Fuse, Sever and Heal: Issues Impacting Health Care Facilities in Bankruptcy

Presented by the Health Care and Real Estate Committees

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FUSE, SEVER AND HEAL:
ISSUES IMPACTING HEALTHCARE FACILITIES IN BANKRUPTCY

American Bankruptcy Institute
Winter Leadership Conference

December 3, 2016

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Deriving Maximum Value in Healthcare Insolvences: The separation of bed licenses from real estate

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A. Introduction

Nursing facility and assisted living bankruptcies often include assets across numerous states. Although the Bankruptcy Code creates useful uniformity in dealing with multijurisdictional assets, including Medicaid and Medicare receivables, the local jurisdiction in which licenses are issued and operated for each facility may have vastly different procedures for everything from involved they want to be in the bankruptcy, to the procedures for transferring nursing bed licenses to new providers. Healthcare providers operate under unique regulatory schemes and it is critical to a successful bankruptcy filing that the parties sort through the applicable state laws and regulations for all facilities, and have an open dialogue with the relevant contacts well in advance of any filing, when possible.

B. Nursing Bed Licenses and Certificates of Need

Bed licenses, and in many states, Certificates of Need ("CONs") represent the primary units upon which assisted living and nursing home providers are able to operate and derive income. Often, the best option for maximizing value is to separate and separately transfer a healthcare provider's real estate from its licenses.

Although a healthcare provider cannot lose its licenses solely as a result of a bankruptcy filing, the ability of a debtor to reorganize or sell its assets will often implicate a "Change of Ownership" or "CHOW." It is not enough for a Bankruptcy Court to approve a CHOW or transfer of licenses in an order; rather, a CHOW will be subject to jurisdictional licensure and CON filings and approvals, and it is critical to confirm those requirements with the appropriate state regulators. Additionally, in many jurisdictions, licenses, CONs (or one or the other) are not transferable. Thus, if parties know early on that the value of the assets can be maximized by separating the licenses from the real estate, it is critical to begin the marketing process several months in advance of the bankruptcy filing to ensure buyers will qualify under applicable state regulations as transferees of bed licenses.

The question of separating bed rights from real estate is further complicated in cases where the real estate is leased by the bankrupt nursing facility operator. In several cases, federal courts have found, by relying upon the underlying state regulatory scheme, that although a bankrupt nursing facility may own the license to operate, the CONs and bed rights are not part of the bankruptcy estate.

In *Berkowitz v. Stratford Nursing & Convalescent Center (In re Stratford Nursing & Convalescent Center),* 2009 Bankr. LEXIS 2990 (Bankr. D.N.J., Sept. 11, 2009), the debtor, a nursing and convalescent center, sought to sell its license to operate 104 nursing beds through a Section 363 sale. The owner of the leased real estate objected to the sale. The Bankruptcy Court found that there was a distinction between the ownership of the license, and the ownership of accompanying bed rights, and that the debtor could not sell the bed rights as they were inseparable from the real estate, which the debtor did not own.

In *Rutherford Hospital, Inc. v. RNH Pshp.*, 168 F.3d 693 (4th Cir. 1999), the Fourth Circuit Court of Appeals considered the legal effect of a bankruptcy court-approved sale of a skilled nursing center operator's interest in four nursing homes. One of the nursing homes, the Rutherford Nursing Center, was identified in the sale motion as a 150-bed facility leased by the debtor. The successful bidder, Rutherford Hospital, Inc., entered into a sale agreement with the debtor that purported to convey three things:

- The lease from RNH Partnership to the debtor for the nursing facility and surrounding land;
- The lease from RNH Partnership to the debtor for related personal property; and
- All right, title and interest in the Certificate of Need issued by the North Carolina Department of Human Resources, including the license and approval for all beds for the Rutherford Nursing Center.

After a dispute arose regarding the transferability of the CONs, Rutherford Hospital filed a declaratory judgment action, seeking a determination that Rutherford Hospital ownsw the CONs, free and clear of any interest by RNH. The Fourth Circuit upheld the District Court's ruling that because the facility at issue was grandfathered into North Carolina's CON law, no CON was ever issued, and thus, upon the expiration of the underlying leases, Rutherford Hospital would have no rights to own or operate the nursing facility or beds.

In *In re Ravenwood Healthcare*, Bankruptcy Case No. 12-10612, M.D. Louisiana, the Debtor sold substantially all of its assets to its DIP Lender, Naples Lending Group, LLC ("Naples"), pursuant to a Section 363 sale. In that case, the 165-bed nursing facility, Harborside Nursing and Rehabilitation Center, had ceased to operate shortly after the bankruptcy was filed. The Debtor owned both the real estate and the underlying bed rights. Prior to making the DIP loan, Naples confirmed that the bed rights were being maintained, notwithstanding that the facility had ceased operating, and further confirmed that if it ultimately became the owner of the bed rights, Naples would be permitted to use or transfer the bed rights to relicense beds at the facility, subject to state approval. Because Naples performed sufficient due diligence before making the DIP Loan and was in constant communication with the Maryland Office of Health Care Quality, it was able to ultimately credit bid for the assets, split the licenses from the real estate, and sell the bed rights to a third party.

Practical Considerations

1. Know the regulatory frame work for each jurisdiction in which assets are located before you formulate a strategy, as the state specific requirements and laws may largely inform what you can, and cannot do.

2. Reach out to the appropriate regulators and attorney generals for each jurisdiction as soon as practicable to build trust, discuss timing and the process if you envision a CHOW.

3. Engage investment bankers who specialize in marketing bed licenses, with experience in the relevant jurisdiction.

4. Ask the appropriate state regulators and departments for input into proposed sale language before filing.

4835-8731-0651, v. 1

UNITED STATES BANKRUPTCY COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION
www.flmb.uscourts.gov

In re:

Bayou Shores SNF, LLC,

Debtor.
_____/

Case No. 8:14-bk-09521-MGW
Chapter 11

MEMORANDUM OPINION
AND ORDER ON CONFIRMATION

The Court can only confirm a debtor's proposed plan if it is feasible. Here, the Debtor, which operates a skilled nursing facility that derives 90% of its revenue from Medicare and Medicaid patients, has proposed a chapter 11 plan that is funded from its continuing operations. All of the creditors in the case have voted in favor of the plan. But the United States Department of Health & Human Services ("HHS") has objected that the plan is not feasible because it says the Debtor's Medicare provider agreement was terminated prepetition, and as a consequence, so was its Medicaid provider agreement. This Court must now decide whether the Debtor's plan is feasible.

The Court concludes the plan is feasible because the Debtor has the right to assume the Medicare provider agreement under Bankruptcy Code § 365. Although HHS, through the Center for Medicare & Medicaid Services ("CMS"),[1] gave the Debtor notice it was terminating its Medicare provider agreement prepetition, that termination was not complete and irreversible until the appeals process was complete. And the appeals process was not completed prepetition. For that reason, the Medicare provider agreement can be assumed under Bankruptcy Code § 365, which means the Debtor's Medicaid provider agreement does not terminate as a matter of law.

[1] CMS is the operating component of HHS charged with administering the Medicare and Medicaid programs.

Because the Debtor's Medicare and Medicaid provider agreements remain in effect, the Court concludes the Debtor's plan is feasible and should be confirmed.

Background

The Debtor cares for patients with severe psychiatric conditions

The Debtor owns and operates a 159-bed skilled nursing facility known as the Rehabilitation Center in St. Petersburg, Florida.[2] The Debtor currently has 109 patients, most of whom have Alzheimer's, dementia, or other serious psychiatric conditions.[3] The Debtor is one of the few facilities—if not the only one—in the area that is capable of meeting the needs of patients with challenging psychiatric needs.[4]

The Debtor relies on Medicare and Medicaid revenue

All but a handful of the Debtor's patients are on Medicaid or Medicare. Medicare, of course, is a federal program that provides payment for skilled nursing services for aged or disabled individuals. Similarly, Medicaid is a joint federal and state program that provides medical assistance to low-income individuals who are disabled. Over 90% of the Debtor's revenue is derived from Medicare and Medicaid.[5]

CMS and AHCA conduct surveys to ensure providers are complying with the Medicare and Medicaid program requirements

To receive payment under the Medicare and Medicaid programs, a skilled nursing facility such as the Debtor must comply with the requirements set forth in 42 C.F.R. Part 483, Subpart B. Skilled nursing facilities like the Debtor are subject to standard, special, and other surveys by the

[2] Doc. No. 250 at ¶ 4; Doc. No. 266 at ¶ 4.

[3] Doc. No. 250 at ¶ 4; Ex. 20 at 33-34 & 38.

[4] Ex. 20 at 29.

[5] Doc. No. 250 at 2 n.1; Doc. No. 266 at 2 n.1.

State or CMS—depending on whether the facility participates in one or both programs—to certify they are in compliance with applicable federal law.[6] If a skilled nursing facility is certified to be in noncompliance, then CMS may terminate any Medicare provider agreements that are in effect at the time or apply alternative remedies instead of—or in addition to—termination.[7]

In determining which remedies to apply, CMS must determine the seriousness of the deficiency that has caused the facility to be noncompliant.[8] The seriousness of a deficiency generally ranges from "no actual harm with a potential for minimal harm" to "immediate jeopardy to resident health or safety."[9] "Immediate jeopardy" means "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident."[10] Regardless of which remedies CMS decides to apply, a skilled nursing facility must complete a "plan of correction" that describes the actions the facility will take to correct any cited deficiencies and the date by which the deficiencies will be corrected.[11]

The Debtor is cited for three deficiencies

Between February 2014 and July 2014, the Debtor was cited for deficiencies—and determined to be in noncompliance—three separate times.[12] The first deficiency had to do with

[6] 42 C.F.R. § 488.308.

[7] 42 C.F.R. § 488.330(b)(2).

[8] 42 C.F.R. § 488.404(a). The possible remedies (instead of or in addition to termination of the provider agreement) include: temporary management, denial of payment, civil monetary penalties, state monitoring, transfer of residents, closure of the facility, and directed plan of correction. 42 C.F.R. § 488.406(a).

[9] 42 C.F.R. § 488.404(b).

[10] *Id.*

[11] 42 C.F.R. § 488.408(f).

[12] Ex. 20 at 19-28.

recordkeeping. A February 2014 survey revealed that, as a result of the facility's transition to electronic medical records, some of the residents' files contained conflicting entries with respect to "Do No Resuscitate Orders."[13] The second deficiency had to do with admissions procedures. In March 2014, an individual with a history of sexual exploitation or abuse was admitted to the Debtor's facility.[14] Staff members, however, failed to identify this threat and placed him in a room with another resident.[15] Fortunately, the patient with the history of abuse—who was in the facility for less than 24 hours—did not touch or otherwise harm the other resident. The third deficiency had to do with facility security. In July 2014, a resident on the Debtor's second-floor secure unit left the facility with visitors and was found unharmed on a nearby street corner fifteen minutes later.[16] Although no resident was hurt in any of the three incidents, the Debtor was nevertheless cited for "immediate jeopardy" on each occasion.[17]

The Debtor is brought back into substantial compliance after the first two deficiencies

The Debtor immediately cured the first two deficiencies.[18] In the case of the "Do Not Resuscitate" orders, the Debtor made sure that the orders for each resident matched.[19] If a patient had a "Do Not Resuscitate Order," the facility made sure the physician order said the patient was not to be resuscitated.[20] As for the admissions procedures, the Debtor wrote a new set of policies

[13] *Id.* at 20-21.

[14] *Id.* at 21.

[15] *Id.* at 21-22.

[16] *Id.* at 24-25.

[17] *Id.* at 19-28.

[18] *Id.* at 20-23.

[19] *Id.* at 21.

[20] *Id.*

and procedures governing abuse of residents.[21] After the Debtor cured the first two deficiencies, CMS revisited the facility and determined the Debtor was in substantial compliance.[22] On May 29, 2014, CMS notified the Debtor it was in substantial compliance with the Medicare and Medicaid requirements as of May 13, 2014.[23]

The Debtor immediately cures the third deficiency

As with the first two deficiencies, the Debtor immediately cured the third deficiency. Specifically, the Debtor implemented an entirely new system for screening and assessing patients for potential elopement issues and changed the procedure for guests and patients to access the facility's secure unit.[24] The Debtor also took the additional step of hiring a third-party consultant—David Hoffman & Associates—to conduct an extensive review of the corrective measures the Debtor had taken and determine whether the Debtor had been brought back into substantial compliance.[25] On July 17, 2014, just one week after the survey that led to the third deficiency, the Debtor provided CMS with a detailed list of the steps it had taken to remove the "immediate jeopardy" and bring its facility back into substantial compliance.[26] Rather than revisit the facility to certify it was in substantial compliance, as is apparently customary where there is no actual harm to residents, CMS instead opted to terminate the Debtor's Medicare provider agreement.[27]

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[21] *Id.* at 22.

[22] *Id.* at 23.

[23] Ex. 2.

[24] Exs. 4 & 5; *see also* Ex. 20 at 23-24.

[25] Doc. No. 250 at ¶¶ 10-11; *see also* Ex. 20 at 25-27.

[26] Exhibit 4; *see also* Ex. 20 at 25. The Debtor had apparently implemented the corrective measures as of July 17, 2014. Hoffman then reviewed those corrective measures on July 29-30, 2014. Doc. No. 250 at ¶¶ 10-11.

[27] Ex. 20 at 27-28, 32 & 48-49; Doc. No. 250 at ¶ 12.

CMS terminates the Debtor's Medicare provider agreement

On July 22, 2014, CMS notified the Debtor that it was terminating the Debtor's Medicare provider agreement effective August 3, 2014, which would also result in termination of the Debtors' Medicaid provider agreement.[28] The Debtor appealed the termination of its Medicare provider agreement and requested an expedited hearing before an administrative law judge. The appeal of the decision to terminate the provider agreement, however, did not prevent CMS from denying payment to the Debtor, which would have set a catastrophic chain of events in motion: denial of payment would have caused the Debtor to default under its lease, default under its lease would have forced the Debtor to close its facility, closure of the facility would have forced the transfer of the Debtor's patients, many of whom would have had no place to go or would have potentially been harmed by the transfer.[29]

The district court temporarily enjoins CMS from terminating the Medicare provider agreement

So on August 1, 2014, two days before the Medicare provider agreement was terminated, the Debtor sought and obtained an ex parte temporary restraining order from district court that enjoined CMS from terminating the agreement through August 15, 2014.[30] HHS then moved to dissolve the temporary restraining order based on the district court's lack of subject-matter jurisdiction.[31] According to HHS, 42 U.S.C. § 405 mandates that the Debtor exhaust all of its administrative remedies before it can bring a claim under the Medicare statute in district court. In particular, 42 U.S.C. § 405(h) precluded the district court from (i) reviewing an agency decision

[28] Ex. 3.

[29] Exhibit 20 at 29-32.

[30] The Debtor filed an action in district court for the Middle District of Florida (Tampa Division) styled *Bayou Shores SNF, LLC v. Sylvia Mathews Burwell*, Case No. 8:14-cv-1849-T-33-MAP.

[31] Dist. Ct. Doc. No. 22.

before all administrative remedies were exhausted; or (ii) taking jurisdiction over a Medicare-related claim against the United States under 28 U.S.C. § 1331, which grants district courts original jurisdiction over all actions arising under the laws of the United States.[32] The district court agreed that it lacked subject-matter jurisdiction over the dispute because the Debtor had not exhausted its administrative remedies, and as a consequence, it dissolved its temporary restraining order on August 15, 2014.[33]

The Debtor files for bankruptcy

Mere hours after the district court dissolved the temporary restraining order, the Debtor filed this chapter 11 case. A week later, the Debtor sought a ruling from this Court that the automatic stay precluded termination of its Medicare provider agreement.[34] At the conclusion of a final evidentiary hearing on the Debtor's motion, this Court enjoined termination of the Medicare provider agreement pending completion of the administrative appeals process. Since then, the Debtor has fast-tracked this case to confirmation, proposing a plan within four months of filing this case.[35]

The Debtor's proposed plan enjoys the support of all of the creditors in the case, including a secured lender holding an $11 million claim and unsecured creditors holding more than $2 million in claims.[36] The plan also satisfies all of the requirements of Bankruptcy Code § 1129(a) with the exception of perhaps one: feasibility. HHS objects that confirmation is not feasible because the Debtor relies almost exclusively on Medicare and Medicaid for revenue, and

[32] *Id.*

[33] Dist. Ct. Doc. No. 35.

[34] Doc. No. 25.

[35] Doc. Nos. 185 & 186.

[36] Doc. No. 249-1.

those agreements have (or will be) terminated.[37] HHS also objects to the Debtor's attempt to assume the Medicare provider agreement based on its purported prepetition termination.[38] This Court must now determine whether the Debtor's proposed plan is feasible in light of that purported termination.

Conclusions of Law

The Court has jurisdiction over the parties' Medicare-related dispute

As a threshold matter, HHS contends that this Court lacks subject-matter jurisdiction over the parties' dispute. According to HHS, "no court has any jurisdiction over any aspect of a Medicare determination, other than to perform a prescribed form of judicial review of a final administrative decision by the Secretary."[39] Because of that, HHS reasons that the Debtor is precluded from raising any challenge to the termination of its Medicare provider agreement before this Court. HHS's argument, however, misses the mark.

It is true that federal courts are generally precluded from exercising federal question jurisdiction over Medicare issues.[40] The statute the district court relied on in dissolving the temporary restraining order—and the statute HHS presumably relies on here—says as much:

> The findings and decision of the Commissioner of Social Security after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Commissioner of Social Security shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Commissioner of Social

[37] HHS contends its Medicare provider agreement has already been terminated. And the parties generally agree that AHCA is obligated to terminate its Medicaid provider agreement once the Medicare provider agreement has been terminated. But there is some question whether termination of the Medicaid provider agreement occurs by operation of law or requires some other action by AHCA.

[38] Doc. Nos. 229 & 255.

