- The Court held that the provider agreements were statutory entitlements that could be sold free and clear of liabilities, rather than executory contracts that would to be fully cured in connection with assumption and/or assignment. (*Note: this opinion was later vacated at the request of the parties, after they reached certain stipulations resolving their disputes.)

- In its holding, the Court first determined that the provider agreements are not even contracts, much less executory contracts, as provider agreements simply create a statutory entitlement to bill the Medi-Cal program for providing services to Medi-Cal beneficiaries.
  - In other words, the amount of reimbursement that the provider receives is governed by statute, not by contract, specifically the Medicare Act's "reasonable cost" provisions. In any event, the Court held that the right to receive reimbursement is a property interest.
- The Court cited various cases that suggest that provider agreements are not actually contracts.
  - *See, e.g.*, *Greater Dallas Home Care All. v. United States*, 10 F. Supp. 2d 638, 647 (N.D. Tex. 1998); *PAMC, Ltd. v. Sebelius*, 747 F.2d 1214, 1221 (9th Cir. 2014); *In re Center City Healthcare, LLC*, Case No. 19-11466 (Bankr. D. Del. 2019) (decision subsequently vacated); *In re B.D.K. Health Mgmt., Inc.*, 1998 WL 34188241 (Bankr. M.D. Fla. Nov. 16, 1998); *but see In re Vitalsigns Homecare, Inc.*, 396 B.R. 232, 239 (Bankr. D. Mass. 2008) ("[M]ajority of bankruptcy courts considering the Medicare-provider relationship conclude that the Medicare provider agreement, with its attendant benefits and burdens is an executory contract.")

Regulatory View

- In the sale of a functioning health care provider, an MPA may be assigned to the purchaser on terms consistent with Medicare law and policy and subject to regulatory approval. 42 C.F.R. § 489.18(d).
- The purchaser/assignee must accept the provider agreement as is, accepting both the benefits and the burdens. *See In re Raintree Healthcare Corp.*, 431 F.3d 685, 687-89 (9th Cir. 2005); *Eagle Healthcare, Inc. v. Sebelius*, 969 F. Supp. 2d 38, 40 (D.D.C. 2013) (merely steps into the shoes of the prior owner); *In re Vitalsigns Homecare, Inc.*, 396 B.R. at 238 (describing non-bankruptcy transfer of MPA).
- Thus, the purchaser/assignee is liable for any previous overpayments or CMPs made under the MPA prior to the assignment and these amounts may be recovered through recoupment. *See United States v. Vernon Home Health, Inc.*, 21 F.3d 693, 696 (5th Cir. 1994).

Liability

- A successor to the MPA is responsible for any overpayment or CMPs even if the terms of the sale or transfer indicate the purchaser assumes no liabilities. *United States v. Vernon Home Health, Inc.*, 21 F.3d 693, 696 (5th Cir. 1994) (liable for prior overpayments despite sale agreement stating assumed no liabilities); *see also Deerbrook Pavilion, LLC v. Shalala*, 235 F.3d 1100, 1104 (8th Cir. 2000) (finding successor liability for prior CMP and rejecting 5th Amendment argument by successor).
- "[P]ublic policy would be ill-served by permitting insolvent providers [] a windfall at the expense of other Medicare providers which have managed their facilities prudently to avoid chapter 11." *In re Holyoke Nursing Home, Inc.*, 372 F.3d 1, 5 (1st Cir. 2004).
- "There is no compelling reason to treat the bankrupt provider differently than any other provider." *In re St. Mary Hosp.*, 123 B.R. 14, 17 (E.D. Pa. 1991). "[T]he careful balance between administrative and judicial review" is unaffected by debtor's "misfortune that [it] is in bankruptcy when [it]has a . . . Dispute with [CMS]." *Id.* at 17.

General Practice

- In a change of ownership (CHOW), assignment is "automatic" (subject to CMS approval) per 42 C.F.R. § 489.18.
- The debtor-in-possession must assume – and therefore cure – the Medicare Provider Agreement before attempting to convey.
- Medicare participation is voluntary: new owner may accept or reject.
  - Acceptance of assignment comes with successor liability.
  - Rejection is a voluntary termination; new owner will apply as a new provider.
  - The new owner cannot "borrow" the existing provider agreement until they have a new one to avoid a break in reimbursement.

