

Commercial Fraud/Health Care
**Lies Lies Lies, Yeah: Can
a Health Care Business
Reorganize When Facing
Allegations of Fraud? The
Role of the Forensic Accountant,
Counsel and the Community**

Warren J. Martin, Jr., Moderator

Porzio, Bromberg & Newman, P.C.; Morristown, N.J.

Carol L. Fox

GlassRatner Advisory & Capital Group LLC; Miami

James R. Porter

ToneyKorf Partners, LLC; Charlotte, N.C.

Andrew M. Troop

Pillsbury Winthrop Shaw Pittman LLP; New York



AMERICAN
BANKRUPTCY
INSTITUTE

DISCOVER



AMERICAN BANKRUPTCY INSTITUTE
JOURNAL
journal.abi.org

ABI's Flagship Publication






***Delivering Expert Analysis
to Members***

With *ABI Journal* Online:

- Read the current issue before it mails
- Research more than 10 years of insolvency articles
- Search by year, issue, keyword, author or column
- Access when and where you want – even on your mobile device
- Receive it **FREE** as an ABI member

Find the Answers You Need
journal.abi.org

66 Canal Center Plaza • Suite 600 • Alexandria, VA 22314-1583 • phone: 703.739.0800 • abi.org

Join our networks to expand yours:   

© 2015 American Bankruptcy Institute All Rights Reserved.

Commercial Fraud/Health Care

Lies Lies Lies, Yeah: Can a Health Care Business Reorganize When Facing Allegations of Fraud? The Role of the Forensic Accountant, Counsel and the Community

December 4, 2015

11:00 a.m. – 12:15 p.m.

Carol L. Fox

GlassRatner Advisory & Capital Group LLC; Miami, FL

James R. Porter

ToneyKorf Partners, LLC; Charlotte, N.C.

Andrew M. Troop

Pillsbury Winthrop Shaw Pittman LLP; New York

Warren J. Martin Jr., Moderator

Porzio, Bromberg & Newman, P.C.; Morristown, NJ

INDEX

| | | |
|-----|--|-----------|
| I. | Medicare Fraud: A Primer on Medicare Fraud and Best Practices..... | Page 1-5 |
| II. | Recent Decisions on Licensure, Offset and Recoupment | Page 6-18 |

Medicare Fraud and Abuse

General Overview

The Medicare program was established by Congress to provide health insurance for:

1. People age 65 or older;
2. People under age 65 with certain disabilities; and
3. People of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Medicare insurance is comprised of the following:

1. Part A – Hospital insurance including inpatient care in hospitals, critical access hospitals, hospice care, skilled nursing facilities (not custodial or long-term care) and some home health care provided the beneficiaries meet the qualifying conditions.
2. Part B – Medical insurance including doctors' visits, outpatient care and medical expenses not covered by Part A such as partial services of physical and occupational therapists and home health care, when medically necessary.
3. Part D - Prescription Drug Coverage

Generally, the insured does not pay a premium for Part A but pays a premium for both Part B and Part D.

Administration and Funding of the Medicare Program

The Centers for Medicare & Medicaid Services (CMS), a branch of the Department of Health and Human Services (HHS) is the federal agency responsible for administering Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), Health Insurance Portability and Accountability Act of 1996 (HIPPA) and various other health-related programs.

Medicare is funded by the following earmarked resources held by the Federal government:

1. Hospital Insurance Trust Fund (Part A) – primarily funded by payroll taxes paid by employees, employers and those individuals who are self-insured and

2. Supplementary Medical Insurance Trust Fund (Part B and Part D) – primarily funded by funds authorized by Congress

Medicare Fraud and Abuse

Medicare fraud is typically characterized by:

1. Knowingly submitting false statements or making misrepresentations of fact to obtain a federal health care payment for which no entitlement would otherwise exist;
2. Knowingly soliciting, paying for, and /or accepting remuneration to induce or reward referrals or services reimbursed by Federal health care programs; or
3. Making prohibited referrals for certain designated health services.