[39] Doc. No. 277 at 2.

[40] 42 U.S.C. § 405(h).

> Security, 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.[41]

But this Court's jurisdiction is not based on 28 U.S.C. § 1331 or § 1346.

This Court has independent grounds for exercising jurisdiction: 28 U.S.C. § 1334. Under § 1334, this Court has jurisdiction over all civil proceedings arising under title 11, arising in a case under title 11, or related to a proceeding under title 11. This bankruptcy case, of course, arises under title 11.[42] Confirmation is a contested matter that arises in a case under title 11. And any dispute over the Debtor's ability to assume the Medicare provider agreement is "related to" this title 11 case since the outcome of that dispute could conceivably have an effect on the Debtor's bankruptcy estate.[43] Accordingly, this Court has subject matter jurisdiction over this case, confirmation, and the parties' dispute over whether the Debtor has the authority to assume its Medicare provider agreement under 28 U.S.C. § 1334(b).

In fact, the court in *First American Health Care of Georgia, Inc. v. HHS* recognized that bankruptcy courts have jurisdiction over some Medicare-related disputes under 28 U.S.C. § 1334.[44] In *First American*, the Debtor filed an adversary proceeding seeking turnover of certain periodic income payments it claimed it was entitled to under the Medicare program. HHS moved to dismiss the adversary proceeding because 42 U.S.C. § 405(h) expressly precluded federal

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[41] *Id.*

[42] Technically, the district court for this district has subject-matter jurisdiction over these proceedings. The district court is statutorily empowered to refer all of these proceedings to this Court, which it has done by a standing order of reference.

[43] A bankruptcy court has "related to" jurisdiction if the outcome of a proceeding could conceivably have an effect on the estate being administered. *Miller v. Kemira (In re Lemco Gypsum, Inc.)*, 910 F.2d 784, 788 (11th Cir. 1990) (adopting the test articulated in *Pacor, Inc. v. Higgins*, 743 F.2d 984, 994 (3d Cir. 1984)).

[44] 208 B.R. 985, 988 (Bankr. S.D. Ga. 1996). The Court later vacated its ruling based on a settlement agreement between the parties. *First Am. Health Care of Georgia, Inc. v. HHS*, 1996 WL 282149 (Bankr. S.D. Ga. 1996). But that does not change the bankruptcy court's analysis, which this Court finds persuasive.

courts from exercising federal question jurisdiction over Medicare claims.[45] In denying HHS's motion to dismiss, the *First American* court acknowledged that 42 U.S.C. § 405(h), as originally drafted, precluded bankruptcy jurisdiction over all Medicare disputes. But the Court correctly observed that Congress passed 28 U.S.C. § 1334 in 1984, which conferred bankruptcy jurisdiction on the district court, and nothing in 42 U.S.C. § 405(h) precludes a court from exercising bankruptcy jurisdiction over Medicare disputes under 28 U.S.C. § 1334.[46]

The Court is aware that some courts have held that omission of 28 U.S.C. § 1334 was essentially a scrivener's error.[47] Those courts begin by observing that 42 U.S.C. § 405(h) previously precluded federal courts from exercising all jurisdiction—including bankruptcy jurisdiction—over Medicare-related claims by prohibiting any action under "section 24 of the Judicial Code of the United States."[48] Section 24 previously contained virtually all of the jurisdictional grants to the district court, including bankruptcy jurisdiction.[49] In 1984, Congress replaced the reference to "section 24" with the phrase "section 1331 or 1346." Since the legislative history regarding that amendment provides the amendment was not to be "construed as changing or affecting any right, liability, status, or interpretation which existed" previously, some courts have ruled that Congress intended 42 U.S.C. § 405(h) to preclude the exercise of bankruptcy jurisdiction under 28 U.S.C. § 1334.[50]

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[45] *Id.* at 987.

[46] *Id.* at 988-89.

[47] *See, e.g., In re St. Johns Home Health Agency, Inc.*, 173 B.R. 238, 244 (Bankr. S.D. Fla. 1994).

[48] *Id.* at 244.

[49] *Id.*

[50] *Id.*

There is one problem with that view: This Court is not free to consider the legislative history of a statute when the statute's text is plain and unambiguous.[51] Here, the text of 42 U.S.C. § 405(h) is plain and unambiguous. It plainly provides that federal courts are precluded from exercising jurisdiction on only two bases: 28 U.S.C. §§ 1331 and 1346. Because 42 U.S.C. § 405(h), by its terms, does not preclude this Court from exercising jurisdiction under 28 U.S.C. § 1334, this Court has subject-matter jurisdiction.

The only plausible argument against this Court having subject-matter jurisdiction is the second sentence of 42 U.S.C. § 405(h), which limits the ability of federal courts to review the findings of fact or an agency decision. Of course, that is not what this Court is doing. HHS had made it plain throughout its various filings in this case that CMS's decision to terminate the Debtor's Medicare provider agreement—the central issue in this case—is not subject to appeal.[52] The only properly appealable issue is CMS's determination that the Debtor was in noncompliance with the Medicare program requirements. But this Court, as part of its executory contract analysis discussed below, assumes that the Debtor was, in fact, in noncompliance. Because this Court assumes the Debtor was in noncompliance, it is not reviewing any findings of fact or agency decision, and as a consequence, 42 U.S.C. § 405(h) does not preclude this Court from considering whether the Debtor can assume its Medicare provider agreement under Bankruptcy Code § 365.

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[51] *Circuit City Stores, Inc. v. Adams*, 532 U.S. 105, 118 (2001) (refusing to examine legislative history where the face of the statutory provision was unambiguous); *Garcia v. Vanguard Car Rental USA, Inc.*, 540 F.3d 1242, 1247 (11th Cir. 2008) (explaining that courts "may consult legislative history to elucidate a statute's ambiguous or vague terms, but legislative history cannot be used to contradict unambiguous statutory text or to read an ambiguity into a statute which is otherwise clear on its face"); *CBS Broad., Inc. v. EchoStar Commc'ns Corp.*, 265 F.3d 1193, 1213 (11th Cir. 2000) (explaining that "resort to legislative history is unnecessary, and indeed, improper, where the statute's terms are plain and unambiguous").

[52] Doc. No. 277 at 6.

The Debtor can assume the Medicare provider agreement

Under Bankruptcy Code § 365, a debtor may assume an executory contract. The Bankruptcy Code does not define "executory contract." In the absence of a definition, courts have generally followed two approaches to determining whether a contract is executory. Under the first approach, proposed by Professor Vern Countryman, a contract is executory if it is so far unperformed that the failure of either party to complete performance would constitute a material breach of the contract.[53] Under the second approach, aptly named the "functional approach," courts "abandon the traditional focus on the 'executoriness' of contracts in bankruptcy in favor of a more practical, functional approach."[54] Regardless of which test is applied, though, the majority of courts have concluded that Medicare provider agreements are executory contracts, a proposition HHS does not appear to dispute.[55] What would otherwise be an executory contract, however, cannot be assumed under Bankruptcy Code § 365 if the contract was terminated pre-petition because there is nothing left for the Debtor to assume.

The central issue in this bankruptcy case is whether the Debtor's Medicare provider agreement was terminated prepetition. According to HHS, the Medicare provider agreement was terminated on August 3, 2014—the date specified in HHS's July 22 notice. The Debtor, however, contends the agreement could not have been terminated prepetition because the right to terminate the agreement expired when the Debtor brought its facility back into substantial

[53] *Walton v. Clark & Washington, P.C.*, 454 B.R. 537, 543 (Bankr. M.D. Fla. 2011).

[54] Bankruptcy Law Manual § 9B:3 (5th ed. 2014); *see also Clark & Washington*, 454 B.R. at 543 (explaining that "[u]nder the functional approach, a court looks to the benefits a debtor and its estate would gain if a contract is assumed or rejected.").

[55] *In re University Med. Center*, 973 F.2d 1065, 1075 n.13 (3d Cir. 1992); *In re Monsour Med. Center*, 11 B.R. 1014, 1018 (W.D. Pa. 1981); *In re Vitalsigns Homecare, Inc.*, 396 B.R. 232, 239 (Bankr. D. Mass. 2008); *In re Heffernan Memorial Hosp. Dist.*, 192 B.R. 228, 231 (Bankr. S.D. Cal. 1996).

compliance, which was on July 18, 2014. The Court concludes the Debtor is correct (i.e., the Medicare provider agreement was not terminated) but for the wrong reason.

The Debtor relies on 42 C.F.R. § 488.454, entitled "Duration of Remedies," in support of its argument.[56] That regulation does provide that certain remedies HHS is entitled to invoke do expire when a revisit by CMS confirms that facility has been brought back into substantial compliance.[57] Expiration of certain remedies can even predate a revisit if the facility can supply HHS with acceptable documentation showing the facility was in substantial compliance at some point before the revisit survey.[58] But as HHS correctly points out, the regulation the Debtor relies on deals with "alternative remedies" other than termination.[59]

In the Court's view, the answer is much simpler. In order 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.[60] Here, the Debtor had a right to appeal termination of the provider agreement. While that appeal may be limited in scope, the fact remains that termination of the provider agreement is not complete—and is, in fact, subject to reversal—until the appeals process is complete. Because the appeals process was not complete before this case was filed, the contract was not "terminated" prepetition for purposes of § 365.

Concluding that a Medicare provider agreement is "terminated"—for purposes of § 365—before the appeals process is complete would lead to absurd results. Consider the

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[56] Doc. No. 278 at 18-21.

[57] 42 C.F.R. § 488.454(a)(1)-(2).

[58] 42 C.F.R. § 488.454(e).

[59] Doc. No. 277 at 2-4.

[60] *In re Fontainebleau Hotel Corp.*, 515 F.2d 913, 915 (5th Cir.1975); *see also Moody v. Amoco Oil Co.*, 734 F.2d 1200, 1212 (7th Cir. 1984); *In re Bricker*, 43 B.R. 344, 347 (Bankr. D. Ariz. 1984).

following hypothetical: a debtor that operates a skilled nursing facility has its Medicare provider agreement terminated because it was improperly cited for noncompliance. The debtor immediately appeals the finding of noncompliance. But because CMS stops payment for Medicare residents, the debtor is forced to file for bankruptcy. If the Court were to adopt HHS's view, the debtor in that hypothetical scenario could never assume its Medicare provider agreement since it is highly unlikely the appeals process will be complete before the debtor files for bankruptcy. The only way to preserve a debtor's right to appeal a finding of noncompliance is to consider a Medicare provider agreement terminated—for purposes of § 365—once the appeals process is complete.

Here, the appeals process was not complete prepetition. So termination of the Medicare provider agreement in this case was not complete and irreversible as of the petition date. For that reason, the Medicare provider agreement is subject to being assumed. The only remaining question is whether the Debtor satisfies the requirements for assuming the provider agreement under Bankruptcy Code § 365.

To assume an executory contract that is in default, a debtor must prove that it can promptly cure the default and provide adequate assurance of future performance.[61] Although HHS has challenged the Debtor's right to assume the Medicare provider agreement, it has made no effort to challenge the Debtor's contention that it has cured the existing default and provided adequate assurances of future performance, instead deciding to rely solely on its argument the agreement cannot be assumed because it was terminated prepetition.[62] HHS also appears to be arguing—at least implicitly—that the § 365 requirements do not apply to Medicare provider

[61] 11 U.S.C. § 365(b); *In re Chapin Revenue Cycle Mgmt.*, 343 B.R. 728, 730 (Bankr. M.D. Fla. 2006).

[62] Doc. No. 255.

agreements because a skilled nursing facility or other provider has no right to cure a deficiency. The Court is sympathetic to HHS's argument, but as the Third Circuit Court of Appeal recognized in *In re University Medical Center* over twenty years ago, "Congress' failure to legislate special treatment for the assumption or rejection of Medicare provider agreements indicates that assumption of these agreements, like that of other executory contracts, should be deemed subject to the requirements of section 365, unless and until Congress decides otherwise."[63]

Given the unrefuted evidence at confirmation, the Court easily concludes the Debtor has satisfied the requirements for assuming the Medicare provider agreement. It cannot be disputed—given CMS's notice that the Debtor was in substantial compliance as of May 13, 2014—that the Debtor previously cured the initial two deficiencies in a timely matter. That leaves only the third deficiency. The Debtor offered into evidence the "allegation of compliance" it submitted to CMS on July 17 & 28, 2014 that outlines the steps it took to cure the final deficiency and remove any immediate jeopardy.[64] As part of the corrective measures it took, the Debtor retained a third-party consultant (David Hoffman) who has concluded that the Debtor is currently in substantial compliance with the Medicare program requirements and that the Debtor's patients are being adequately cared for.[65]

Hoffman's conclusions are consistent with the opinions offered by the Patient Care Ombudsman. At the outset of this case, the Court issued an order to show cause to determine whether it was necessary to appoint a patient care ombudsman for the protection of the Debtor's

[63] 973 F.2d 1065, 1077 (3d Cir. 1992).

[64] Exs. 4 & 5.

[65] Doc. No. 250 at ¶¶ 10 & 11; Ex. 20 at 44-49.

patients.[66] Ultimately, the Court directed the U.S. Trustee to appoint a patient care ombudsman to monitor the quality of patient care and represent the interests of patients in this case. The U.S. Trustee appointed Robert Rosenthal, president of Health Care Management Specialist, Inc., as Patient Care Ombudsman.[67] So far, the Patient Care Ombudsman has issued two reports indicating that the Debtor is adequately and satisfactorily providing for the health and welfare of the Debtor's patients.[68] Significantly, HHS opted not to offer any evidence—presumably because it could not—that the Debtor is not currently in substantial compliance with the Medicare program requirements (i.e., that the Debtor has not cured the prepetition default).

And the Court is persuaded that the Debtor has provided adequate assurances of future performance. In part, those assurances are based on the corrective actions the Debtor has taken to cure the previous deficiencies and the fact that the Debtor has been satisfactorily and adequately providing for patients' health and welfare under the watchful eye of the Patient Care Ombudsman since this case was filed. It is also based on the fact that the Debtor has retained Hoffman in an ongoing role to evaluate the Debtor's regulatory compliance and Hoffman's willingness to remain on as an advisor as long as necessary to ensure the Debtor is adequately and satisfactorily protecting its residents and complying with applicable regulations. Not to mention, HHS has again failed to offer any evidence refuting the Debtor's ability to perform in

[66] Doc. No. 36.

[67] Doc. No. 97. Although Rosenthal is not a doctor or nurse, he has extensive experience operating healthcare and assisted living facilities. AHCA has previously recommended Rosenthal as a receiver for a number of assisted living and skilled nursing facilities. And AHCA submitted his name to the U.S. Trustee for consideration in this case, as well. Because Rosenthal is not a medical professional, the Court authorized him to hire healthcare assistants (such as registered nurses and social workers), including RB Health Partners, Inc., to assist him in his review of the Debtor's operations.

[68] Doc. No. 178-1 at 21; Doc. No. 252 at 17.

the future. Accordingly, the Court concludes the Debtor has satisfied the requirements of § 365 and is permitted to assume its Medicare provider agreement.

The Debtor's plan is feasible even though AHCA indicates it intends to deny renewal of the Debtor's license

The only remaining issue that needs to be considered—even though not raised in an objection to confirmation—is whether the Debtor's plan is feasible despite the fact that AHCA has indicated it intends to seek revocation or deny renewal of the Debtor's nursing home license. Back in June, after the second deficiency had been cited and the facility had been brought back into substantial compliance, AHCA filed an administrative complaint seeking to revoke the Debtor's license.[69] That administrative proceeding has since been abated. But in the meantime, the Debtor filed an application to renew its license. AHCA says it intends on denying the Debtor's application to renew its license, and more recently, AHCA asked the Court to modify its injunction to permit AHCA to either deny the Debtor's license renewal application or invoke the administrative process to revoke the Debtor's license since neither action is prohibited by the automatic stay.[70]

AHCA appears to raise two grounds for refusing to renew or seeking to revoke the Debtor's license. First, AHCA says Florida law requires that it deny renewal of or revoke the Debtor's license because its Medicare and Medicaid provider agreements have been terminated. Second, AHCA says the three deficiencies previously discussed are grounds for both refusing to renew and revoking the Debtor's license. It appears AHCA is correct that refusing to renew the Debtor's license on either ground, at least theoretically, does not run afoul of the automatic stay.

[69] Doc. No. 246-3.

[70] Doc. No. 246.

As AHCA contends, Bankruptcy Code § 362(b)(4) does, in fact, except from the automatic stay actions to enforce a state's police or regulatory powers. In determining whether a government's actions qualify as police powers, courts generally apply the "pecuniary" purpose and "public policy" tests.[71] Under those tests, courts consider whether the government action is intended to protect the public safety or welfare or effectuate public policy, on the one hand, or protect the government's pecuniary interest or adjudicate private rights, on the other hand:

> There are two tests for determining whether agency actions fit within the section 362(b)(4) exception: (1) the "pecuniary purpose" test and (2) the "public policy" test. Under the pecuniary purpose test, the court determines whether the government action relates primarily to the protection of the government's pecuniary interest in the debtor's property or to matters of public safety and welfare. If the government action is pursued solely to advance a pecuniary interest of the governmental unit, the stay will be imposed. The public policy test "distinguishes between government actions that effectuate public policy and those that adjudicate private rights."[72]

AHCA says its actions satisfy both tests because it is attempting to protect the public safety and welfare and effectuate public policy by denying the Debtor's license renewal application or seeking to revoke the Debtor's license.

The Court agrees that AHCA's refusal to renew or intent to revoke the Debtor's license is an attempt to protect the public safety and welfare. That is perhaps best illustrated by comparing AHCA's actions to those of HHS. In enjoining HHS from terminating the Debtor's Medicare provider agreements, the Court reasoned, in part, that HHS's actions did not fall within the "police powers" exception to the automatic stay.[73] That was because it was apparent to the Court that HHS was only seeking to protect its pecuniary interest in terminating the Debtor's Medicare

[71] *In re Pollock*, 402 B.R. 534, 536-38 (Bankr. N.D.N.Y. 2009); *In re Allegheny Health, Educ. Research Found.*, 252 B.R. 309, 327 (W.D. Pa. 1999); *In re Selma Apparel Corp.*, 132 B.R. 968, 969-70 (Bankr. S.D. Ala. 1991).