Automatic Stay

The Automatic Stay

- Automatic Stay
  - The Automatic Stay prohibits termination of:
    - Federal and state provider agreements, Medicare, physician contracts, specialized service agreements (e.g. radiology); ambulatory service contracts, contracts to supply blood.
  - The Automatic Stay does NOT prohibit exclusion from Medicare and Medicaid.
    - Section 362(b)(28): the Automatic Stay does not prevent HHS from excluding a health care business from participation in Medicare or any other federal health care program.
  - Compare: Termination vs. Exclusion
    - Termination from Medicare or Medicaid is the discontinuation or refusal to renew a provider contract.
    - Termination is non-permanent.
  - Section 362(b)(28) only refers to exclusion, not termination. HHS cannot use section 362(b)(28) to terminate a contract if the factors for exclusion are not met.

The Automatic Stay

- Automatic Stay
  - How to terminate?
    - HHS must first seek relief from stay
  - Post-termination, a new contract can be granted if reasons for termination are remedied and there are reasonable assurances that reasons for termination will not re-occur.
  - Note: both exclusion and termination are prohibited under section 525(a) if the exclusion/termination action is undertaken solely because the Debtor is (a) in bankruptcy or (b) has not paid pre-petition debt.

Withholding Medicare Payments & the Automatic Stay

- Can withholding of Medicare reimbursements by CMS violate the automatic stay?
  - Federal statutes/regulations permit CMS to suspend, offset, and recoup Medicare payments to providers for various reasons. There is some debate over whether this is a right of setoff (subject to the automatic stay) or recoupment (not subject to the automatic stay).
  - A recent and noteworthy case that examines this issue is *True Health Diagnostics LLC v. Azar (In re THG Holdings LLC)*, 604 B.R. 154 (Bankr. D. Del. 2019).
    - In *True Health*, the debtor was a "laboratory provider of diagnostic and disease management solutions" that filed for bankruptcy in 2019.
    - In 2017, CMS informed the Debtor that it was suspending 100% of its Medicare payments on the basis of "credible allegations of fraud." In 2019, the Debtor received a second suspension notice, based on certain of the same allegations of fraud from 2017.
    - Debtor sought to enjoin CMS from withholding Medicare payments for postpetition services rendered by Debtor, arguing that such actions would violate the automatic stay.

Withholding Medicare Payments & the Automatic Stay

- In *True Health*, the Court granted a preliminary injunction against CMS, which remained in place for the entire case.
  - The Court held that it had jurisdiction to do so under the Third Circuit's decision in *University Medical Center v. Sullivan (In re University Medical Center)*, 973 F.2d 1065 (3d Cir. 1992) to enjoin CMS from withholding Medicare payments, even though the Debtor did not exhaust administrative remedies pursuant to the applicable Medicare statute.
  - The Court further held that "the post-petition Medicare reimbursements [for medical tests performed by debtor postpetition] were indisputably property of the estate" under section 541(a) of the Bankruptcy Code, and that CMS' withholding of such payments after the Debtor's bankruptcy filing violated the automatic stay.
  - The Court rejected the Government's contention that withholding Medicare payments to True Health fit within the police power exception to the automatic stay under section 362(b)(4)—the Court indicated that this was all about CMS protecting its pecuniary interests and not about protecting public safety, health, or welfare, or to effectuate public policy.
- Accordingly, CMS was required to continue making Medicare payments owed to True Health on or after the petition date.

Withholding Medicare Payments & the Automatic Stay

- Presumably significant to the Court's decision in *True Health* was the distinction between CMS' prepetition allegations of fraud/overpayments and CMS' withholding of postpetition payments.
  - In essence, it appeared that CMS was trying to help itself collect on a prepetition claims by withholding funds relating to postpetition payments.
- Other courts across a variety of jurisdictions have addressed similar issues.
  - *Compare Holyoke Nursing Home v. Health Care Fin. Admin. (In re Holyoke Nursing Home, Inc.)*, 372 F.3d 1 (1st Cir. 2004) (allowing recoupment of Medicare overpayments); *Sims v. United States Dep't of Health & Human Servs. (In re TLC Hosps., Inc.)*, 224 F.3d 1008 (9th Cir. 2000) (same); *United States v. Consumer Health Servs. of America, Inc.*, 108 F.3d 390 (D.C. Cir. 1997) (same); *with In re University Medical Center*, 973 F.2d 1065 (3d Cir. 1992) (right of recoupment is limited to overpayments arising in the same cost report year as the ongoing payments government seeks to offset).