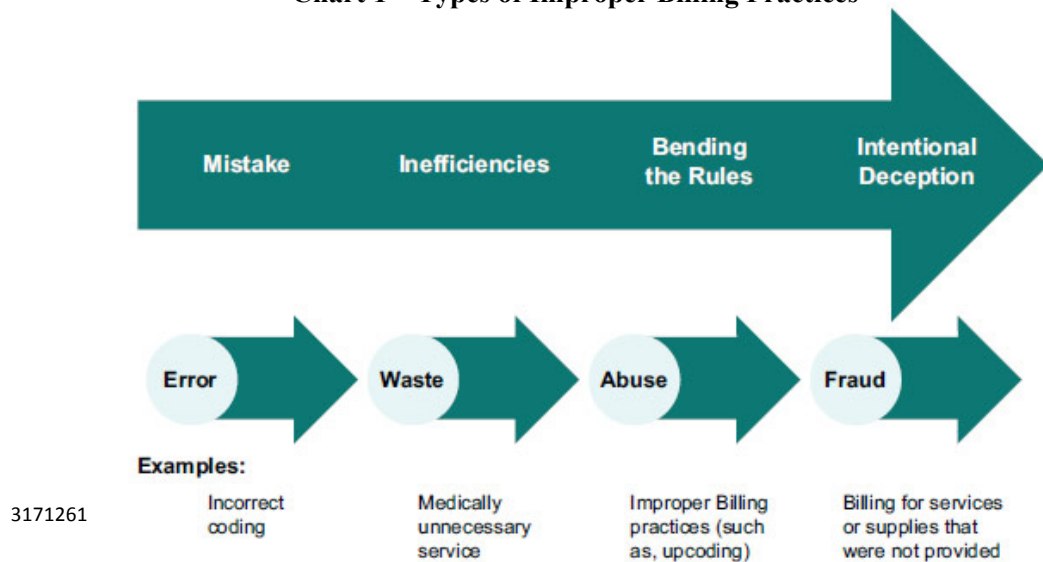
Medicare abuse describes practices that, either directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse includes any practice that is not consistent with the goals of providing patients with services that are medically necessary, meet professionally recognized standards, and are priced fairly.

Medicare fraud and/or abuse can result in, at a minimum, the government's offset and recoupment of ill-gotten payments and/or suspension of a provider from the program.

The difference between fraud and abuse is intent.

Chart 1 demonstrates the progression from error or mistake to fraud with respect to billing practices:

Chart 1 – Types of Improper Billing Practices



Medicare Fraud and Abuse Laws

Federal laws governing Medicare fraud and abuse include these set forth at **Chart 2**.

Chart 2 – Federal Laws Governing Medicare Fraud and Abuse

| Law | Civil/ Criminal | Code Section | Description |
|--|----------------------------|-------------------------|--|
| False Claims Act (FCA) | Criminal | 31 U.S.C. §§3729-33 | The FCA protects the government from being overcharged or sold substandard goods or services. The FCA imposes liability on any person who knowingly submits, or causes the submission of, a false or fraudulent claim to the Federal government. The “knowing” standard includes acting in deliberate ignorance or reckless disregard of the truth related to the claim. |
| Anti-Kickback Statute (AKS) | Criminal | 42 U.S.C. §1320a-7b | The AKS makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration directly or indirectly to induce or reward referrals of items or services reimbursable by a Federal health care program. |
| Physician Self-Referral Law (Stark Law) | Civil | 42 U.S.C. §1395nn | The Physician Self-Referral Law, often called the Stark Law, prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or member of his or her immediate family) has an ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies. |
| Criminal Health Care Fraud | Criminal | 18 U.S.C. §1347 | The Criminal Health Care Fraud Statute prohibits knowingly and willfully executing, or attempting to execute, a scheme or artifice in connection with the delivery of or payment for health care benefits, items, or services to: <ul style="list-style-type: none"> • Defraud any health care benefit program; or • Obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. |