[72] *Universal Life Church, Inc. v. United States*, 128 F.3d 1294, 1297 (9th Cir. 1997) (internal citations omitted).

[73] Ex. 20 at 89-91.

provider agreement. After all, HHS made no attempt to shut down the Debtor's facility. As far as HHS was concerned, the Debtor could continue to operate its facility and provide care for its patients; HHS simply was not going to pay for it. By contrast, by refusing to renew the Debtor's license, AHCA is essentially attempting to shut down the Debtor's facility because it believes the Debtor's operations are jeopardizing the patients' safety and welfare. While it may be an open question whether shutting down the Debtor's facility is in the best interest of its patients, there can be no question the attempt to shut it down is an effort by AHCA to protect what it believes is in the best interests of the patients' safety and welfare.

But the Court concludes that the Debtor's plan is still feasible notwithstanding AHCA's unwillingness to renew the Debtor's license. For starters, AHCA is collaterally estopped from raising the first ground—i.e., termination of the Medicare and Medicaid provider agreements—as a basis for refusing to renew or seeking to revoke the Debtor's license. This Court has ruled that the Debtor has the right to assume the Medicare provider agreement. And the only basis for terminating the Medicaid provider agreement was that the Medicare provider agreement had been terminated. Since that is no longer the case, the Medicaid provider agreement remains in effect. So the only grounds for refusing to renew or seeking to revoke the Debtor's license are the three deficiencies the Debtor has previously been cited for.

Under Florida law, AHCA does have the right to revoke the Debtor's license if the Debtor has been cited for two "class 1 deficiencies" arising from unrelated circumstances during the same survey or from separate surveys during a 30-month period.[74] AHCA contends that the three deficiencies the Debtor has been cited for constitute "class 1 deficiencies" under Florida law. As a result AHCA contends it is required to revoke or deny renewal of the Debtor's license.

[74] § 400.121(3)(c)-(d), Fla. Stat.

But Florida's Medicaid statutes provide additional protections that are not afforded under the Medicare regulations.

Critically, under the Medicare regulations, the Debtor has no right to challenge the termination of a Medicare provider agreement. The Debtor can challenge the underlying finding of noncompliance that gave rise to termination; but once noncompliance has been established, it appears the Debtor cannot challenge termination of the provider agreement. Florida's Medicaid statutes are different. Under section 400.121, Florida Statutes, the Debtor has the right to present factors that mitigate against revocation or nonrenewal of its license.

Although this Court has no say on whether revocation is appropriate under the circumstances—that decision is up to AHCA under section 400.121, Florida Statutes—it is apparent to the Court that there are a number of mitigating factors that could reasonably lead to the conclusion revocation is not appropriate. For one, the three deficiencies were isolated incidents, and each of them was cured immediately. Moreover, the Debtor has been operating its facility for the last five months in apparent substantial compliance with the Medicare and Medicaid requirements and, according to the Patient Care Ombudsman, in a manner that adequately and satisfactorily provides for the patients' health and welfare.[75] Finally, and perhaps most importantly, the Debtor's facility serves a particularly needy population (i.e., patients with severe psychiatric conditions) that may have trouble finding another skilled nursing facility, and to the extent they can find one, the patients may be at a greater risk if they transfer—because of a phenomenon known as transfer trauma—than if they remained at the Debtor's facility. All of this is to say that AHCA's stated intention of refusing to renew—or seeking to revoke—the Debtor's

[75] Doc. No. 178-1 at 21; Doc. No. 252 at 17.

license does not sound the death knell for the Debtor's business, and as such, it is not a basis for concluding the Debtor's plan is not feasible.

The Court recognizes there are cases holding that feasibility is not established when a debtor's prospects hinge on the uncertain outcome of pending litigation.[76] And it is true the Debtor's license renewal or revocation is uncertain. But what is certain is that denial of confirmation—before the Debtor has even had the opportunity to avail itself of its rights under Florida's license revocation statutes—will displace 109 nursing patients, many of whom suffer from severe psychiatric conditions and will have difficulty finding a place to go. And HHS and AHCA would be hard-pressed to argue there is harm to allow the Debtor to go forward under a confirmed plan until the licensure renewal or revocation issue is fully adjudicated considering that HHS has made no attempt to close the Debtor's facility (even though it has that right under the Medicare regulations) and AHCA has abated its efforts to do so (and allowed the Debtor to operate) since July. So while the Debtor's plan does hinge on the uncertain resolution of the pending licensure renewal or revocation action, the Court cannot allow what appears to be a litigation tactic to derail the Debtor's confirmation and displace over 100 nursing home patients.[77]

Conclusion

The sole issue before this Court on confirmation is whether the Debtor's plan is feasible. Because the Debtor has the right to assume its Medicare provider agreement, the Court concludes the plan is feasible. And the fact that AHCA intends to seek revocation or deny

[76] Doc. No. 242, citing *in re Am. Capital Equip.*, 688 F.3d 145, 156 (3d Cir. 2012); *In re Ewald*, 298 B.R. 76, 82 (Bankr. E.D. Va. 2002); *In re Gregory & Parker, Inc.*, 2013 WL 2285671, at *7 (Bankr. E.D.N.C. May 23, 2013).

[77] The Court says that raising the licensure renewal or revocation appears to be a litigation tactic because, although AHCA filed its administrative complaint back in July, it did not raise revocation of the Debtor's license (which is technically separate from licensure renewal) until four months after the Court enjoined CMS from terminating the Medicare provider agreement and shortly before confirmation.

renewal of the Debtor's license does not change this Court's feasibility analysis. Accordingly, it is

ORDERED:

1. The Debtor has satisfied the requirements of Bankruptcy Code § 1129 for confirming its proposed chapter 11 plan.

2. The Debtor shall prepare a confirmation order finding that the specific requirements of Bankruptcy Code § 1129 have been met, incorporating the relevant terms of this Memorandum Opinion, and confirming the Debtor's proposed chapter 11 plan.

3. This order is a nonfinal order and will not become a final order until entry of a confirmation order.

DATED: December 31, 2014.

MGWilliamson

Michael G. Williamson
United States Bankruptcy Judge

Attorney Elizabeth A. Green is directed to serve a copy of this order on interested parties and file a proof of service within 3 days of entry of this order.

Elizabeth A. Green, Esq.
Baker & Hostetler LLP
Counsel for Debtor

Andrew Sheeran, Esq.
Counsel for Agency for Health Care Administration

Sean Flynn, Esq.
Office of the United States Attorney
Counsel for U.S. Department of Health & Human Services

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

In re:

BAYOU SHORES SNF, LLC,

Debtor.
_____/

CASE NO: 8:14-bk-9521-MGW

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION and THE UNITED STATES OF AMERICA, ON BEHALF OF THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Appellants,

v.

BAYOU SHORES SNF, LLC,

Appellee.
_____/

CASE NO: 8:14-cv-02816-T-30
(Lead Case) as consolidated with
8:14-cv-02617-T-30;
8:15-cv-00103-T-30; and
8:15-cv-00128-T-30

ORDER

THIS CAUSE came before the Court on appeal of the Bankruptcy Court's entry of an injunction prohibiting any action to terminate the Debtor's Medicare and Medicaid provider agreements (the September 5, 2014 Order) and subsequent entry of a confirmation order that ordered the assumption of the Medicare and Medicaid provider agreements (the Confirmation Order) (collectively, the "Orders"). The Court consolidated four appeals related to the Orders. The appeals present numerous arguments; the heart of the appeals,

however, deals with the Bankruptcy Court's jurisdiction to enjoin the termination of and later order the assumption of the Debtor's Medicare and Medicaid provider agreements. The Court concludes that the Bankruptcy Court's Orders violated the Medicare jurisdictional bar set forth in 42 U.S.C. § 405(h); this jurisdictional bar moots any remaining arguments on appeal.

The Court has jurisdiction to hear this bankruptcy appeal under 28 U.S.C. § 158(a).

STANDARD OF REVIEW

A district court reviews a bankruptcy court's findings of fact for clear error and conclusions of law *de novo*. *See In re JLJ, Inc.*, 988 F.2d 1112, 1116 (11th Cir. 1993).

BACKGROUND

Although the disposition of the consolidated appeals turns solely on a question of law, a brief summary of the background facts is helpful. The Debtor Bayou Shores SNF, LLC operates a skilled nursing facility, the Rehabilitation Center of St. Petersburg. Most of the Debtor's patients have Alzheimer's disease, dementia, or other serious psychiatric conditions; it is one of the few facilities in the area that accommodates patients with challenging psychiatric needs.

The Debtor provides Medicare and Medicaid services through provider agreements issued by the federal and state government under the Social Security Act's Medicare and Medicaid provisions. Most of the Debtor's patients are on Medicare or Medicaid. Over ninety percent of the Debtor's revenue is derived from Medicare and Medicaid.

A skilled nursing facility like the Debtor must comply with the requirements set forth in 42 C.F.R. Part 483, Subpart B, to receive payment under the Medicare and Medicaid programs. As such, the Debtor is subject to surveys conducted by the Centers for Medicare and Medicaid Services ("CMS"), an agency of the United States Department of Health and Human Services. CMS may take certain actions, including termination of the Medicare and Medicaid provider agreements, if a survey reflects that a facility is not compliant with the applicable regulations.

The Agency for Health Care Administration ("AHCA"), the Florida state agency that performs nursing home surveys and that administers the Medicaid program in Florida, conducted surveys of the Debtor in approximately February, March, and July of 2014. Each time, the Debtor was cited for deficiencies and determined to be in noncompliance.[1] Ultimately, based on AHCA's July 2014 survey, CMS exercised its discretion to terminate the Debtor's Medicare provider agreement.

In a letter dated July 22, 2014, CMS notified the Debtor that AHCA's survey demonstrated that the Debtor was not in substantial compliance with Medicare and Medicaid requirements and that the conditions constituted immediate jeopardy to residents' health and

[1] The facts surrounding the surveys, CMS' determinations of noncompliance, and the Debtor's actions in response to same are outlined in the Bankruptcy Court's "Memorandum Opinion and Order on Confirmation" and need not be repeated here because they are not relevant to the Court's conclusion that the Bankruptcy Court lacked jurisdiction to take action related to the termination of the Medicare and Medicaid provider agreements. (Dkt. 45-36).

safety. The letter stated that the Debtor's "Medicare provider agreement will be terminated at 11:59 pm on August 3, 2014" and that Medicare and Medicaid payments would continue for only 30 days from that date. (Dkt. 1-20).

On August 1, 2014, the Debtor filed a Verified Complaint for Injunctive Relief and Mandamus in the federal district court for the Middle District of Florida (Tampa Division). Specifically, in that action, *Bayou Shores SNF LLC v. Sylvia Mathews Burwell, et al.*, Case No. 8:14-cv-1849-T-33-MAP (the "Civil Action"), the Debtor sought and obtained an *ex parte* temporary restraining order ("TRO") that enjoined CMS from terminating the Medicare and Medicaid provider agreements through August 15, 2014.

On August 11, 2014, the Secretary moved to dismiss the Civil Action for lack of subject matter jurisdiction. On August 15, 2014, the district court granted the United States' motion, dismissed the Civil Action, and dissolved the TRO. The district court concluded that Medicare's jurisdictional bar, 42 U.S.C. § 405(h), precluded the court from exercising jurisdiction over the controversy prior to the Debtor exhausting its administrative remedies. It was undisputed that the Debtor had not exhausted its administrative remedies.

Less than one hour after the district court issued its order in the Civil Action dissolving the TRO, the Debtor filed a Voluntary Petition for Chapter 11 bankruptcy. In the bankruptcy action, the Debtor filed an emergency motion to enjoin CMS and AHCA from terminating the Debtor's Medicare and Medicaid provider agreements. On August 25, 2014, the Bankruptcy Court entered an order provisionally granting the Debtor's motion subject

to a final evidentiary hearing. (Dkt. 1-15). The Bankruptcy Court noted that it had jurisdiction to consider the motion under 28 U.S.C. § 1334 and that the Debtor had made a "prima facie showing that [its] Medicare and Medicaid provider agreements [were] property of the estate sufficient to warrant the entry of an order providing that the automatic stay [prohibited] CMS, AHCA, and/or any managed care provider from taking action to terminate the Debtor's Medicare and/or Medicaid provider agreements." *Id.*

On August 26, 2014, the Bankruptcy Court held an evidentiary hearing. On September 5, 2014, based on the evidence presented at the evidentiary hearing, the Bankruptcy Court issued its "Order Granting Debtor's Emergency Motion to Enforce the Automatic Stay and/or for an Order Pursuant to 11 U.S.C. § 105, Prohibiting Any Action to Terminate Debtor's Medicaid and Medicare Provider Agreements, to Deny Payment of Claims and/or to Relocate Residents" (the "September 5, 2014 Order). The September 5, 2014 Order granted the Debtor's motion "for the reasons stated in open Court." (Dkts. 1-31 and 1-2).

At the August 26, 2014 hearing, the Bankruptcy Court noted that it had jurisdiction under section 1334. It also concluded that the Medicare provider agreement was not terminated prior to the Debtor's bankruptcy filing; as such, the provider agreement was an executory contract that could be assumed. (Dkt. 1-31). The Bankruptcy Court stated that it had a responsibility to "look at the big picture," that is, "the welfare and concern for the

patients." *Id.* at 116:6-11. Based on the testimony presented at the evidentiary hearing, the Bankruptcy Court concluded that the Debtor's patients were not "in any danger." *Id.*

Both AHCA and the United States of America, on behalf of the Secretary of the United States Department of Health and Human Services ("Secretary") appealed the September 5, 2014 Order (the "First Appeals). These are the First Appeals in front of this Court. In relevant part, both AHCA and the Secretary argue that the Bankruptcy Court lacked jurisdiction to enjoin the terminations of the Debtor's provider agreements.

During the pendency of the First Appeals, the Bankruptcy Court issued the Confirmation Order that asserted jurisdiction over, and ordered the assumption of, the Debtor's Medicare and Medicaid provider agreements. Both AHCA and the Secretary appealed the Confirmation Order (the "Second Appeals") and argue, in relevant part, that the Bankruptcy Court was without jurisdiction to take any action related to the Medicare and Medicaid provider agreements. These are the Second Appeals before this Court. The jurisdictional arguments in the First and Second Appeals are essentially the same: 42 U.S.C. § 405(h), the Medicare jurisdictional bar, precluded the Bankruptcy Court from taking *any* action related to the provider agreements until the Debtor had exhausted its administrative remedies.

As explained below, the Bankruptcy Court erred as a matter of law because the jurisdictional bar in section 405(h) precluded the Bankruptcy Court from delaying or

preventing the effect of CMS' determination that the provider agreements should be terminated.

DISCUSSION

In its "Memorandum Opinion and Order on Confirmation," the Bankruptcy Court concluded, as a matter of law, that it had jurisdiction under 28 U.S.C. § 1334. Specifically, under section 1334, the Bankruptcy Court held that it had jurisdiction "over all civil proceedings arising under title 11, arising in a case under title 11, or related to a proceeding under title 11." (Dkt. 45-36). The Bankruptcy Court noted that "any dispute over the Debtor's ability to assume the Medicare provider agreement is 'related to' [the] title 11 case since the outcome of that dispute could conceivably have an effect on the Debtor's bankruptcy estate." *Id.*[2] The Court finds error in this conclusion of law because it ignores the jurisdictional bar contained in the Medicare Act. The Bankruptcy Court exceeded its subject matter jurisdiction when it interfered with CMS' termination of the provider agreements.

Under 42 U.S.C. § 1395cc(h)(1), an institution, like the Debtor in this case, that is "dissatisfied with a determination by the Secretary ... described in subsection (b)(2) of this section shall be entitled to a hearing thereon by the Secretary ... and to judicial review of the Secretary's final decision *after such hearing* as is provided in section 405(g) of this title."

[2] As stated above, the Bankruptcy Court's prior rulings also implied that it was exercising jurisdiction under section 1334.

(emphasis added). The referenced subsection (b)(2) outlines the Secretary's power to terminate a Medicare provider agreement in certain situations, including situations in which "the provider fails to comply substantially with the provisions of the agreement, [or] with the provisions of [the Medicare Act] and regulations thereunder." 42 U.S.C. § 1395cc(b)(2)(A).

Upon an exhaustion of the administrative remedies and upon the issuance of a final agency decision by the Secretary, a provider may seek judicial review. *See* 42 U.S.C. § 405(g). Under section 405(g): "Any individual, after any final decision of the [Secretary] made after a hearing to which he was a party ..., may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the [Secretary] may allow." Thus, with respect to a Medicare dispute, the judicial review provision at section 405(g) is the "exclusive source of federal court jurisdiction." *See Jackson v. Astrue*, 506 F.3d 1349, 1353 (11th Cir. 2007).

Clearly, the Secretary's decision to terminate the Debtor's provider agreements is an issue that arises under Medicare because termination of a provider agreement is specifically covered under the Medicare statute and regulations. Thus, a court, including the Bankruptcy Court here, is barred from exercising jurisdiction over the parties' dispute except for conducting judicial review of the Secretary's final decision. The Medicare Act incorporates 42 U.S.C. § 405(h) under 42 U.S.C. § 1395ii. Section 405(h) states: "[n]o findings of fact or decision of the [Secretary] shall be reviewed by any person, tribunal, or governmental agency except as herein provided" and no action against the Secretary "shall be brought

under section 1331 or 1346 of Title 28 to recover on any claim arising under" the Medicare Act. There is no jurisdiction for a court to interpose itself in a provider's termination from the Medicare and Medicaid programs except to provide judicial review under section 405(g) *after* administrative remedies have been exhausted and the Secretary has issued a final agency decision.