Withholding Medicare Payments & the Automatic Stay

- Following confirmation and the Effective Date of the *True Health* Plan, the Liquidating Trust and CMS engaged in ongoing disputes regarding the Medicare payments, culminating in mediation and ultimately a 9019 settlement between the parties.
- On April 16, 2021, the Court entered an order approving the settlement, which provided as follows:
  - The Liquidating Trust receives $10,851,641.05 from CMS following the effective date of the Settlement Agreement;
    - The Liquidating Trust retains $5,151,61.05 of the payments previously ordered by the Court and receives $5,700,000 from CMS within 30 days of the Settlement Agreement.
  - The $29,639,417.17 administrative expense claim of CMS is fully resolved as follows:
    - CMS reduces the secured portion of its overpayment proof of claim to $14,517,645.53 and is permitted to set off that amount against its pre-petition Medicare overpayment claim;
    - The remaining amount ($9,421,771.64) is allowed and treated as a general unsecured claim, subject to offset against any federal tax refund owed by the U.S. to True Health.
  - Both the Liquidating Trust and the U.S. shall dismiss each of their outstanding litigation against the other with prejudice and shall also move for the vacatur of the related orders and/or opinions from the Bankruptcy Court and District Court.

Not For Profit Sale

Not-For-Profit Healthcare Sale Rules

- The Bankruptcy Code has three provisions that deal with the sale of not-for-profit assets.
  - 11 U.S.C. § 363(d): Trustee may use, sell, or lease property of a not-for-profit "only in accordance with nonbankruptcy law applicable to the transfer of property by a debtor that is such a corporation or trust."
  - 11 U.S.C. § 541(f): Notwithstanding any other provision of this title, property that is held by a debtor that is a corporation described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code may be transferred to an entity that is not such a corporation, but only under the same conditions as would apply if the debtor had not filed a case under this title.
  - 11 U.S.C. § 1129(a)(16): All transfers of property under the plan shall be made in accordance with any applicable provisions of nonbankruptcy law that govern the transfer of property by a corporation or trust that is not a moneyed, business, or commercial corporation or trust.

Sale of Not-For-Profit Healthcare Entities

- Two implications from these provisions:
  - (1) Debtors and courts considering the sale of not-for-profit hospitals can consider charitable mission when selecting the "best" offer for assets. *In re United Healthcare Sys., Inc.*, No. CIV. A. 97-1159 (D.N.J. Mar. 26, 1997).
  - (2) Debtors and courts must consider implications of state law when selling not-for-profit assets. *In re Gardens Regional Hospital and Med. Ctr., Inc.*, 567 B.R. 820 (Bankr. C.D. Cal. 2017).
- However, state control over the disposition of non-profit assets is subject to limits. A bankruptcy court in California determined conditions imposed on a sale by the California attorney general were an interest in property and that the debtor could sell free and clear of those interests. *In re Verity Health Sys. of Cal., Inc.*, No. 2:18-BK-20151-ER, 2019 WL 5585007 (Bankr. C.D. Cal. Oct. 23, 2019), *vacated by* No. 2:18-BK-20151-ER, 2019 WL 6519342 (Bankr. C.D. Cal. Nov. 13, 2019).

Not-For-Profit Challenges with 363 Sales

- When a sale process is used in a bankruptcy case of a not-for-profit entity, there are certain issues that must be considered other than simply maximizing value, including whether the purchaser is committed to continuing the debtor's charitable mission.
  - It may be the case that the bidder submitting the offer for the most consideration (*i.e.* the highest purchase price) will not be the "highest and best" offer if that purchaser cannot appropriately demonstrate that the debtor's charitable mission will be furthered by the sale transaction.
- For example, in *In re United Healthcare System, Inc.*, 1997 WL 175674 (D.N.J. Mar. 26, 1997), the district court noted that purchase price alone should not be used to determine the best offer for a not-for-profit's assets. Rather, the "overriding consideration of public health" as well as the purchaser's ability to further the debtor's charitable mission must be analyzed.