Preventing Fraud and Abuse – Best Practices

1. A provider should seek to ensure that the claims submitted are for services that were:
 - a. Rendered,
 - b. Medically necessary and not excessive,
 - c. Billed with the correct diagnoses and procedures and re not up-coded, and
 - d. Not otherwise included in a global billing fee (un-bundled).
2. Patient records should be well documented by all treating medical professionals and reviewed by the Medical Director in order to justify the entire patient history with respect to the inpatient or outpatient visit including, but not limited to, procedures, tests, medications and length of stay.
3. Providers should maintain a compliance program including:
 - a. Internal monitoring and auditing;
 - b. Implementation of written standards and procedures;
 - c. A compliance officer;
 - d. Conducting training and education on standards and procedures; and
 - e. Responding promptly and appropriately to detected violations.
4. Additional guidance may be found in the Medicare Program Integrity Manual
<https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms019033.html>

References:

1. Centers For Medicare and Medicaid Services (CMS). (September 2015). Health Care Fraud and Program Integrity: An Overview for Providers. <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/fwa-overview-booklet.pdf>
2. CMS. (August 2014). Medicare Fraud & Abuse - Prevention, Detection and Reporting. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Fraud_and_Abuse.pdf
3. CMS. Medicare Program Integrity Manual. <https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms019033.html>
4. Medicare Program – General Information. <https://www.cms.gov/medicare/medicare-general-Information/medicareGenInfo/index.html>
5. Medicare.gov – The Official U.S. Government Site for Medicare. <https://www.medicare.gov/>

Introduction

The sale or transfer of an institution with significant Medicare or Medicaid liabilities can present a variety of obstacles. This is particularly true in the context of an insolvency proceeding or when fraud may be suspected. Regulators are likely to object or assert rights to certain aspects of a sale, including but not limited to the impact of the automatic stay on regulatory exercises, the assumption of provider agreements, whether certain obligations are released pursuant to a sale under Section 363 of the Bankruptcy Code and what interests and obligations a debtor can sell its assets free and clear of in a sale under Section 363 of the Bankruptcy Code (e.g., recoupment rights).

This brief article examines three decisions issued in the last twelve months that analyze these issues in connection with chapter 11 healthcare restructurings. The decisions present a mixed bag in terms of the battle between the Debtor armed with the automatic stay and the regulators armed with the power to tax, license and recoup. In In re Bayou Shores SNF, LLC, the Bankruptcy Court and District Court reached opposite conclusions on whether a debtor healthcare provider could assume a provider agreement that is in the process of being terminated by the Centers for Medicare and Medicaid Services (“CMS”) for bad behavior. That case is currently on appeal to the United States Court of Appeals for the Eleventh Circuit. In Ind. Family & Soc. Servs. Admin. v. St. Catherine Hosp. of Ind., LLC, the U.S. Court of Appeals for the Seventh Circuit prohibited a state regulatory body’s attempt to recoup a “fee” that was retroactively levied on a hospital and involuntarily collected both pre and post-petition through the withholding of subsequent Medicaid payments. Finally, in In re Skyline Manor, Inc., the court supported a state agency’s recapture of certain depreciation obligations in connection with a sale under section 363 of the Bankruptcy Code.

Assumption of Provider Agreements

Fla. Agency for Health Care Admin v. Bayou Shores SNF, LLC (In re Bayou Shores SNF, LLC), 2015 U.S. Dist. LEXIS 83390 (M.D. Fla. 2015)

Background

Bayou Shores SNF, LLC (“Bayou Shores”) owned and operated a psychiatric nursing facility that derived over 90% of its revenues from Medicaid or Medicare reimbursements. Between February and July of 2014, CMS cited Bayou Shores for three infractions: first, in February of 2014, relating to recordkeeping with respect to “Do Not Resuscitate Orders;” the second, in March of 2014, relating to admissions procedures (accepting a patient with a history of sexual exploitation/abuse and placing him with another patient); and the third, in July of 2014, relating to facility security (permitting a patient to leave the facility without authorization).