Here, the Debtor did not exhaust its administrative remedies with respect to the Secretary's decision to terminate its provider agreements. Rather, after the district court concluded that it lacked jurisdiction and dissolved the TRO, the Debtor filed for Chapter 11 bankruptcy and argued that the provider agreements were property of the estate. The Bankruptcy Court then enjoined any termination of the provider agreements which essentially thwarted the administrative process and allowed the Debtor to circumvent its administrative obligations. But the Bankruptcy Court was without jurisdiction to interpose itself in the process, including entering an injunction to enjoin the provider agreements' termination. *See Bayou Shores SNF, LLC v. Burwell*, No. 8:14-cv-1849-T-33MPA, 2014 WL 4059900 (M.D. Fla. Aug. 15, 2014) (holding that the district court was without jurisdiction to enjoin the termination of the provider agreements prior to exhaustion of administrative remedies); *Cathedral Rock of North Coll. Hill v. Shalala*, 223 F.3d 354 (6th Cir. 2000) (same); *Affil. Prof'l Home Health Care v. Shalala*, 164 F.3d 282 (5th Cir. 1999) (same); *Livingston Care Ctr., Inc. v. United States*, 934 F.2d 719 (6th Cir. 1991) (same); *Americana Healthcare Corp. v. Schweiker*, 688 F.2d 1072 (7th Cir. 1982) (same); *Forum*

Healthcare Grp., Inc. v. Ctrs. for Medicare & Medicaid Servs., 495 F. Supp. 2d 1321 (N.D. Ga. 2007) (same); *Trade Around the World of PA v. Shalala*, 145 F. Supp. 2d 653 (W.D. Pa. 2001) (same); *Northwest Healthcare, L.P. v. Sullivan*, 793 F. Supp. 724 (W.D. Tex. 1992) (same).

The Bankruptcy Court concluded that its jurisdiction was not barred under section 405(h) because section 405(h) does not expressly proscribe bankruptcy jurisdiction under 28 U.S.C. § 1334. The Eleventh Circuit has not directly addressed this issue. But the majority of courts that have considered the omission of section 1334 (and other jurisdictional grants) from section 405(h) have examined Congress' intent when it enacted the jurisdictional bar and concluded that the omission of section 1334 and other jurisdictional grants (like section 1332) was inconsistent with that intent. The Court agrees with this majority view.

"When originally enacted, the third sentence in section 405(h) specifically prohibited any action under 'Section 24 of the Judicial Code of the United States.'" *In re Hosp. Staffing Servs., Inc.*, 258 B.R. 53, 57-58 (Bankr. S.D. Fla. 2000). Section 24 (codified at 28 U.S.C. § 41) contained virtually all jurisdictional grants, including bankruptcy jurisdiction. *See* Amendments to Title II of the Social Security Act, § 201, 53 Stat. 1362, 1371 (1939). Jurisdictional grants were placed in separate sections when the judicial code was subsequently revised in 1948. *See* Pub.L.No. 80-773, 62 Stat. 869, 930-35 (1948).

In 1984, Congress revised the Social Security Act's jurisdictional bar, 42 U.S.C. § 405(h) and replaced "Section 24" with "Section 1331 or 1346." Upon this amendment,

Congress stated "none of such amendments shall be construed as changing or affecting any right, liability or status or interpretation which existed." Pub.L. 98–369, § 2664(b), 98 Stat. 1171-72 (1984).

"Many courts have analyzed the amendments to section 405(h) and determined that the jurisdictional bar applies to all cases in which administrative remedies have not been exhausted, and not simply those in which jurisdiction is asserted under § 1331 or § 1346." *In re Hosp. Staffing Servs.*, 258 B.R. at 57-58 (citing *Midland Psychiatric Assocs., Inc. v. United States,* 145 F.3d 1000, 1004 (8th Cir.1998); *Bodimetric Health Servs., Inc. v. Aetna Life & Cas.*, 903 F.2d 480, 488-89 (7th Cir.1990); *Total Renal Labs., Inc. v. Shalala,* 60 F. Supp. 2d 1323, 1331 (N.D. Ga. 1999)).

In *Bodimetric Health Services*, the Seventh Circuit analyzed in detail the technical amendments to section 405(h) and rejected the argument that diversity jurisdiction, 28 U.S.C. § 1332, could be used to evade section 405(h)'s jurisdictional bar because section 405(h) did not expressly reference section 1332. The same analysis and conclusion have applied in the bankruptcy context. *See In re Hosp. Staffing Servs.*, 258 B.R. at 57-58 ("It is clear that the Bankruptcy Court considered the history of § 405(h) and the cases analyzing § 405(h) and correctly concluded that it had no jurisdiction over Appellant's Complaint."); *In re St. Johns Home Health Agency, Inc.*, 173 B.R. 238, 244 (Bankr. S.D. Fla. 1994) ("[T]he omission of 28 U.S.C. § 1334 from the amended version of 42 U.S.C. § 405(h) was not meant to create bankruptcy jurisdiction where it previously was precluded. The intent and effect of the 1984

amendments are that bankruptcy court jurisdiction under § 1334 for claims arising under the Medicare Program is and remains precluded by § 405(h)."); *see also In re St. Mary Hosp.*, 123 B.R. 14, 17 (E.D. Pa. 1991).

The Bankruptcy Court dismissed these decisions as "improperly considering the legislative history of a statute when the statute's text is plain and unambiguous." (Dkt. 45-36). The Court respectfully disagrees and aligns itself with the majority view. As no other independent basis for jurisdiction existed to enjoin and order the assumption of the Medicare and Medicaid provider agreements, the Bankruptcy Court's Orders, to the extent that they impacted those agreements, must be reversed.

Finally, it is worth noting that the Court need not determine the exact timing of any termination of the provider agreements (a hotly contested issue on appeal) because, even if the provider agreements had not been terminated prior to the bankruptcy filing, any action by the Bankruptcy Court to prevent or delay the effect of the Secretary's determination, including a Confirmation Order ordering the assumption of the provider agreements, constituted a breach of section 405(h)'s jurisdictional bar and was thus in excess of the Bankruptcy Court's subject matter jurisdiction.

CONCLUSION

The Bankruptcy Court erred as a matter of law when it exercised subject matter jurisdiction over the treatment of the provider agreements after the Secretary had determined that the provider agreements would be terminated. The Bankruptcy Court was without

jurisdiction under the Medicare jurisdictional bar to issue the injunction that enjoined the Secretary's termination of the provider agreements and this error continued when the Bankruptcy Court subsequently authorized the Debtor to assume the provider agreements.

It is therefore **ORDERED AND ADJUDGED** that:

1. The September 5, 2014 Order and Confirmation Order are reversed to the extent explained herein.[3]
2. This appeal is remanded to the Bankruptcy Court for further proceedings.
3. The Clerk of Court is directed to close this case and terminate any pending motions as moot.

DONE and **ORDERED** in Tampa, Florida on June 26, 2015.

JAMES S. MOODY, JR.
UNITED STATES DISTRICT JUDGE

Copies furnished to:
Bankruptcy Judge Michael Williamson
Bankruptcy Clerk of Court
Counsel/Parties of Record

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I certify the foregoing is a true and correct copy of the original.
SHERYL L. LOESCH, Clerk
United States District Court
Middle District of Florida
By: _____ Deputy Clerk

[3] Notably, the reversal of the Confirmation Order is only with respect to the assumption of the Debtor's Medicare and Medicaid provider agreements.

[PUBLISH]

IN THE UNITED STATES COURT OF APPEALS

FOR THE ELEVENTH CIRCUIT

No. 15-13731

D.C. Docket Nos. 8:14-bk-09521-MGW; 8:14-cv-02816-JSM

In Re: BAYOU SHORES SNF, LLC,

Debtor.

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION, UNITED STATES OF AMERICA, on behalf of the Secretary of the United States Department of Health and Human Services,

Plaintiffs - Appellees,

versus

BAYOU SHORES SNF, LLC,

Defendant - Appellant.

Appeal from the United States District Court
for the Middle District of Florida

(July 11, 2016)

Before HULL, JULIE CARNES, and CLEVENGER,* Circuit Judges.

CLEVENGER, Circuit Judge:

Bayou Shores SNF, LLC ("Bayou Shores") operates a skilled nursing facility in St. Petersburg, Florida. Most of Bayou Shores' patients are on Medicare or Medicaid, and over ninety percent of its revenue is derived from Medicare and Medicaid patients. It receives compensation for Medicare and Medicaid services through provider agreements entered into with the federal and state governments. Bayou Shores' entitlement to participate in the provider agreements depends on its continued compliance with qualification requirements for such facilities that are established by the Secretary of the Department of Health and Human Services. After an unchallenged exercise of her statutory oversight authority, the Secretary determined that Bayou Shores was not in substantial compliance with the Medicare program participation requirements, and that conditions in its facility constituted an immediate jeopardy to residents' health and safety. By letter dated July 22, 2014, the Secretary notified Bayou Shores that its Medicare provider agreement "will be terminated at 11:59 pm on August 3, 2014." The termination of Bayou Shores' Medicare provider agreement triggered the termination of its Medicaid provider agreement as well.

* Honorable Raymond C. Clevenger, III, United States Circuit Judge for the Federal Circuit, sitting by designation.

To avoid the consequences of termination of its provider agreements, Bayou Shores sought protection in the United States Bankruptcy Court for the Middle District of Florida. Rejecting the jurisdictional challenge from the Secretary, the bankruptcy court assumed authority over the Medicare and Medicaid provider agreements as part of the debtor's estate, enjoined the Secretary from terminating the provider agreements, determined for itself that Bayou Shores was qualified to participate in the provider agreements, required the Secretary to maintain the stream of monetary benefit under the agreements, reorganized the debtor's estate, and finally issued its Confirmation Order on December 31, 2014.

On appeal, in a June 26, 2015, Order, the United States District Court for the Middle District of Florida upheld the Secretary's jurisdictional challenge and reversed the Confirmation Order with respect to the assumption of the debtor's Medicare and Medicaid provider agreements. *See In re Bayou Shores SNF, LLC*, 533 B.R. 337, 343 (M.D. Fla. 2015).

Bayou Shores timely appeals the decision of the district court. The appeal turns on the jurisdictional question. From the Social Security Amendments of 1939 until 1984, it is undisputed that bankruptcy courts lacked jurisdiction over Medicare claims. The statute barring such jurisdiction was finally recodified in 1984 to reflect an earlier recodification of the Judicial Code. In cases involving the interpretation of statutory language changed in a recodification, it has long been

established that no change in the previous recodified law is recognized unless Congress's intention to make a substantive change is "clearly expressed." *United States v. Ryder*, 110 U.S. 729, 740 (1884). Now the central question is whether the statutory revision in this case demonstrated Congress's clear intention to vest the bankruptcy courts with jurisdiction over Medicare claims. We think it is abundantly clear that Congress expressed no such intention.

Therefore, after careful review of the record and the parties' briefs, and with the benefit of oral argument, and for the reasons set forth below, we affirm the district court's Order.

I. BACKGROUND

The relevant facts of this case are generally undisputed and ably set out by the district court in the opinion below. *See In re Bayou Shores SNF, LLC*, 533 B.R. 337, 338-40 (M.D. Fla. 2015). A brief summary follows.

A. Bayou Shores' "Skilled Nursing Facility"

As noted above, Bayou Shores operates a "skilled nursing facility"[1] in St. Petersburg, Florida, and approximately ninety percent of Bayou Shores' revenue is derived from caring for Medicare and Medicaid patients. To be eligible for the Medicare/Medicaid program, Bayou Shores entered into so-called "provider agreements" with the federal and Florida state governments, respectively, which

[1] A "skilled nursing facility" is statutorily defined at 42 U.S.C. § 1395i-3(a).

provide reimbursement to Bayou Shores for the provision of medical services to Bayou Shores' Medicare/Medicaid patients. As a condition of payment under these agreements Bayou Shores must comply with certain regulatory requirements pertaining to skilled nursing facilities.[2] The Plaintiffs in this case are the government agencies primarily tasked with monitoring Bayou Shores' compliance with these regulations: the Florida Agency for Health Care Administration ("AHCA") and the United States Department of Health and Human Services ("HHS") (collectively, "the Government"). AHCA is responsible for conducting surveys of skilled nursing facilities in Florida and administering the state's Medicaid program. HHS administers Medicare nationally, and uses AHCA's surveys to decide whether skilled nursing facilities in Florida are compliant with the regulations, and if not, what remedial action to take. When conditions at a skilled nursing facility pose immediate jeopardy to the health or safety of the facility's patients, the law requires the Secretary to select and execute an appropriate remedy.[3]

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[2] *See e.g.* 42 C.F.R. Part 483, Subsection B.

[3] The Secretary of HHS's duty to take remedial action in the face of immediate jeopardy to a facility's patients is explained in 42 U.S.C. § 1395i-3(h)(2), where Congress specified that the Secretary "shall" take remedial action in response to immediate jeopardy. *See* 42 U.S.C. § 1395i-3(h)(2)(A)-(B) (statutorily defined remedies include termination from program, denial of payments, civil monetary penalties, and appointment of temporary management); *see also id.* at (f)(1) ("It is the duty and responsibility of the Secretary to assure that requirements which govern the provision of care in skilled nursing facilities under this subchapter, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.").

On February 10, 2014, AHCA conducted such a survey at Bayou Shores' skilled nursing facility. As a result of the survey, AHCA reported to HHS that Bayou Shores was not compliant with the relevant regulations. The survey noted a number of problems including failing to correctly track residents' "Do Not Resuscitate" orders, poor patient hygiene, and unsecured expired medications. AHCA determined that at least some of these deficiencies posed a threat of immediate jeopardy to Bayou Shores' patients.[4] Bayou Shores was given an opportunity to remedy these deficiencies. In a follow-up survey on March 20, 2014, AHCA again found a number of deficiencies. These included Bayou Shores placing a "known sexual offender" in a room with a disabled patient without informing that patient, and subsequently failing to appropriately handle an alleged sexual assault by the "known sexual offender" reported by the disabled patient. As with the previous survey, AHCA found that at least some of these deficiencies posed a threat of immediate jeopardy to Bayou Shores' patients. Bayou Shores was again given the opportunity to remedy the deficiencies.

The proverbial "last straw" was a final survey on July 11, 2014, in which further deficiencies were identified, including allowing a mentally impaired

[4] Immediate jeopardy exists if the nursing home's noncompliance has caused or is likely to cause "serious injury, harm, impairment or death to a resident." 42 C.F.R. § 488.301. The regulation only requires that the nursing home's noncompliance is likely to cause harm to "a resident." Though correctly quoting the regulation, the bankruptcy court appears to have incorrectly believed that actual harm is required for a finding of "immediate jeopardy." *See In re Bayou Shores SNF, LLC*, 525 B.R. 160, 163 (Bankr. M.D. Fla. 2014). However, actual harm is not a prerequisite for a finding of immediate jeopardy.

resident to leave the facility unaccompanied on a hot Florida day (he was later found at a bus station). AHCA again determined that at least some of these deficiencies placed Bayou Shores' residents in immediate jeopardy. After the third finding of non-compliance, HHS sent Bayou Shores a letter on July 22, 2014 notifying Bayou Shores that its non-compliance posed an "immediate jeopardy to [Bayou Shores'] residents' health and safety," and that HHS was exercising its regulatory discretion to terminate Bayou Shores' Medicare provider agreement. HHS's letter stated that the "Medicare provider agreement will be terminated at 11:59 pm on August 3, 2014."[5] The termination of Bayou Shores' Medicare provider agreement triggered the termination of Bayou Shores' Medicaid provider agreement.[6]

B. Bankruptcy Court Proceedings

Two days before this looming deadline, on August 1, 2014, Bayou Shores sought emergency injunctive relief from the U.S. District Court for the Middle

[5] The statute permits HHS to terminate a provider agreement in light of a finding of immediate jeopardy without a pre-termination hearing for the provider. *See* 42 U.S.C. § 1395i-3(h)(2)(a); *see also Cathedral Rock of N. Coll. Hill, Inc. v. Shalala*, 223 F.3d 354, 366 (6th Cir. 2000) (no pre-termination hearing required under Due Process Clause); *Northlake Cmty. Hosp. v. United States*, 654 F.2d 1234, 1241-43 (7th Cir. 1981) (same).

[6] Though Bayou Shores disputes whether Florida has followed the correct procedure to "finalize" the termination of their Medi*caid* provider agreement, Bayou Shores does not appear to dispute that such termination will be the end result of the termination of the Medi*care* provider agreement. *See e.g.* 42 U.S.C. § 1396a(a)(39); Fla. Stat. § 409.913(14); *see also Livingston Care Ctr., Inc. v. United States*, 934 F.2d 719, 720 (6th Cir. 1991) ("The Secretary of Health and Human Services's termination of the plaintiffs' Medicare certification automatically triggered termination of plaintiffs' Medicaid certification as well").

District of Florida to prevent the termination of the provider agreements. The district court initially granted Bayou Shores' request for a temporary restraining order. However, on motion of HHS, the district court dismissed Bayou Shores' complaint for lack of subject matter jurisdiction. On August 15, 2014, the court found that Bayou Shores had not exhausted its administrative remedies, and thus Medicare's jurisdictional bar (42 U.S.C. § 405(h)) prevented the district court from exercising jurisdiction over the termination of the provider agreements. *See Bayou Shores SNF, LLC v. Burwell*, No. 8:14-CV-1849-T-33MAP, 2014 WL 4059900,*6-8 (M.D. Fla. Aug. 15, 2014). Approximately an hour after issuance of the district court's order, Bayou Shores filed a Voluntary Petition for Chapter 11 bankruptcy, and sought an emergency injunction from the bankruptcy court preventing HHS and AHCA from terminating the provider agreements. The Government, at each opportunity, challenged the bankruptcy court's jurisdiction to order assumption of the provider agreements.

On August 25, 2014, the bankruptcy court issued the preliminary injunction sought by Bayou Shores. The bankruptcy court reasoned that it had jurisdiction pursuant to 28 U.S.C. § 1334,[7] the provider agreements were property of the estate, and an automatic stay preventing HHS and AHCA from terminating the agreements was thus proper. At a subsequent evidentiary hearing on August 26,

[7] 28 U.S.C. § 1334, titled "Bankruptcy cases and proceedings," generally defines the original and exclusive jurisdiction of district courts over bankruptcy proceedings.

the bankruptcy court heard testimony from doctors, patients, and other Bayou Shores witnesses. Concluding that in its view Bayou Shores' patients did not appear to be in any immediate jeopardy, the bankruptcy court issued an order on September 5, 2014 that (among other things) forbade HHS and AHCA from terminating Bayou Shores' provider agreements.

After further proceedings, on December 31, 2014 the bankruptcy court issued its Confirmation Order. *See In re Bayou Shores SNF, LLC*, 525 B.R. 160 (Bankr. M.D. Fla. 2014). In the Confirmation Order, the bankruptcy court again stated its belief that jurisdiction was proper under 28 U.S.C § 1334, and rejected HHS and AHCA's argument that the same 42 U.S.C. § 405(h) bar applied to the bankruptcy court as applied to the district court. The bankruptcy court reasoned that the plain language of § 405(h), which refers only to 28 U.S.C §§ 1331 and 1346, did not prevent the bankruptcy court from exercising jurisdiction over the assumption of the provider agreements under § 1334. *Id.* at 166. The bankruptcy court further concluded that because Bayou Shores appeared to have remedied the deficiencies it was originally cited for, Bayou Shores had provided adequate assurances of future performance under the provider agreements, and thus was eligible to assume them. Finding the remainder of the statutory requirements fulfilled, the bankruptcy court confirmed Bayou Shore's Chapter 11 plan. The

bankruptcy court also ordered the dissolution of the automatic stay and preliminary injunction.[8]

C. District Court Proceedings

HHS and AHCA separately appealed both the bankruptcy court's September 5, 2014 Order, and the Confirmation Order. The appeals were consolidated by the district court. As they had argued to the bankruptcy court, HHS and AHCA asserted to the district court that 42 U.S.C. § 405(h) denied the bankruptcy court jurisdiction over the provider agreements. The district court agreed. While acknowledging that the bankruptcy court's reading of § 405(h) was an issue that the Eleventh Circuit had not squarely addressed, the district court noted that the majority of other circuit courts addressing the issue "have examined Congress' intent when it enacted the jurisdictional bar and concluded that the omission of section 1334 and other jurisdictional grants (like section 1332) was inconsistent with that intent." *In re Bayou Shores*, 533 B.R. at 342. The district court reviewed the relevant statutory language and legislative history, as well as decisions from other courts examining the same. In particular, the district court noted that the absence of § 1334 in the recodified 42 U.S.C. § 405(h) appeared to be the result of a codification error. Based on that analysis, the district court held that it

[8] *See* Bankr. ECF No. 285 at 12-13 (ordering that "all injunctions and stays previously provided for in this case pursuant to sections 105 and/or 362 of the Bankruptcy Code shall remain in full force and effect until the Effective Date."). As explained further *infra*, the parties dispute what effect this dissolution has on the issues in this case.

"respectfully disagree[d] [with the bankruptcy court] and align[ed] itself with the majority view" in finding that § 405(h) must be understood to bar jurisdiction under § 1334. *Id.* at 343.

Because it was undisputed that Bayou Shores had yet to exhaust its administrative remedies, and "no other independent basis for jurisdiction existed to enjoin and order the assumption of the Medicare and Medicaid provider agreements," the district court reversed the orders of the bankruptcy court (with respect to the provider agreements). *Id.*

The district court also noted that a hotly contested issue on appeal was "the exact timing of any termination of the provider agreements." *Id.* However, the district court found that it did not need to resolve that issue, because the timing was irrelevant to whether or not the bankruptcy court lacked jurisdiction to hear the case in the first place. *Id.*[9]

Bayou Shores timely appealed the district court's order.

II. STANDARD OF REVIEW

In a bankruptcy case, this Court sits as a second court of review and thus examines independently the factual and legal determinations of the bankruptcy court and employs the same standards of review as the district court. *See Brown v.*

[9] The Government argues that the provider agreements terminated prior to Bayou Shores filing their bankruptcy petition, thus depriving the bankruptcy court of jurisdiction over the provider agreements. Bayou Shores (for various reasons) contests that argument. For reasons we explain below, we do not find it necessary to resolve this dispute.

Gore (In re Brown), 742 F.3d 1309, 1315 (11th Cir. 2014). We review the bankruptcy court's factual findings for clear error and its legal conclusions de novo. *Id.* The district court's legal determinations are also reviewed de novo. *See Dionne v. Simmons (In re Simmons)*, 200 F.3d 738, 741 (11th Cir. 2000).

III. BANKRUPTCY COURT JURISDICTION OVER MEDICARE CLAIMS

The primary dispute in this case is purely legal: does 42 U.S.C. § 405(h) bar a bankruptcy court from exercising 28 U.S.C. § 1334 jurisdiction over claims that arise under the Medicare Act? Bayou Shores' primary argument is that the plain text of § 405(h) precludes district court jurisdiction under 28 U.S.C. §§ 1331 and 1346 only. The Government argues that the lack of a reference to § 1334 is merely a result of a codification error, and that properly construed the statute requires exhaustion of administrative remedies before bringing a Medicare claim before any district court.

Because we conclude that the lack of a reference to § 1334 in § 405(h) is the result of a codification error, we agree with the Government that the bankruptcy court lacked jurisdiction over the termination of the provider agreements. To see why, we turn first to an examination of the history of § 405(h).

A. Legislative history of § 405(h)

The relevant text of the 42 U.S.C. § 405(h) currently reads (emphasis added):

> (h) Finality of Commissioner's decision
>
> The findings and decision of the Commissioner of Social Security after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Commissioner of Social Security shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Commissioner of Social Security, 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.[10]

Bayou Shores argues that the third sentence of § 405(h) forbids only an "action" brought under "section 1331 [*i.e.* federal question jurisdiction] or 1346 [*i.e.* suits against the federal government] of Title 28." Because Bayou Shores' action was brought under section 1334 of Title 28 (*i.e.* bankruptcy jurisdiction), Bayou Shores argues that § 405(h) does not apply. To understand why Bayou Shores is incorrect however requires a thorough examination of the history of § 405(h), which reveals that the issue is not as straightforward as Bayou Shores suggests.

The original text of § 405(h) when passed in 1939 was largely the same as it is today, with the crucial difference for this case emphasized below:

> (h) The findings and decision of the Board after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Board shall be reviewed by any

[10] § 405(h) applies to Medicare via 42 U.S.C. § 1395ii, which states that "any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively."

> person, tribunal, or governmental agency except as herein provided. No action against the United States, the Board, or any officer or employee thereof shall be brought under *section 24 of the Judicial Code of the United States* to recover on any claim arising under this title.

See Social Security Amendments of 1939, Pub. L. No. 76-379, 53 Stat. 1360 (1939) (emphasis added). In 1939, "section 24 of the Judicial Code" defined the original jurisdiction granted to district courts, including jurisdiction over bankruptcy claims (*see* Judicial Code, Pub. L. No. 61-475, 36 Stat. 1087, § 24(19) (1911)), diversity and federal question claims (*id.* at § 24(1)), and claims against the United States (*id.* at § 24(20)). With few exceptions then, section 24 of the Judicial Code originally "contained all of that title's grants of jurisdiction to United States district courts, save for several special-purpose jurisdictional grants of no relevance to the constitutionality of [Medicare] statutes." *See Weinberger v. Salfi*, 422 U.S. 749, 756, n. 3 (1975). It is thus undisputed that under the original text of § 405(h), bankruptcy court jurisdiction over Medicare claims was barred.

In 1948, however, Congress recodified section 24 of the Judicial Code under title 28 of the U.S. Code.[11] As part of that revision, Congress split the district

[11] Codification refers generally to the process of arranging and organizing the Statutes at Large into the U.S. Code. *See generally* Proceedings of the Fifty-First Annual Meeting of the American Association of Law Libraries, Fifth General Session, 51 Law Libr. J. 388 (1958) (remarks of Dr. Charles Zinn, Law Revision Counsel, explaining the process of codification); *see also* William W. Barron, *The Judicial Code*, 8 F.R.D. 439 (1949) (the "Chief Reviser, Title 28, U.S. Code, Judiciary and Judicial Procedure, and Title 18, U.S. Code, Crime and Criminal Procedure" explaining generally the 1948 Judicial Code revisions).

courts' jurisdictional grants into multiple sections under Title 28. *See* U.S. Code, Title 28, Pub. L. No. 80-773, 62 Stat. 869 (1948). Among other things, federal question jurisdiction was re-codified to 28 U.S.C. § 1331, diversity jurisdiction to § 1332, suits against the government to § 1346, and bankruptcy jurisdiction to § 1334. *See id.* at Ch. 85, §§ 1331-1359 ("District Courts; Jurisdiction").

After the 1948 re-codification however, the text of § 405(h) continued to incorrectly refer to "section 24 of the Judicial Code" for approximately the next thirty years. Indeed, the Supreme Court noted this issue in its 1975 *Salfi* decision. The text in the body of the Court's opinion replaced the reference in § 405(h) to "section 24 of the Judicial Code" with "[§ 1331 et seq.] of Title 28." *See Salfi*, 422 U.S. at 756. A footnote in the opinion acknowledged the apparent error created by the 1948 Judicial Code recodification. *See id.* at n. 3.

By 1976 (after the *Weinberger* decision), the Office of the Law Revision Counsel appears to have recognized the error.[12] In the edition of the U.S. Code published that year, the revisers substituted the phrase "section 24 of the Judicial Code of the United States" in § 405(h) with the now current language, "sections 1331 or 1346 of title 28." A "Codification" note included in the 1976 revision indicates the following about the change:

[12] The Office of the Law Revision Counsel, created in 1974, is a body within the U.S. House of Representatives whose principal purpose is to codify the laws of the U.S. and periodically publish updates to the U.S. Code. *See* 2 U.S.C. §§ 285 *et. seq.*

> In subsec. (h), "sections 1331 or 1346 of title 28" was substituted for "section 24 of the Judicial Code of the United States" on authority of act June 25, 1948, ch. 646, 62 Stat. 869, section 1 of which enacted Title 28, Judiciary and Judicial Procedure. Prior to the enactment of Title 28, section 24 of the Judicial Code was classified to section 41 of Title 28.

See 42 U.S.C. § 405 (1976). The revisers expanded somewhat on this note in the 1982 version of the code (added text emphasized):

> In subsec. (h), "sections 1331 or 1346 of title 28" was substituted for "section 24 of the Judicial Code of the United States" on authority of act June 25, 1948, ch. 646, 62 Stat. 869, section 1 of which enacted Title 28, Judiciary and Judicial Procedure. Prior to the enactment of Title 28, section 24 of the Judicial Code was classified to section 41 of Title 28. *Jurisdictional provisions previously covered by section 41 of Title 28 are covered by sections 1331 to 1348, 1350 to 1357, 1359, 1397, 1399, 2361, 2401, and 2402 of Title 28.*

See 42 U.S.C. § 405 (1982).

A year later, H.R. 3805, the "Technical Corrections Act of 1983" was introduced to the floor of the House. 129 Cong. Rec. 23,439 (1983) (statement of Rep. Rostenkowski). A report on the bill describes its derivation and purpose as follows:

> The technical amendments made by the Technical Corrections Act of 1983 are intended to clarify and conform various provisions adopted by the acts listed above. The bill is based on a review by the staffs of the Joint Committee on Taxation and the Committee on Ways and Means, taking into account the comments submitted to the Congress that concerned changes that would be technical in nature. The bill was developed with the assistance of the Treasury Department, the Social Security Administration, and the Health Care Financing Administration.

See STAFF OF J. COMM. ON TAXATION, 98TH CONG., DESCRIPTION OF H.R. 3805 (TECHNICAL CORRECTIONS ACT OF 1983), at 1 (J. Comm. Print 1983) ("H.R. 3805 Rept.").

Among the numerous "technical amendments" was an amendment to § 405(h), proposing to enact the prior codification into positive law:

> (D) Section 205(h) of such Act is amended by striking out "Section 24 of the Judicial Code of the United States" and inserting in lieu thereof "section 1331 or 1346 of title 28, United States Code,".

See Technical Corrections Act of 1983: Hearing on H.R. 3805 Before the H. Comm. on Ways and Means, 98th Cong. 79 (1984) (draft text of H.R. 3805).[13] That section of the act, titled "Sec. 403. Other Technical Corrections in [old age, survivors, and disability insurance] Provisions,"[14] was followed by this in "Sec. 404. Effective Dates":

> (b)(1) Except to the extent otherwise specifically provided in this title, the amendments made by section 403 shall be effective on the date of enactment of this Act; *but none of such amendments shall be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date*.

[13] The U.S. Code is not necessarily "positive law." Rather, the text of the U.S. Code is *prima facie* evidence of the law of the United States; where the code conflicts with the Statutes at Large however, the Statutes at Large trump. *See U.S. Nat. Bank of Oregon v. Indep. Ins. Agents of Am., Inc.*, 508 U.S. 439, 448 (1993). Additionally, some parts of the code have been enacted into positive law; when this happens, the text of the code becomes evidence of the law. *See id.* at 448 n. 3 (citing to 1 U.S.C. § 204(a)); *see generally* Alice I. Youmans, et. al., *Questions & Answers*, 78 Law. Libr. J. 585, 590 (1986) (explaining the relationship between the U.S. Code, Statutes at Large, and positive law).

[14] *See e.g.* H.R. 3805 Rept. at 20.

See id. at 89-90 (emphasis added). The legislative history of H.R. 3805 appears to characterize this and other "technical corrections" as "certain corrections of spelling, punctuation, and cross-references in title XVIII of the Social Security Act and in cross-references to the Internal Revenue Code." *See* H.R. 3805 Rept. at 37.[15] Moreover, the bill's sponsor, Rep. Dan Rostenkowski, noted when the bill was introduced: "I would like to emphasize that this bill intends simply to correct technical errors and to better reflect the policies established by the Congress in enacting the original legislation." 129 Cong. Rec. 23321, 23440 (1983). H.R. 3805 did not contain any provisions relating to the jurisdiction of bankruptcy courts.

Although H.R. 3805 did not become law, in 1984 it was merged into another bill, H.R. 4170, which Congress passed as The Deficit Reduction Act of 1984, Pub. L. No. 98-369, 98 Stat. 494 (1984) (hereinafter, the "DRA").[16] As noted in the bill itself, the general purpose of the DRA was "to provide for tax reform, and for deficit reduction." *See* 98 Stat. at 494. The DRA did not contain any provisions relating to the scope of bankruptcy court jurisdiction.

The amendment to § 405(h) is located in "DIVISON V – SPENDING REDUCTION ACT OF 1984", "TITLE VI — OASDI, SSI, AFDC, AND OTHER

[15] The report similarly notes that where no descriptions are provided, the amendments are "clerical in nature." *Id.* at 1.

[16] *See* H.R. Rep. No. 98-432, pt. 2, at 1027 (1984) (explaining that "Title VI – Technical Corrections" of H.R. 4170 originated as the amended H.R. 3805).

PROGRAMS," "Subtitle D — Technical Corrections," "Sec. 2663. Other technical corrections in the Social Security Act and related provisions." Consistent with the 1976 and 1982 codification (and the amendment originally proposed in H.R. 3805), section 2663(a)(4)(D) ordered that "Section 205(h) of [the Social Security Act] is amended by striking out 'section 24 of the Judicial Code of the United States' and inserting in lieu thereof 'section 1331 or 1346 of title 28, United States Code,'." *See* 98 Stat. at 1162. Section 2664 of the DRA further requires that "[e]xcept to the extent otherwise specifically provided in this subtitle, the amendments made by section 2663 shall be effective on the date of the enactment of this Act; but none of such amendments shall be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date." *See id.* at 1171-72.

The House committee report on the DRA explains the reasons for the "technical corrections" of certain sections in the bill, but does not specifically address the amendments to § 405(h). The report generally states that the "bill makes certain corrections of spelling, punctuation, cross-references and other clerical amendments to the Social Security Act and related provisions in the Internal Revenue Code." *See* H.R. Rep. No. 98-432, pt. 2, at 1663 (1984). Nothing in the report or elsewhere in the legislative history, in so far as we have been able to determine, expresses any intention to change the jurisdiction of bankruptcy

courts, let alone to grant bankruptcy courts parallel authority with HHS over Medicare claims.

It thus appears that the current text of § 405(h) is the result of the Office of the Law Revision Counsel's mistaken codification, an error enacted into positive law by the DRA. While the Supreme Court has yet to speak on this precise issue, the Court has had reason to interpret § 405(h) in a number of cases that are helpful in resolving the current dispute. We thus turn to an examination of those cases before turning back to the codification issue.

B. Supreme Court cases interpreting § 405(h)

The earliest relevant Supreme Court decision, *Salfi*, was decided prior to the DRA amendment to § 405(h). In *Salfi* the plaintiff brought suit to challenge the Social Security Administration's "duration-of-relationship requirements" as unconstitutional. 422 U.S. at 752-53. The district court exercised jurisdiction over the case pursuant to 28 U.S.C. § 1331. *Id.* at 755. While deciding the constitutional question against the plaintiff, more relevant for our purposes is the Court's analysis of the "serious question as to whether the District Court had jurisdiction over this suit" to begin with. *See Salfi*, *Id.* at 756.