Bayou Shores immediately took steps cure the first two deficiencies. On May 29, 2014, after the recordkeeping and admissions incidents, CMS notified Bayou Shores that the deficiencies had been remedied and, as of May 13, 2014, Bayou Shores was in substantial compliance with CMS’ guidelines. However, following the security incident, and even though Bayou Shores had immediately implemented a new system to rectify the problem and presented CMS with a list of its remedial actions, CMS opted, without reviewing Bayou Shores’ curative measures with respect to this matter, to terminate Bayou Shores’ Medicare provider agreement. On July 22, 2014, CMS notified Bayou Shores that the termination of Bayou Shores’ Medicare and Medicaid provider agreements would be effective as of August 3, 2014.

Bayou Shores sought an expedited appeal of the termination of its Medicare provider agreement. The elimination of Bayou Shores’ Medicare and Medicaid revenues would close the facility and force Bayou Shores to evict its patients. On August 1, 2014, the District Court

granted an ex parte temporary restraining order enjoining CMS from terminating the agreement. The United States Department of Health and Human Services (“HHS”) opposed the injunction on the basis that Bayou Shores had not exhausted all of its administrative remedies and therefore, due to Medicaid’s jurisdictional bar under 42 U.S.C. § 405, the District Court had no subject matter jurisdiction to consider the dispute. The District Court agreed with HHS and dissolved the injunction.

Immediately after the injunction was lifted, Bayou Shores filed for chapter 11 protection. The Bankruptcy Court granted a stay of the termination of the Medicare provider agreement, finding that the agreement was property of the debtor’s estate. Bayou Shores then proposed a reorganization plan that relied primarily on the assumption of the Medicare and Medicaid provider agreements and the availability of the related reimbursements for future revenue. HHS objected to the plan, arguing that it was unfeasible due to the pending termination of the provider agreements, and also objected to Bayou Shores’ assumption of the agreements.

Bankruptcy Court Decision

In In re Bayou Shores SNF, LLC, 525 B.R. 160 (Bankr. M.D. Fla. 2014), HHS challenged the Bankruptcy Court’s jurisdiction over the assumption of the Medicare provider agreements. HHS contended that until the issue of whether the provider agreements were properly terminated was decided by a final administrative decision, Bayou Shores could not use the Bankruptcy Court to challenge the termination of its Medicare agreement through the assumption process. The Bankruptcy Court disagreed and found that it had jurisdiction under 28 U.S.C. § 1334, which provides for jurisdiction over all civil proceedings either arising under, in a case under, or related to a proceeding under the Bankruptcy Code.

The Bankruptcy Court also determined that although executory contracts may not be assumed if they were terminated prepetition, “for a prepetition termination of contract to cut off a debtor’s rights under § 365, the termination must be complete and not subject to reversal.”¹ Even though HHS contended that the agreement had terminated on August 3, 2014, the Bankruptcy Court found that because Bayou Shores had the option to appeal the termination, the termination was not final. Consequently, the Court held that the provider agreement could be assumed as long as Bayou Shores could comply with the provisions of § 365(b) of the Bankruptcy Code and prove that it was able to cure any defaults promptly and assure future performance of the contract’s terms.