In examining the requirements of § 405(h), the Court found that the third sentence, "No action against the United States, the Secretary, or any officer or employee thereof shall be brought under (§ 1331 et seq.) of Title 28 to recover on

any claim arising under (Title II of the Social Security Act)"[17] should be read as more than merely a "codified requirement of administrative exhaustion" because the first two sentences of § 405(h) already require administrative exhaustion. *Id.* at 757.[18] Those first two sentences prevent review of any decision of the Secretary other than as set out in § 405(g), which prescribes "typical requirements for review of matters before an administrative agency, including administrative exhaustion." *Id.* at 758. The Court thus explained that the third sentence of § 405(h) acted to bar actions under § 1331, even where administrative remedies had been exhausted. *Id.* at 757.

Somewhat less than a decade later, the Court again considered § 405(h) again in *Heckler v. Ringer*, 466 U.S. 602 (1984). In *Ringer*, the underlying factual dispute involved "challenges to the policy of the Secretary of Health and Human Services (Secretary) as to the payment of Medicare benefits for a surgical procedure known as bilateral carotid body resection (BCBR)." *Id.* at 604-05. The focus of the case was whether the plaintiff's claims "arose" under the Medicare Act. *See e.g. id.* at 612-613. But in characterizing § 405(h) and its own holding in

[17] As noted previously, the third sentence of § 405(h) at the time incorrectly referred to title 24 of the Judicial Code, and the Court's opinion inserted the correct cross-reference to the relevant section of Title 28 of the U.S. Code. *See id.* at 756 n. 3. While surely strong evidence of how the Supreme Court reads § 405(h), *Salfi* did not raise the interpretive issue at the heart of this case, and thus does not dispose of the issue.

[18] The first two sentences read: "The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided." 42 U.S.C. § 405(h).

Salfi, the Court held that "[t]he third sentence of 42 U.S.C. § 405(h), made applicable to the Medicare Act by 42 U.S.C. § 1395ii, provides that § 405(g), to the exclusion of 28 U.S.C. § 1331, is the sole avenue for judicial review for all 'claim[s] arising under' the Medicare Act." *Id.* at 614-15.

Perhaps most instructive is a more recent case, decided long after the 1984 DRA amendments to § 405(h), *Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1 (2000). The plaintiffs in *Illinois Council* were an association of nursing homes challenging the legality and constitutionality of certain Medicare-related regulations. *Id.* at 5. As in *Ringer*, the key issue in *Illinois Council* was whether the plaintiff's claims "arose" under the Medicare Act (and were thus subject to the § 405(h) jurisdictional bar). *Id.* at 9-10.

However, in explaining the application of § 405(h) to the case, the Court again emphasized that the effect of § 405(h) was to reach beyond normal principles of "administrative exhaustion" and "ripeness," and prevent even the application of normal exceptions to those doctrines. *Id.* at 12. The Court held that § 405(h) "demands the 'channeling' of *virtually all legal attacks* through the agency." *Id.* at 13 (emphasis added). Moreover, the Court explained the balancing policy interests inherent in such a scheme:

> [I]t assures the agency greater opportunity to apply, interpret, or revise policies, regulations, or statutes without possibly premature interference by different individual courts applying "ripeness" and "exhaustion" exceptions case by case. But this assurance comes at

> a price, namely, occasional individual, delay-related hardship. In the context of a massive, complex health and safety program such as Medicare, embodied in hundreds of pages of statutes and thousands of pages of often interrelated regulations, any of which may become the subject of a legal challenge in any of several different courts, paying this price may seem justified.

Id. at 13. As the Court noted, whatever one may think of such a policy, it was clearly that chosen by Congress in creating § 405(h).[19]

A few salient points about § 405(h) are thus clear from the relevant Supreme Court cases. *Salfi* makes clear that the first two sentences of § 405(h) require standard administrative exhaustion of remedies prior to bringing Medicare claims before a district court. *See Salfi*, 422 U.S. at 757. Moreover, § 405(h) "demands the 'channeling' of virtually all legal attacks through the agency," making § 405(g) the "sole avenue for judicial review for all 'claim[s] arising under' the Medicare Act." *See Illinois Council*, 529 U.S. at 13; *Ringer*, 466 U.S. at 615-14. However, we must acknowledge a common thread running through all three cases: each involved a suit brought under 28 U.S.C. § 1331, a jurisdictional grant that all parties agree was barred by § 405(h) prior to the 1984 amendments and continues to be barred after the amendments.[20] Thus, none of these cases answers the

[19] *See id.* at 13 (noting that "[i]n any event, such was the judgment of Congress as understood in *Salfi* and *Ringer*").

[20] Similarly, to the extent our Court has addressed the reach of the jurisdictional bar of § 405(h) since the 1984 DRA amendments, it appears that the cases have been § 1331 cases. *See e.g. Dial v. Healthspring of Alabama, Inc.*, 541 F.3d 1044, 1047-48 (11th Cir. 2008); *Cochran v. U.S. Health Care Fin. Admin.*, 291 F.3d 775, 778-79 (11th Cir. 2002); *United States v. Blue Cross & Blue Shield of Alabama, Inc.*, 156 F.3d 1098, 1101 (11th Cir. 1998); *Am. Acad. of Dermatology*

question before us, namely, does § 405(h) bar jurisdiction under § 1334? To further examine the question, we turn to the decisions of our sister circuits.

C. Courts split over the application of § 405(h) to district courts

The decisions of our sister circuits (and the lower courts) fall into two categories. The first group of cases holds that the jurisdictional bar of § 405(h) applies to cases brought under § 1332 jurisdiction (*i.e.* diversity jurisdiction), notwithstanding the fact that § 1332 (like § 1334) is not mentioned in the statute. The second group of cases directly considers whether § 1334 jurisdiction can lie in the face of § 405(h).

1. Cases holding that § 405(h) bars jurisdiction

The primary case among the first category of § 1332 decisions is from the Seventh Circuit in *Bodimetric Health Servs., Inc. v. Aetna Life & Cas.*, 903 F.2d 480 (7th Cir. 1990). In determining whether a review of plaintiff's claims in a district court was precluded by § 405(h), the Seventh Circuit noted the "curious" fact that § 405(h) on its face appears to bar "actions brought pursuant to federal

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v. Dep't of Health & Human Servs., 118 F.3d 1495, 1499 n. 8 (11th Cir. 1997); *Am. Fed'n of Home Health Agencies, Inc. v. Heckler*, 754 F.2d 896, 897-98 (11th Cir. 1984). Both parties cite and discuss *V.N.A. of Greater Tift Cty., Inc. v. Heckler*, 711 F.2d 1020 (11th Cir. 1983). Though *V.N.A.* was decided before the 1984 amendments, it appears the Court in that case cited to the Law Revision Counsel's 1976 (or 1982) re-codified version of the statute in its opinion. *See V.N.A.*, 711 F.2d at 1024. In a footnote of the opinion, the Court notes that "[t]here can be no question that § 405(h) fully applies to the present case, because the district court's jurisdiction is founded on 28 U.S.C. § 1331." *Id.*at n. 5. We also note *Lifestar Ambulance Serv., Inc. v. United States*, 365 F.3d 1293, 1295 n. 3 (11th Cir. 2004), in which this Court assumed, but did not decide, that mandamus jurisdiction under § 1361 was not barred under § 405(h). These cases do not address the issue of whether actions brought under § 1334 are barred by § 405(h).

question jurisdiction and actions brought against the United States but appears to permit actions brought pursuant to diversity jurisdiction." *See id.* at 488. However, the Seventh Circuit then analyzed the codification history described *supra,* holding that in § 2664(b) of the DRA Congress had "clearly expressed" its intent not to substantively change the scope of § 405(h). *Id.* at 489. Thus, because the statute prior to amendment had clearly barred diversity jurisdiction, the revised statute continued to bar diversity jurisdiction. *Id.*

Both the Third and Eighth circuits have subsequently adopted the holding and analysis of *Bodimetric*. See *Nichole Med. Equip. & Supply, Inc. v. TriCenturion, Inc.*, 694 F.3d 340, 346-47 (3d Cir. 2012); *Midland Psychiatric Associates, Inc. v. United States*, 145 F.3d 1000, 1004 (8th Cir. 1998). An earlier Third Circuit case, *In re Univ. Med. Ctr., Inc.*, 973 F.2d 1065, 1073-74 (3d Cir. 1992), appears to suggest (but not hold) that § 405(h) may not apply to bankruptcy courts. However, that case involved a claim that HHS had violated an automatic bankruptcy stay. The court's opinion hinged on its holding that such a claim did not "arise" under the Medicare act. *Id.* at 1073. In *Nichole Med. Equip.*, the Third Circuit explicitly adopted *Bodimetric*, noting that "Congress clearly prohibited federal courts from exercising subject matter jurisdiction or diversity jurisdiction over claims arising under the [Medicare] Act." *See* 694 F.3d at 347.

Several circuits have thus addressed the question of whether § 405(h) bars districts court jurisdiction other than pursuant only to §§ 1331 and 1346. Those circuits read the history of § 405(h) to conclude that the codification error acts to carry forward the original § 405(h)'s jurisdictional restrictions.[21]

2. Cases holding that § 405(h) does not bar § 1334 jurisdiction

The second category of cases come first from the Ninth Circuit and begin with *In re Town & Country Home Nursing Servs.*, 963 F.2d 1146 (9th Cir. 1991). The court there was asked to determine if the failure to exhaust administrative remedies precluded a bankruptcy court from exercising jurisdiction over state law tort and contract claims "arising out of the government's setoff of Medicare overpayments." *Id.* at 1154. The Ninth Circuit held that "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." *Id.* at 1155. The Ninth Circuit appears to have placed great weight on "section 1334's broad jurisdictional grant over all matters conceivably having an effect on the bankruptcy estate." *Id.* However, the court did not discuss or analyze the legislative history relied on in the *Bodimetric* line of cases.

[21] Although not squarely deciding the issue, a number of other circuit court decisions have suggested that § 405(h) bars jurisdictions other than pursuant to only §§ 1331 and 1346. *See BP Care, Inc. v. Thompson*, 398 F.3d 503, 515 n. 11 (6th Cir. 2005) (citing favorably to *Bodimetric* analysis); *St. Vincent's Med. Ctr. v. United States*, 32 F.3d 548, 550 (Fed. Cir. 1994) (holding that Court of Federal claims jurisdiction barred by § 405(h)). The First Circuit has recognized the issue, but declined to address it. *See In re Ludlow Hosp. Soc., Inc.*, 124 F.3d 22, 25 n. 7 (1st Cir. 1997) (recognizing, but avoiding, § 405(h) jurisdictional issue by deciding case on merits).

A later Ninth Circuit case, *Kaiser v. Blue Cross of California*, 347 F.3d 1107, 1114 (9th Cir. 2003), cites favorably to both *Bodimetric* and *Midland Psychiatric* for what those cases say about a claim that "arises under Medicare." It appears that the court in *Kaiser* assumed that the plaintiffs were proceeding under federal-question jurisdiction (which is indisputably precluded by § 405(h)), and thus the only relevant question was whether their claims "arose" under Medicare. But in a dicta discussion of whether there had been a waiver of sovereign immunity, the court noted that "11 U.S.C. § 106(a), which refers to waivers of sovereign immunity in bankruptcy proceedings, could not apply since any consideration of claims against the government in [debtor]'s bankruptcy would likely require consideration of the merits of the Medicare claims, again invoking 42 U.S.C. § 405(g)." *Id.* at 1117. Thus, *Kaiser* at least hints that the court would have come to the opposite conclusion of *In re Town & Country*, *i.e.* by holding that bankruptcy jurisdiction could not trump the exhaustion requirements of §§ 405(g) and (h).

A more recent Ninth Circuit decision, *Do Sung Uhm v. Humana, Inc.*, 620 F.3d 1134 (9th Cir. 2010) attempted to address what it characterized as a possible conflict between *Kaiser* and *In re Town & Country*. The *Do Sung Uhm* court cites *Kaiser* for the proposition that "[j]urisdiction over cases 'arising under' Medicare exists only under 42 U.S.C. § 405(g), which requires an agency decision in

advance of judicial review." *Id.* at 1140-41. In a footnote though, the court acknowledges the tension between *Kaiser*'s broad reading of § 405(h) and *In re Town & Country*'s more narrow reading, but reconciles the two on the grounds that *In re Town & Country* relied on the "special status" of bankruptcy court jurisdiction over bankruptcy issues. *Id.* at 1141 n. 11. The court concludes that *In re Town & Country*'s reading of 42 U.S.C. § 405(h) applies "only to actions brought under § 1334, while not bearing on the relationship between § 405(h) and other jurisdictional provisions such as § 1332." *Id.* The Ninth Circuit thus joins the other circuit courts in unanimously opining that § 405(h) bars diversity jurisdiction under § 1332, notwithstanding the omission of § 1332 from the text of § 405(h).

However, the Ninth Circuit is alone among circuit court decisions in reading § 405(h) to permit bankruptcy court jurisdiction over Medicare claims under § 1334. Many lower courts have also considered the issue of § 1334 jurisdiction. These lower courts have split, with some assuming jurisdiction,[22] and others

[22] *See e.g. In re Nurses' Registry & Home Health Corp.*, 533 B.R. 590, 593-97 (Bankr. E.D. Ky. 2015); *In re Slater Health Ctr., Inc.*, 294 B.R. 423, 428 (Bankr. D.R.I. 2003), *vacated in part*, 306 B.R. 20 (D.R.I. 2004), *aff'd*, 398 F.3d 98 (1st Cir. 2005); *In re Healthback, L.L.C.*, 226 B.R. 464, 472-74 (Bankr. W.D. Okla. 1998), *vacated*, *In re HealthBack, L.L.C.*, Case No. 97-22616-BH, 1999 WL 35012949 (Bankr. W.D. Okla. May 28, 1999); *First Am. Health Care of Georgia Inc. v. Dep't of Health & Human Servs.*, 208 B.R. 985, 988-90 (Bankr. S.D. Ga. 1996), *vacated and superseded sub nom.*, *First Am. Health Care of Georgia, Inc. v. U.S. Dep't of Health & Human Servs.*, Case No. 96-2007, 1996 WL 282149 (Bankr. S.D. Ga. Mar. 11, 1996); *In re Healthmaster Home Health Care, Inc.*, Case No. 95-10548, 95-01031A, 1995 WL 928920, at *1 (Bankr. S.D. Ga. Apr. 13, 1995); *In re Shelby Cty. Healthcare Servs. of AL, Inc.*, 80 B.R. 555, 557-60 (Bankr. N.D. Ga. 1987).

deciding jurisdiction was barred.[23] Case going both ways have recognized and analyzed the codification error that led to the present omission of § 1334 from the text of § 405(h). *Compare e.g. In re Nurses' Registry & Home Health Corp.*, 533 B.R. 590, 593-97 (Bankr. E.D. Ky. 2015) (assuming jurisdiction under § 1334) *to In re St. Johns Home Health Agency, Inc.*, 173 B.R. 238, 245-46 (Bankr. S.D. Fla. 1994) (holding that § 1334 jurisdiction is barred).

We also note some limited scholarship addressing this issue as well. Articles written by members of the bankruptcy bar argue that under the "plain meaning" doctrine, bankruptcy courts' § 1334 jurisdiction is not barred by § 405(h). *See* 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. 19, 66 (2015); Peter R. Roest, *Recovery of Medicare and Medicaid Overpayments in Bankruptcy*, 10 Annals Health L. 1, 1 (2001). Conversely, an article written by current and former counsel for HHS argues that, based on the

[23] *Excel Home Care, Inc. v. U.S. Dep't of Health & Human Servs.*, 316 B.R. 565, 572-574 (D. Mass. 2004); *In re Hodges*, 364 B.R. 304, 305-6 (Bankr. N.D. Ill. 2007); *In re House of Mercy, Inc.*, 353 B.R. 867, 869-73 (Bankr. W.D. La. 2006); *In re Fluellen*, Case No. 05-40336 (ALG), 2006 WL 687160, at *1 (Bankr. S.D.N.Y. Mar. 13, 2006); *U.S., Dep't of Health & Human Servs. v. James*, 256 B.R. 479, 481-82 (W.D. Ky. 2000); *In re Hosp. Staffing Servs., Inc.*, 258 B.R. 53, 57-58 (S.D. Fla. 2000); *In re Mid-Delta Health Sys., Inc.*, 251 B.R. 811, 814-15 (Bankr. N.D. Miss. 1999); *In re Tri Cty. Home Health Servs., Inc.*, 230 B.R. 106, 108 n. 1 (Bankr. W.D. Tenn. 1999); *In re S. Inst. for Treatment & Evaluation, Inc.*, 217 B.R. 962, 965 (Bankr. S.D. Fla. 1998); *In re Home Comp Care, Inc.*, 221 B.R. 202, 206 (N.D. Ill. 1998); *In re AHN Homecare, LLC*, 222 B.R. 804, 807-10 (Bankr. N.D. Tex. 1998); *In re Orthotic Ctr., Inc.*, 193 B.R. 832, 835 (N.D. Ohio 1996); *In re St. Johns Home Health Agency, Inc.*, 173 B.R. 238, 245–46 (Bankr. S.D. Fla. 1994); *In re Upsher Labs., Inc.*, 135 B.R. 117, 117-20 (Bankr. W.D. Mo. 1991); *In re St. Mary Hosp.*, 123 B.R. 14, 16-18 (E.D. Pa. 1991).

legislative history, the amended § 405(h) should have the same effect as the prior version, *i.e.* barring bankruptcy court jurisdiction. *See* John Aloysius Cogan Jr. & Rodney A. Johnson, *Administrative Channeling Under the Medicare Act Clarified: Illinois Council, Section 405(h), and the Application of Congressional Intent*, 9 Annals Health L. 125, 125 (2000).