HHS also argued “at least implicitly”² that Medicare provider agreements are not subject to assumption under section 365 of the Bankruptcy Code. The Bankruptcy Court rejected this argument, noting that the issue had been decided 20 years ago by the Third Circuit Court of Appeals when it determined that Congress failed to “legislate special treatment for the assumption or rejection of Medicare provider agreements[,] indicat[ing] that assumption of these agreements . . . should be deemed subject to the requirements of section 365.”³

The Bankruptcy Court also determined that Bayou Shores’ plan was feasible despite clear statements by the Agency for Healthcare Administration (“AHCA”) that it intended to revoke, or deny the renewal of, Bayou Shores’ nursing home license. AHCA’s grounds for termination of the license included (1) the fact that the debtor’s Medicare provider agreement had been terminated by CMS, and (2) the three infractions committed by Bayou Shores. The Court quickly rejected AHCA’s first argument, noting that because the Bankruptcy Court had stayed the termination of the Medicare provider agreement, AHCA was collaterally estopped from

¹ *In re Bayou Shores SNF, LLC*, 525 B.R. 160, 169 (Bankr. M.D. Fla. 2014).

² *Id.*

³ *Id.*, at 169-70, quoting *In re University Medical Center*, 973 F.2d 1065, 1077 (3d Cir. 1992).

revoking Bayou Shores' Medicaid provider agreement on the grounds that CMS had terminated the agreement.

With respect to the infractions that Bayou Shores had committed, the Bankruptcy Court found that they were isolated incidents and that Bayou Shores had been operating in substantial compliance with CMS' regulations for the past several months. The Court also acknowledged that "perhaps most importantly, the Debtor's facility serves a particularly needy population . . . that may have trouble finding another skilled nursing facility."⁴ Given these mitigating circumstances and the right of a healthcare provider under Florida statutes to present mitigating factors that weigh against revocation or nonrenewal of its license, the Bankruptcy Court determined that AHCA's stated intention to revoke or deny renewal of the debtor's license did not necessarily mean that the license would certainly be terminated.

AHCA also argued that the revocation could not be stayed because it constituted an exercise of the state's police or regulatory powers, which made AHCA's actions exempt from the automatic stay under section 362(b)(4) of the Bankruptcy Code. The Bankruptcy Court agreed that AHCA's refusal to renew or intent to revoke Bayou Shores' license was an attempt to protect the public safety and welfare (and thus AHCA's attempt to close the facility was exempt from the automatic stay); however, the Bankruptcy Court still proceeded to confirm the plan because revocation of the debtor's license was uncertain for the reasons described above. Accordingly the Bankruptcy Court entered an order confirming Bayou Shores' chapter 11 plan.

⁴ *Id.*, at 173.

District Court Decision

On appeal to the U.S. District Court for the Middle District of Florida, AHCA and the United States argued that 42 U.S.C. § 405(h) prohibited the Bankruptcy Court from ruling on the termination of Bayou Shores' provider agreements before Bayou Shores exhausted all administrative remedies.

The District Court concluded that the Bankruptcy Court exceeded its subject matter jurisdiction when it interfered with CMS' termination of the provider agreements. The jurisdictional bar in 42 U.S.C. § 405(h) limited court review only to the procedures found "herein," and therefore, "with respect to a Medicare dispute, the judicial review provision at [42 U.S.C.] section 405(g) is the 'exclusive source of federal court jurisdiction.'"⁵ Accordingly, in Medicare disputes, courts are only permitted to review a final decision by HHS after the affected party has exhausted all of its administrative remedies.

Noting that the U.S. Court of Appeals for the Eleventh Circuit had not ruled on this issue before, the District Court elected to follow the majority view on the issue. The District Court cited the Seventh and Eighth Circuits, which had previously found that the omission of section 1334 from the jurisdictional bar language of 405(h) (which only explicitly precludes jurisdiction under sections 1331 or 1346 of Title 28) was not meant to permit courts to exercise subject matter jurisdiction under sections that were not explicitly prohibited – any other conclusion would contradict the Congressional intent found in the relevant legislative history. As a result, the jurisdictional bar of 42 U.S.C. § 405(h) precluded the Bankruptcy Court's subject matter jurisdiction under 28 U.S.C. § 1334.