3. Mandamus jurisdiction and § 405(h)

We note in passing a related issue: whether § 405(h) bars mandamus jurisdiction exercised pursuant to 28 U.S.C. § 1361. As noted *supra,* n. 20, this circuit has not decided that issue. *See Lifestar Ambulance Serv., Inc. v. United States*, 365 F.3d 1293, 1295 n. 3 (11th Cir. 2004). The Supreme Court has also repeatedly declined to decide whether mandamus jurisdiction is prohibited by § 405(h). *See e.g. Your Home Visiting Nurse Servs., Inc. v. Shalala*, 525 U.S. 449, 456 n. 3 (1999). However, the great weight of authority from other circuits has almost uniformly found that § 405(h) does not necessarily deprive district courts of mandamus jurisdiction over Medicare claims.[24]

Superficially at least, there is some commonality between the issue in those cases regarding § 1361, and the issue in our case involving § 1334, because both

[24] *See e.g. Randall D. Wolcott, M.D., P.A. v. Sebelius*, 635 F.3d 757, 766 (5th Cir. 2011); *Cordoba v. Massanari*, 256 F.3d 1044, 1047 (10th Cir. 2001); *Buchanan v. Apfel*, 249 F.3d 485, 491–92 (6th Cir. 2001); *Briggs v. Sullivan*, 886 F.2d 1132, 1142 (9th Cir. 1989); *Burnett v. Bowen*, 830 F.2d 731, 738 (7th Cir. 1987); *Ganem v. Heckler*, 746 F.2d 844, 851-52 (D.C. Cir. 1984); *Kuehner v. Schweiker*, 717 F.2d 813, 819 (3d Cir. 1983), *judgment vacated sub. nom. on other grounds*, *Heckler v. Kuehner*, 469 U.S. 977 (1984); *Belles v. Schweiker*, 720 F.2d 509, 513 (8th Cir. 1983); *Ellis v. Blum*, 643 F.2d 68, 81 (2d Cir. 1981).

jurisdictional provisions are not listed in the text of § 405(h). The commonality is just that though, superficial. As Judge Friendly of the Second Circuit accurately explained, when § 405(h) was passed in 1939, mandamus jurisdiction was not one of the jurisdictional provisions contained in Section 24 of the Judicial Code. *See Ellis v. Blum*, 643 F.2d 68, 81 (2d Cir. 1981).[25] Thus, unlike § 1334, there is no argument to be made that the codification of section 24 into Title 28 had any impact on the availability of mandamus relief under § 1361. *See id.; see also Ganem v. Heckler*, 746 F.2d 844, 851 (D.C. Cir. 1984) (noting that absence of § 1361 was unrelated to codification error because even in original version of § 405(h), § 24 of the Judicial Code did not include District of Columbia's common law jurisdiction to issue mandamus writs).

However, the issue of whether a district court can exercise mandamus jurisdiction related to Medicare claims, notwithstanding the § 405(h) bar, is neither in front of the court, nor necessary to resolve the current dispute. As previously,

[25] In fact, at that time only district courts in the District of Columbia could exercise mandamus jurisdiction, pursuant to an uncodified grant of authority dating back to the early nineteenth century and the District of Columbia's adoption of Maryland law. *See id.* District courts elsewhere in the country were granted mandamus jurisdiction explicitly when Congress passed the Mandamus and Venue Act, Pub. L. No. 87-748, 76 Stat. 744 (1962). Judge Friendly reasoned that Congress likely did not intend to bar District of Columbia courts' mandamus jurisdiction when it passed § 405(h) because that uncodified jurisdiction was not specifically excluded, and Congress similarly did not intend mandamus jurisdiction to suddenly become subject to § 405(h) when mandamus jurisdiction was extended to other courts in 1962. *See Ellis,* 643 F.2d at 81.

we thus decline to decide the issue. *See Lifestar Ambulance Serv.*, 365 F.3d at 1295 n. 3.

D. The Bankruptcy Court Lacked Jurisdiction Under § 405(h)

With that considerable background in mind, we turn now to the issue in this case: did 42 U.S.C. § 405(h) bar the bankruptcy court below from taking jurisdiction over Bayou Shore's Medicare provider agreement under 28 U.S.C. § 1334? Because we are persuaded that the 1984 amendments to § 405(h) were a codification and not a substantive change, we 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]."

1. The Deficit Reduction Act of 1984 amendment to § 405(h) was a codification and did not substantively change the law.

Bayou Shores' primary argument, and the primary argument of courts holding that § 1334 jurisdiction is not barred § 405(h), is relatively straightforward: the text of the third sentence of § 405(h) does not mention § 1334, and thus, under the "plain meaning" of the statute § 1334 jurisdiction is not barred by § 405(h). Bayou Shores is certainly correct that "when [a] statute's language is plain, the sole function of the courts—at least where the disposition required by the text is not absurd—is to enforce it according to its terms." *Lamie v. U.S. Tr.*, 540 U.S. 526, 534 (2004) (internal quotation marks and citations removed); *see also Owner-*

Operator Indep. Drivers Ass'n, Inc. v. Landstar Sys., Inc., 622 F.3d 1307, 1327 (11th Cir. 2010) (holding that "[t]here is no reason for this Court to rewrite a statute because of an alleged scrivener error unless a literal interpretation would lead to an absurd result.")

But that is not the end of the analysis because this case is governed by a particular canon in statutory construction regarding the codification of law, *i.e.* the process of converting and organizing the Statues at Large into the U.S. Code. Since virtually the founding of the Republic, it has been recognized that when legislatures codify the law, courts should presume that no substantive change was intended absent a clear indication otherwise. For example, in the oldest case we have been able to locate,[26] *Taylor v. Delancy*, 2 Cai. Cas. 143, 151 (N.Y. Sup. Ct. 1805), the New York Supreme Court of Judicature[27] held "that where the law, antecedently to the revision was settled, either by clear expressions in the statutes, or adjudications on them, the mere change of phraseology shall not be deemed or construed a change of the law, unless such phraseology evidently purports an intention in the legislature to work a change."

[26] The difficulties inherent in codifying and organizing the law are older still, and plagued even the earliest democracy. Aristotle notes that after the Athenian statesmen Solon "had organized the [Athenian] constitution in the manner stated, people kept coming to him and worrying him about his laws, criticizing some points and asking questions about others," causing him to leave Greece for Egypt for the next ten years. *See* ARISTOTLE, THE ATHENIAN CONSTITUTION, Ch. 11 (H. Rackham trans., Cambridge, MA, Harvard University Press 1952).

[27] The Supreme Court of Judicature was the "highest common-law" state court in New York at that time. *See William J. Jenack Estate Appraisers & Auctioneers, Inc. v. Rabizadeh*, 22 N.Y.3d 470, 478 (2013).

The Supreme Court appears to have recognized the canon at least as early as *Stewart v. Kahn*, 78 U.S. 493, 502 (1870), where the Court held that "[a] change of language in a revised statute will not change the law from what it was before, unless it be apparent that such was the intention of the legislature." The Court reiterated the principle in *United States v. Ryder*, 110 U.S. 729, 740 (1884), holding that "[i]t will not be inferred that the legislature, in revising and consolidating the laws, intended to change their policy, unless such intention be clearly expressed." This canon of statutory construction has remained undisturbed since that time. *See e.g. McDonald v. Hovey*, 110 U.S. 619, 629 (1884); *Logan v. United States*, 144 U.S. 263, 302 (1892), *abrogated on other grounds*, *Witherspoon v. State of Ill.*, 391 U.S. 510 (1968); *Holmgren v. United States*, 217 U.S. 509, 520 (1910); *Anderson v. Pac. Coast S.S. Co.*, 225 U.S. 187, 199 (1912); *United States v. Sischo*, 262 U.S. 165, 168-69 (1923); *Hale v. Iowa State Bd. of Assessment & Review*, 302 U.S. 95, 102 (1937); *Fourco Glass Co. v. Transmirra Products Corp.*, 353 U.S. 222, 227 (1957); *United States v. FMC Corp.*, 84 S. Ct. 4, 7 (Goldberg, Circuit Justice 1963); *United States v. Welden*, 377 U.S. 95, 98 n. 4 (1964); *Tidewater Oil Co. v. United States*, 409 U.S. 151, 162 (1972); *Cass v. United States*, 417 U.S. 72, 82 (1974); *Aberdeen & Rockfish R. Co. v. Students Challenging Regulatory Agency Procedures (S.C.R.A.P.)*, 422 U.S. 289, 309 n. 12 (1975); *Muniz v. Hoffman*, 422 U.S. 454, 470 (1975); *Fulman v. United States*, 434

U.S. 528, 538 (1978); *Walters v. Nat'l Ass'n of Radiation Survivors*, 473 U.S. 305, 318 (1985); *Finley v. United States*, 490 U.S. 545, 554 (1989); *Ankenbrandt v. Richards*, 504 U.S. 689, 700 (1992); *Keene Corp. v. United States*, 508 U.S. 200, 209 (1993); *Scheidler v. Nat'l Org. for Women, Inc.*, 547 U.S. 9, 20 (2006); *John R. Sand & Gravel Co. v. United States*, 552 U.S. 130, 136 (2008).

As it happens, a number of these cases from the 20th century arise from an event that directly touches on the issues in our case: the 1948 recodification of the Judicial Code.[28]

In one of the earlier cases to examine the 1948 recodification, *Fourco Glass Co. v. Transmirra Products Corp.*, 353 U.S. 222 (1957), the Court considered whether the recodification had substantively changed venue rules in patent cases. The issue was whether or not the specific patent venue statute, 28 U.S.C. § 1400(b) was supplemented by the more general (and more expansive) civil suit venue statute, 28 U.S.C. § 1391. *Id.* at 222. The Court first noted that in a pre-1948 recodification case, *Stonite Products Co. v. Melvin Lloyd Co.*, 315 U.S. 561 (1942), the Court had already determined that the more specific patent venue provisions in the old Judicial Code of 1911 trumped more general venue provisions

[28] The 1948 recodification moved "section 24 of the Judicial Code" to Title 28 of the U.S. Code, but 42 U.S.C. § 405(h) continued to refer to "section 24 of the Judicial Code" until the DRA amendment in 1984.

for civil suits.[29] The only issue therefore was whether the 1948 recodification (which recodified § 48 of the Judicial Code to 28 U.S.C. § 1400(b)) had substantively changed the patent venue statute. *Fourco Glass*, 353 U.S. at 225. Noting that neither the legislative history, nor the Reviser's Notes, indicated that any substantive change was intended, the Court reasoned that "[t]he change of arrangement, which placed portions of what was originally a single section in two separated sections cannot be regarded as altering the scope and purpose of the enactment. For it will not be inferred that Congress, in revising and consolidating the laws, intended to change their effect, unless such intention is clearly expressed." *Id.* at 227 (internal quotation marks and citations omitted) (quoting from *Anderson v. Pac. Coast S.S. Co.*, 225 U.S. 187, 198 (1912)). The Court thus held that no substantive change to 28 U.S.C. § 1400(b) had occurred during the 1948 recodification and the result in *Stonite Products* dictated the outcome of the case. *Id.* at 227-28.

Similarly, in *Tidewater Oil Co. v. United States*, 409 U.S. 151, 162 (1972), the Court rejected the argument that the 1948 Judicial Code revisions substantively changed the existing law concerning appellate court jurisdiction over interlocutory appeals in Government civil antitrust cases. The 1948 revision to 28 U.S.C. § 1292(a)(1) allowed interlocutory appeals of district court order to the courts of

[29] *Compare* Judicial Code, Pub. L. No. 61-475, 36 Stat. 1087, § 48 (1911) *with id.* at § 52.

appeals, "except where a direct review may be had in the Supreme Court." *Id.* Under then-existing law, appellate courts had no jurisdiction over any appeals in Government civil antitrust cases (which were appealed directly to the Supreme Court), and interlocutory appeals to the Supreme Court in Government civil antitrust cases were not permitted. *Id.* at 154-56, 160. The Court thus reasoned that a possible interpretation of the new language added by the 1948 revisions, "except where a direct review may be had in the Supreme Court," was that appellate court jurisdiction over interlocutory appeals in Government civil anti-trust cases was now available (contrary to prior law) because "direct review" in the Supreme Court of an interlocutory appeal could not "be had." *Id.* at 162.

Citing to *Fourco Glass*, the Court rejected that interpretation because no such change to existing law had been "clearly expressed" by the 1948 revisions. "To the contrary, the Revisers' Notes fail to reveal any intention to expand the scope of the pre-existing jurisdiction of the courts of appeals over interlocutory appeals; the new § 1292 is described merely as a consolidation of a number of previously separate code provisions—including the general interlocutory appeals provision—'with necessary changes in phraseology to effect the consolidation.'" *Id.* at 162-63. The Court thus concluded that the 1948 revisions did not substantively expand the jurisdiction of appellate courts. *Id.* at 163.

Muniz v. Hoffman, 422 U.S. 454, 456-57 (1975) arose out of a labor dispute between the San Francisco Typographical Union and a local daily newspaper, in which the union and its officers had been cited for criminal contempt in violating certain court orders and subsequently denied a jury trial in the criminal contempt proceedings. A key issue in the case was whether the Wagner and Taft-Hartley Acts,[30] which authorized courts to grant certain injunctions, permitted jury trials to those found in contempt of the injunctions. *Id.* at 461. The parties appeared to agree that prior to the 1948 revisions of the Criminal Code,[31] a contemnor had no right to a jury trial in contempt actions to enforce injunctions issued under the Wagner and Taft-Hartley Acts, notwithstanding the jury requirements in § 11 of the earlier passed Norris-LaGuardia Act.[32] Petitioners argued however that in recodifying § 11 of Norris-LaGuardia as 18 U.S.C. § 3692 in 1948, Congress had overruled its prior policy of not permitting jury trials in contempt actions to enforce injunctions issued under the Wagner and Taft-Hartley Acts. *Id.* at 467.

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[30] National Labor Relations Act, Pub. L. No. 74-198, 49 Stat. 449 (1935) (the "Wagner Act"); Labor Management Relations Act, Pub. L. No. 80-101, 61 Stat. 136 (1947) (the "Taft-Harley Act").

[31] As the Court notes, the 1948 revision to the Criminal Code followed a "parallel course" to the revision to the Judicial Code, and was prepared by the same staff of experts. *See Muniz*, 422 U.S. at 470 n. 10.

[32] Injunctions in Labor Disputes, Pub. L. No. 72-65, 47 Stat. 70 (1932) (the "Norris-LaGuardia Act"). §11 of the Norris-LaGuardia Act provided jury trials in certain contempt actions, but unquestionably did not provide a jury right in contempt actions arising out of injunctions issued pursuant to the Wagner or Taft-Harley Acts. *See Muniz*, 422 U.S. at 462-463.

The Court rejected this argument, holding that "[w]e cannot accept the proposition that Congress, without expressly so providing, intended in § 3692 to change the rules for enforcing injunctions," which rules existed when § 11 was originally passed. *See Muniz*, 422 U.S. at 468. The Court examined the legislative history of the recodification and the Reviser's Notes, which consistently expressed that no substantive change was intended by the revision. *Id.* at 467-469. Citing *Fourco Glass*, the Court reiterated the longstanding rule that "[n]o changes of law or policy…are to be presumed from changes of language in the revision unless an intent to make such changes is clearly expressed." *Id.* at 472 (internal quotation marks omitted). The Court thus expressed some incredulity at the proposition that the major policy change petitioners argued for could be effected by Congress without any mention of it in any of the legislative history or notes:

> In view of the express disavowals in the House and Senate Reports on the revisions of both the Criminal Code and the Judicial Code, it would seem difficult at best to argue that a change in the substantive law could nevertheless be effected by a change in the language of a statute without any indication in the Revisers' Note of that change. It is not tenable to argue that the Revisers' Note to § 3692, although it explained in detail what words were deleted from and added to what had been § 11 of the Norris-LaGuardia Act, simply did not bother to explain at all, much less in detail, that an admittedly substantial right was being conferred on potential contemnors that had been rejected in the defeat of the Ball amendment the previous year and that, historically, contemnors had never enjoyed.

See id. at 472.

Finley v. United States, 490 U.S. 545, 553-54 (1989), involved a question of whether the 1948 recodification of the Judicial Code substantively created new "pendent-party" jurisdiction when it recodified the Federal Tort Claims Act, 28 U.S.C. § 1346(b) (the "FTCA").[33] Writing for the Court, Justice Scalia rejected that argument, holding that "[u]nder established canons of statutory construction, it will not be inferred that Congress, in revising and consolidating the laws, intended to change their effect unless such intention is clearly expressed." *Id.* at 554 (internal quotation marks omitted) (quoting from *Anderson v. Pac. Coast S.S. Co.*, 225 U.S. 187, 199 (1912) and citing to *United States v. Ryder*, 110 U.S. 729, 740 (1884)). Finding "no suggestion, much less a clear expression, that the minor rewording at issue here imported a substantive change," the Court held that the pre-codification interpretation of the statute continued to hold (*i.e.* no "pendent-party" jurisdiction under the FTCA). *Id.* at 554-56.

Finally, our own court has recently applied this canon in *Koch Foods, Inc. v. Sec'y, U.S. Dep't of Labor*, 712 F.3d 476 (11th Cir. 2013). There we held that certain amendments to 49 U.S.C. § 31105 enacted by the Revision of Title 49, United States Code Annotated, "Transportation", Pub. L. No. 103-272, 108 Stat. 745 (1994) were simply revisions and codifications, and thus did not change the

[33] "Pendent-party" jurisdiction is "jurisdiction over parties not named in any claim that is independently cognizable by [a] federal court." *See Finley*, 490 U.S. at 549. As opposed to "pendent-claim" jurisdiction, which is "jurisdiction over nonfederal claims between parties litigating other matters properly before the court." *Id.* at 548.

pre-amendment scope of the law. *Koch Foods*, 712 F.3d at 485. We noted in *Koch Foods* that (much like § 2664(b) of the DRA amendments here) the recodification statute cautioned that the revisions and codifications were enacted "without substantive change," and that the legislative history (like the legislative history of the DRA here) emphasized that the changes were not substantive. *Id.* The interpretive canon used in *Koch Foods* is the one we use in this case: "As the Supreme Court has observed, 'it will not be inferred that Congress, in revising and consolidating the laws, intended to change their effect unless such intention is clearly expressed.'" *Id.* at 486 (quoting from *Finley*, 490 U.S. at 554).