⁵ Fla. Agency for Health Care Admin v. Bayou Shores SNF, LLC (In re Bayou Shores SNF, LLC), 2015 U.S. Dist. LEXIS 83390 *13 (M.D. Fla. 2015) (citing *Jackson v. Astrue*, 506 F.3d 1349, 1353 (11th Cir. 2007)).

Based on this analysis, the District Court ultimately concluded that the Bankruptcy Court did not have subject matter jurisdiction either to enjoin the termination of the provider agreements or to permit Bayou Shores to assume those agreements.

Post-Trial

On September 2, 2015, Bayou Shores appealed the District Court's decision to the U.S. Court of Appeals for the Eleventh Circuit. A decision by the Eleventh Circuit may provide clarity with respect to whether the Bankruptcy Code's automatic stay will protect medical providers from a pending termination of their Medicare and Medicaid provider agreements.

Recoupment

St. Catherine Hosp. of Ind. v. Ind. Family & Soc. Servs. Admin., 2015 U.S. App. LEXIS 15211 (7th Cir. 2015)

Background and Bankruptcy Court Decision

Saint Catherine is a general acute care facility, the majority of whose patients are insured through Medicare and Medicaid, located in Charlestown, Indiana. Indiana Family and Social Services Administration ("FSSA") administers the state Medicaid program. Indiana imposed a one-time fee, the Hospital Assessment Fee ("HAF"), that was retroactively levied on Indiana hospitals to increase the funds available for future Medicaid reimbursements. The HAF for each hospital was based on their cost reports and other financial information from 2010-2012. The fee, which was assessed beginning July 1, 2011, was payable in two installments in 2012 and 2013.

After determining that St. Catherine owed an HAF of approximately \$1.1 million for the 2012 fiscal year (from July 1, 2011 to June 30, 2012), FSSA withheld Medicaid reimbursements otherwise owed to St. Catherine to "recoup" the fee. On June 5th and 12th of 2012, FSSA

withheld a total of \$615,912.64 from St. Catherine's reimbursements. St. Catherine filed for chapter 11 protection on June 19, 2012. FSSA continued to withhold Medicaid payments that otherwise were to be paid after the commencement of St. Catherine's chapter 11 case. In 2012, FSSA withheld an additional \$159,053.24 and, in 2013 FSSA further withheld an additional \$989,738.78 in satisfaction of St. Catherine's 2013 fiscal year HAF, which was also determined to be approximately \$1.1 million.

On March 14, 2013, St. Catherine commenced an adversary proceeding against FSSA seeking (1) an injunction against FSSA's further self-help collection of the HAF through the withholding of reimbursements, and (2) to recover the amounts "recouped" by FSSA pre- and post-petition in satisfaction of the HAF. On March 14, 2013, the Bankruptcy Court issued an injunction prohibiting FSSA from continuing to withhold reimbursements to St. Catherine. And, on September 19, 2013, the Bankruptcy Court granted St. Catherine summary judgment, ruling that FSSA was required to disgorge the pre- and post-petition withholdings it had retained as payment of St. Catherine's HAF. The Court found that the pre-petition withholdings were preference payments and the post-petition withholdings were acts to collect, assess, or recover a claim against the debtor that arose before the commencement of the case.

District Court Decision

The District Court affirmed, in part, and reversed, in part, the Bankruptcy Court's decision.

The District court upheld the Bankruptcy Court's determination that the pre-petition withholding by FSSA of reimbursements against HAF obligations was a preference and it rejected FSSA's ordinary course defense. To qualify as an ordinary course payment, transactions must be of a recurring nature, and the HAF was (from the view of St. Catherine) a

two-time obligation that “significantly upset the hospital’s week-to-week finances.”⁶ Furthermore, the District Court found that the HAF represented a tax, distinct from payments between St. Catherine and FSSA for Medicaid payments and reimbursements. Therefore the HAF must be viewed “as a form of debt whose bankruptcy implications may differ from the law’s typical treatment of a hospital’s Medicaid obligations.”⁷ Having found that the obligation was a tax, the Court ruled that it would not fit within the ordinary course of business exception.

The District Court reversed the Bankruptcy Court’s holding regarding the post-petition withholdings for the 2013 HAF. Here, the District Court held that the withholdings for the 2013 HAF were payments on account of a post-petition debt. Acknowledging that the Seventh Circuit had not yet taken a definitive position on the issue of when a claim arises, the District Court followed the majority rule (i.e., the “conduct test”) that “a claim arises when the conduct giving rise to it occurs.”⁸ Although the Bankruptcy Court concluded that the HAF was a pre-petition claim because the HAF was based on St. Catherine’s pre-petition hospital cost reports, the District Court disagreed and found that the HAF was analogous to a tax that was assessed annually and “triggered by a hospital’s eligibility at the beginning of a given assessment period . . . [and] if St. Catherine had ceased to be an eligible acute care hospital before July 1, 2012, then it would have no liability for the fiscal year 2013 HAF.”⁹ Because the trigger occurred post-petition, the District Court determined that the withholdings for the 2013 HAF were for payments on account of a post-petition debt that was not subject to the protections of the automatic stay.

⁶ Ind. Family & Soc. Servs. Admin. v. St. Catherine Hosp. of Ind., LLC (In re St. Catherine Hosp. of Ind. LLC), 511 B.R. 117, 124 (S.D. Ind. 2014).

⁷ Id. at 123.

⁸ Id. at 125.

⁹ Id. at 126.

Finally, the District Court agreed with the Bankruptcy Court's conclusion that the recoupment doctrine did not apply to the post-petition withholdings on account of the 2012 HAF. Recoupments only apply where "the claims . . . arise from a single contract or transaction . . . [and] there [is] some type of 'overpayment.'"¹⁰ Because the District Court had determined that the HAF was akin to a tax, the HAF could not be deemed to have arisen from the same contract or transaction as Medicaid payments from the FSSA. Although the Seventh Circuit had previously permitted a state agency to recoup post-petition Medicaid overpayments out of subsequent Medicaid reimbursements to a hospital, "recouping an unrelated *tax* debt by withholding portions of Medicaid reimbursements was a different matter."¹¹

Circuit Court Decision

On appeal to the United States Court of Appeals for the Seventh Circuit, the Court first addressed the issue of when the claim arose.

The Court noted that because the authorizing statute provided for only one "fee period," the HAF did not consist of two separate liabilities, but rather one liability payable in two installments. In addition, because the enactment of the legislation authorizing the HAF occurred pre-petition and the calculation of the HAF was done pre-petition (and based on cost reports and financial statements prepared prior to St. Catherine's filing), the Court concluded that the conduct which gave rise to the claim occurred pre-petition.

The Circuit Court disagreed with the District Court's reasoning that the claim was related to post-petition conduct because St. Catherine's liability under the HAF was based on its continued post-petition operation. Instead, the Circuit Court determined that although the HAF

¹⁰ *Id.*, at 127 (quoting *In re CDM Mgmt. Servs., Inc.*, 226 B.R. 195, 197 (Bankr. S.D. Ind. 1997)).

¹¹ *Id.* (citing *In re Doctors Hospital of Hyde Park, Inc.*, 337 F.3d 951, 954-55 (7th Cir. 2003)) (emphasis in original).

was contingent on St. Catherine's eligible operation, this did not alter the existence of the underlying claim or the date on which the claim arose.

Based on the above analysis, the Circuit Court concluded that the entire amount of the HAF constituted a pre-petition claim that was subject to the protections of the automatic stay. The Court concluded by stating that "finding that a claim arose 'at the earliest point possible' will best serve the policy goals underlying the bankruptcy process."¹²

In re Skyline Manor, Inc., 2014 Bankr. LEXIS 5057 (Bankr. D. Neb. Dec. 17, 2014)

Background

Skyline Manor, Inc. ("Skyline") operated an Omaha retirement community that included a nursing facility. The Nebraska Department of Health & Human Services ("DHHS") governs the nursing facility's ability to function as a licensed health care facility and Medicaid provider. Under DHHS' regulations, depreciation is an allowable fixed cost in the per diem rate calculations for healthcare facilities. However, if an eligible nursing facility is sold for a profit, DHHS is permitted to recapture a portion of that facility's earlier Medicare payments.

Skyline's trustee proposed a sale of the nursing facility to Menomonee Health Holdings LLC ("Menomonee") and DHHS objected, arguing that the sale would require Skyline to pay DHHS approximately \$373,000 in recaptured depreciation costs and the assets could not be sold free and clear of this obligation. More specifically, DHHS argued that (1) its right to recapture depreciation was not an interest in the property to be sold and therefore could not be cleared from the property in a sale under section 363 of the Bankruptcy Code; and, in the alternative, (2) if the depreciation was not recaptured, Menomonee would be required to assume a lower cost basis upon acquiring the nursing facility, thus reducing its depreciation allowance in the future.

¹² Id., at *13 (citing Matter of Chicago, 974 F.2d at 781).

The trustee intended to reject the provider agreement and classify the amount owed for depreciation recapture as a general unsecured claim. DHHS refused to enter into a new provider agreement with Menomonee unless Menomonee agreed to assume liability for any unpaid amounts owed to DHHS, which would obligate Menomonee to pay the \$373,000 in depreciation recapture. The sale agreement between the trustee and Menomonee provided for a \$500,000 escrow in an indemnification fund to pay certain liabilities, including DHHS' depreciation recapture claim. Any funds remaining in the escrow account a year after the close of the sale would revert to the trustee for distribution to creditors. Accordingly, the trustee argued that DHHS' insistence on being compensated by Menomonee would ultimately harm the debtor's creditors.

Discussion

With respect to whether DHHS' depreciation recapture right was an "interest" in the property, the Bankruptcy Court cited WBQ P'ship v. Virginia Dep't of Med. Assistance Servs. (In re WBQ P'ship), 189 B.R. 97 (Bankr. E.D. Va. 1995), which had concluded in a similar case that a state agency's right to recapture depreciation was an interest in property because the state could be compelled to accept a monetary satisfaction of the interest under section 363(f)(5) of the Bankruptcy Code. Additionally, the court in WBQ P'ship determined that to the extent state law sought to impose any successor liability on the property, state law was preempted by section 363(f) of the Bankruptcy Code, which authorizes the sale of estate property free and clear of liens and encumbrances. Persuaded by this reasoning, the Skyline Bankruptcy Court found that DHHS' interest in recapturing depreciation was an "interest" in the facility as contemplated by section 363(f)(5) of the Bankruptcy Code.

The Bankruptcy Court, however, also criticized the trustee for taking two inconsistent provisions by arguing that (1) DHHS' recapture right was an interest in property that could be expunged from the sold property, and (2) DHHS' recapture right under state law arose from the trustee's rejection of its Medicaid provider agreement, which should result in an unsecured pre-petition claim.

The Bankruptcy Court ultimately concluded that because DHHS' depreciation claim was an interest in the nursing facility as contemplated by section 363(f)(5) of the Bankruptcy Code, the trustee was authorized to sell the facility free and clear of DHHS' recapture rights if the trustee also provided DHHS with a monetary satisfaction of its interest. Accordingly, DHHS was entitled to collect its depreciation recapture from the indemnification fund contemplated by the sale agreement between the trustee and Menomonee, and this monetary satisfaction of DHHS' interest permitted the trustee to sell the nursing facility free and clear of DHHS' recapture rights.