We turn then to applying the recodification canon of statutory construction to our case. It is clear that the Office of the Law Revision Counsel made an error in revising § 405(h) in 1976 (and again in 1982). Rather than include the full range of jurisdictional grants that were clearly forbidden under the prior law,[34] the Law Revision Counsel (who it must be recalled has no authority to pass laws or alter the jurisdiction of federal district courts)[35] mistakenly decided to update the cross-reference only to § 1346 and § 1331 of the new Title 28. We find no indication whatsoever, let alone a "clear indication," in the Law Revision Counsel's

[34] *I.e.* each district court jurisdictional grant listed in Section 24 of the Judicial Code of 1911.

[35] *See e.g. N. Dakota v. United States*, 460 U.S. 300, 311 n. 13 (1983) (noting that the editorial decisions made by a codifier without the approval of Congress should be given no weight in interpreting a statute).

Codification note that the revisers intended or were suggesting an expansion of district court jurisdiction to review Medicare and Social Security claims, thereby reversing forty years of Congressional policy. On the contrary, the title of the note ("Codification") and its contents indicate that the change was a mere codification (*i.e.* updating the cross-reference to "section 24 of the Judicial code" to its new location in Title 28 of the U.S. Code), and not a substantive change. One would expect that if the revisers intended the kind of fundamental change in policy and expansion of the jurisdiction of bankruptcy courts that Bayou Shores suggests, it would merit *some* mention. *See Muniz*, 422 U.S. at 472 ("It is not tenable to argue that the Revisers' Note ..., although it explained in detail what words were deleted ... and added ..., simply did not bother to explain at all, much less in detail, that an admittedly substantial right was being conferred...").

Moreover we do not find it significant, contrary to Bayou Shores' suggestion, that Congress enacted the error into positive law when it passed the DRA in 1984. There is no evidence in the DRA that Congress "clearly expressed" an intention to reverse decades of Medicare and Social Security Act policy and give bankruptcy courts parallel jurisdiction with HHS to adjudicate Medicare claims (and parallel jurisdiction with the Social Security Administration to adjudicate Social Security claims). Again, if Congress intended such an important expansion of bankruptcy court jurisdiction to be enacted in a recodification, one

would expect to find some indication in the statute or legislative history stating as much. *See Tidewater Oil*, 409 U.S. at 162-63 (finding no indication in Reviser's Notes or legislative history that Congress intended recodification to expand federal appellate court jurisdiction). Bayou Shores points to no such indication, nor are we able to find one.

To the contrary, the *statute itself* tells us that the amendment in question is not to be interpreted as making any substantive change to the law: "none of such amendments shall be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date." *See* DRA, § 2664(b); *see also Koch Foods*, 712 F.3d at 485 (noting that the statute "expressly states that no substantive change is intended by the revisions to the language").[36] The legislative history of the bill similarly emphasizes that the amendments in § 2663 (including the amendment to § 405(h)) were not intended to be substantive. *See* H.R. Rep. No. 98-432, pt. 2, at 1663 (1984) (noting that the bill "makes certain corrections of spelling, punctuation, cross-references and other clerical amendments to the Social Security Act and related provisions in the Internal Revenue Code"). Rep. Dan Rostenkowski (the original sponsor of H.R.

[36] The bankruptcy court referred to § 2664(b) as "legislative history." *See In re Bayou Shores,* 525 B.R. at 167. Strictly speaking, that is not correct. "Legislative history" refers to "proceedings leading to the enactment of a statute, including hearings, committee reports, and floor debates." *Black's Law Dictionary* (10th ed. 2014). Conversely, § 2664(b) of the DRA is positive law: it is part of a statute that was passed by Congress and signed into law by the President.

3805, containing the "technical corrections" that were merged into the DRA) "emphasize[d] that this bill intends simply to correct technical errors and to better reflect the policies established by the Congress in enacting the original legislation." 129 Cong. Rec. 23321, 23440 (1983).

Per long standing Supreme Court precedent, we "will not … infer[] that the legislature, in revising and consolidating [§ 405(h)] intended to change their policy, unless such intention be clearly expressed." *See United States v. Ryder*, 110 U.S. 729, 740 (1884). Here, we find no clear expression of any intent to change Congressional policy with respect to bankruptcy court jurisdiction over Medicare claims. To the contrary, the statute and legislative history detailed above expresses an intent *not* to substantively amend § 405(h).[37]

In reply, Bayou Shores attempts to downplay the mandate of § 2664(b) in the DRA by arguing that despite the statute's command that the amendments are not to be interpreted as substantive, certain of the amendments were in fact substantive. *See* Appellant's Reply Br. at 2-9. We are not persuaded by this argument. As an initial matter, Bayou Shores essentially asks us to ignore § 2664(b) and Congress's command that the amendments are not substantive, which

[37] The Seventh Circuit's *Bodimetric* decision (and thus the decisions of the Third and Eighth Circuits adopting *Bodimetric*) recognized and correctly applied this recodification canon of statutory interpretation. *See Bodimetric*, 903 F.2d at 489 (citing to *Muniz* and *U.S. v. Ryder*). Conversely, the cases holding that § 405(h) does not bar jurisdiction under § 1334 do not appear to have recognized the existence of the canon, let alone analyzed whether it applies to this issue. It is clear that in ignoring a canon of statutory construction that courts have been applying for more than a century, these latter courts erred.

we are clearly not free to do. In *Muniz* the Supreme Court indicated that "[t]he nature of the revision process itself requires the courts, including this Court, to give particular force to the many express disavowals in the House and Senate Reports of any intent to effect substantive changes in the law." *See Muniz*, 422 U.S. at 472 n. 11. Here we think it most reasonable to give force to Congress's express disavowals in the DRA itself and in the legislative history "of any intent to effect substantive changes in the law."

Moreover, the two examples that Bayou Shores cites as "substantive" amendments in § 2663 of the DRA are, on closer review, at least arguably non-substantive. First, Bayou Shores argues that § 2663(e)(3) of the DRA expanded criminal liability for impersonating certain persons in order to obtain information about their Social Security benefits. Appellant's Reply Br. at 3-4. The language in § 2663(e)(3) orders that "Section 1107(b) of [the Social Security Act] is amended by striking out 'former wife divorced,' each place it appears and inserting in lieu thereof 'divorced wife, divorced husband, surviving divorced wife, surviving divorced husband, surviving divorced mother, surviving divorced father,'." The House committee report on the bill indicates that this amendment was intended to bring Section 1107(b) into conformity with an earlier amendment eliminating

gender-based distinctions in the Social Security Act.[38] Thus, arguably the earlier amendment had already eliminated gender distinctions in Section 1107(b), and the DRA amendments merely revised the text of Section 1107(b) to correctly reflect those earlier amendments.[39]

Second, Bayou Shores points to §2663(a)(15)(C), and characterizes it as denying certain benefits to college students that they otherwise would have received under the prior version of the statute. Appellant's Reply Br. at 5. The relevant text of the amendment orders that "(C) Section 222(b)(4) of such Act is amended by striking out 'full–time student' and inserting in lieu thereof 'full-time elementary or secondary school student'." *See* DRA at §2663(a)(15)(C). A close reading of the legislative history suggests that Bayou Shores is mistaken about this provision as well. Section 222(b)(4) of the Social Security Act (codified at 42

[38] *See* H.R. Rep. No. 98-432, pt. 2, at 1659 (1984) ("While the Social Security Amendments of 1983 sought to eliminate all gender-based distinctions in the Social Security Act, this gender-based distinction was not eliminated by those amendments. In order to assure that the Social Security Act provides the same penalty for fraud regardless of sex, the bill provides that the penalty for fraud would also apply to an individual who falsely represents that he is the divorced husband of a worker or beneficiary.")

[39] Even assuming Bayou Shores is correct that this provision substantively changed existing law, it would not change the result in this case. The House report indicates the "clear intent" behind the amendment to Section 1107(b) (whether substantive or not), whereas nothing in the legislative history indicates a "clear intent" to change the jurisdiction of bankruptcy courts with the amendment to § 405(h). Thus, the amendment to Section 1107(b) is not analogous to the amendment to § 405(h). It is certainly possible that Congress intended to make substantive amendments in the codification and revision section of the DRA. However, under *United States v. Ryder* and its progeny we require *some* indication that a substantive change in the revision was intended. *See e.g. Ex parte Collett*, 337 U.S. 55, 65-71 (1949) (explaining that reviser's notes and legislative history made clear that addition of 28 U.S.C. § 1404(a), which made forum non coveniens transfers available in any district court civil action, was a substantive amendment enacted by the 1948 Judicial Code revision).

U.S.C. § 422) was added by Congress in 1965.[40] At the time § 222(b)(4) was added to the larger section, the term "full-time student" was "as defined and determined under section 202(d)."[41] Turning then to Section 202(d), that section was amended in 1981 (prior to the DRA in 1984) in a section titled "Elimination of child's insurance benefits in the case of children age 18 through 22 who attend postsecondary schools."[42] The 1981 amendment makes clear that "full time student" was to be defined as elementary and high-school students, not college students.[43] A Senate report issued the following year noted that under the prior law children beneficiaries could receive benefits until they were 22 as long as they were in school, while the 1981 amendments eliminated those benefits for anyone over 18 attending post-secondary schooling.[44] It thus appears that the 1984 amendment in the DRA referenced by Bayou Shores was a "technical correction" because it simply updated § 222(b)(4) of the statute to be consistent with the definitions in the earlier amended § 202(d).

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[40] *See* Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 at § 306(14) (1965).

[41] Section 202 of the Social Security Act is codified at 42 U.S.C. § 402. The current statute continues to refer to section 202 for its definition of "full-time elementary or secondary school student."

[42] *See* Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, 95 Stat. 357 at §2210 (1981).

[43] *See id.* ("SEC. 2210. (a)(1) Section 202(d) of the Social Security Act is amended … by striking out 'full-time student' each place it appears and inserting in lieu thereof 'full-time elementary or secondary school student'.")

[44] *See* S. Rep. No. 97-314, Vol. I, at 106 (1982).

Finally, even if we assume for the sake of argument that Bayou Shores has correctly identified two substantive changes in § 2663, the examples Bayou Shores relies on are minor substantive amendments at best, compared to the massive shift in policy that giving bankruptcy courts parallel authority to adjudicate Medicare disputes would represent. This is akin to finding a few hidden firecrackers in the bill and thus inferring the presence of an atomic bomb. In other words, the presence of two minor substantive changes in § 2663 (assuming they are substantive), can hardly justify interpreting the amendment to § 405(h) as enacting a significant change in Congressional policy by creating bankruptcy court jurisdiction over Medicare claims.

Therefore, we conclude that because the previous version of § 405(h) precluded bankruptcy court review of Medicare claims under § 1334, so too must the newly revised § 405(h) bar such actions.

2. § 1334 does not give bankruptcy courts special jurisdiction over Medicare claims

In light of the above explanation, this Court is constrained to disagree with the Ninth Circuit's *In re Town & Country* opinion, and thus holds that § 405(h) bars a bankruptcy court acting pursuant to § 1334 from exercising jurisdiction over Medicare claims. However, both the Ninth Circuit in *Do Sung Uhm v. Humana, Inc.*, 620 F.3d 1134 (9th Cir. 2010) and Bayou Shores here argue that § 1334 has a

"special status" that is different and distinct from other jurisdictional provisions (such as § 1332).[45] In particular, Bayou Shores argues that the text of § 1334(b) itself defines the expansive nature of bankruptcy court jurisdiction: "notwithstanding any Act of Congress that confers exclusive jurisdiction on a court or courts other than the district courts, the district courts shall have original but not exclusive jurisdiction of all civil proceedings arising under title 11." *See* 28 U.S.C. § 1334(b). However, we read the Supreme Court's opinion in *Bd. of Governors of Fed. Reserve Sys. v. MCorp Fin., Inc.*, 502 U.S. 32 (1991) as effectively foreclosing that argument.

In *MCorp Fin.*, the Court held that bankruptcy law's automatic stay provision (11 U.S.C. § 362) could not stay an administrative proceeding by the Board of Governors of the Federal Reserve System against MCorp Financial. The Court first found that the administrative proceeding fell squarely into the exception in § 362 for proceedings to enforce a "governmental unit's police or regulatory power." *Id.* at 39-40.[46] The Court rejected MCorp Financial's argument that for the exception to apply, the bankruptcy court would need to determine in the first instance whether the exercise of regulatory power was legitimate; the Court held that such a reading "would require bankruptcy courts to scrutinize the validity of

[45] *See e.g.* Appellant's Reply Br. at 9-12.

[46] The parties dispute a similar question on appeal. However, our decision that the bankruptcy court lacked subject matter jurisdiction over the provider agreements renders moot the question of whether HHS's actions fall in § 362's exceptions. We thus decline to decide that issue.

every administrative or enforcement action brought against a bankrupt entity," and that "[s]uch a reading is problematic, both because it conflicts with the broad discretion Congress has expressly granted many administrative entities and because it is inconsistent with *the limited authority Congress has vested in bankruptcy courts*." *Id.* at 40 (emphasis added).

Importantly, the Court rejected MCorp's broad reading of 28 U.S.C. § 1334(b), holding that "[s]ection 1334(b) concerns the allocation of jurisdiction between bankruptcy courts and other 'courts,' and, of course, an administrative agency such as the Board is not a 'court.'" *Id.* at 41-42. That is precisely the situation here: Bayou Shores' provider agreement was terminated by the Centers for Medicare & Medicaid Services ("CMS"), which is an administrative agency within HHS and not a "court." Thus, § 1334(b) does not concern the allocation of jurisdiction between the bankruptcy court and HHS, and cannot trump the § 405(h) jurisdictional bar.

Bayou Shores raises an additional argument relating to the 1984 amendments to § 1334. Bayou Shores points out that the Bankruptcy Amendments and Federal Judgeship Act of 1984, Pub. L. No. 98-353, 98 Stat 333 (July 10, 1984) (the "Bankruptcy Act") was passed only eight days prior to passage of the DRA, and among other things significantly enlarged the scope of bankruptcy court

jurisdiction.[47] According to Bayou Shores, because "28 U.S.C. § 1334 was enacted first, and 42 U.S.C. § 405(h) was enacted days later," Congress's failure to include § 1334 in § 405(h) indicates a positive intent to expand the scope of bankruptcy court jurisdiction. Appellant's Br. at 45. We disagree. *See N. L. R. B. v. Plasterers' Local Union No. 79, Operative Plasterers' & Cement Masons' Int'l Ass'n, AFL-CIO*, 404 U.S. 116, 129-30 (1971) ("The Court has frequently cautioned that it is at best treacherous to find in Congressional silence alone the adoption of a controlling rule of law.") (quotation marks omitted).

As an initial matter, reading too much into the significance of the timing of the passage of these acts is at best speculative, particularly since the DRA had nothing to do with bankruptcy court jurisdiction, nor does Bayou Shores point to any evidence suggesting that Congress had the Bankruptcy Act in mind when passing the DRA.[48] Moreover Bayou Shores' timing argument also cuts the opposite way: one would equally expect that if Congress were inclined to expand the jurisdiction of bankruptcy courts to include hearing Medicare and Social Security claims, it would have done that in the Bankruptcy Act that it had just

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[47] The Bankruptcy Act added subsection 1334(b), discussed *supra. See* Bankruptcy Act at § 101(a).

[48] Approximately forty-some public laws were passed by Congress in July of 1984. *See* https://www.congress.gov/public-laws/98th-congress. We are skeptical of the suggestion that the temporal proximity between any one of these laws and the Bankruptcy Act, standing alone, has any particular significance in interpreting any of these laws.

passed, rather than burying it as a "Technical Correction" in a bill wholly unrelated to bankruptcy courts (*i.e.* the DRA).

3. Barring bankruptcy court jurisdiction is consistent with Congressional Medicare policy

The bankruptcy court also relied on what was essentially a policy argument about the wisdom of allowing a bankruptcy court rather than HHS to adjudicate Medicare claims:

> Consider the following hypothetical: a debtor that operates a skilled nursing facility has its Medicare provider agreement terminated because it was improperly cited for noncompliance. The debtor immediately appeals the finding of noncompliance. But because CMS stops payment for Medicare residents, the debtor is forced to file for bankruptcy. If the Court were to adopt HHS's view, the debtor in that hypothetical scenario could never assume its Medicare provider agreement since it is highly unlikely the appeals process will be complete before the debtor files for bankruptcy.

See In re Bayou Shores, 525 B.R. at 169.[49] In other words, unless the bankruptcy court can take jurisdiction over the provider agreements, Bayou Shores would

[49] *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. 19, 27-29 (2015) (noting that because of the length of the HHS appeals process, a hospital could be faced with the "fatal dilemma" of being put out of business before being able to challenge an adverse HHS decision); *but see Oakland Med. Grp., P.C. v. Sec'y of Health & Human Servs., Health Care Fin. Admin.*, 298 F.3d 507, 511 (6th Cir. 2002) ("[T]he government has a strong interest in expediting provider-termination procedures because: (1) the Secretary's responsibility for insuring the safety and care of elderly and disabled Medicare patients is of primary importance, and (2) the government has a strong interest in minimizing the expenses of administering the Medicare program.") (internal quotation marks and citations omitted); *Northlake Cmty. Hosp. v. United States*, 654 F.2d 1234, 1242 (7th Cir. 1981) (explaining that "a

cease to exist as a going concern long before the HHS administrative appeals process could complete.[50]

While we are not unsympathetic to this argument, the choice of whether the bankruptcy court or HHS is best positioned to adjudicate Medicare claims is a policy decision that the bankruptcy court was not empowered to make. As explained at length above, § 405(h) and (g) restricts the role of district courts to a limited review of final HHS decisions, thus reflecting Congressional policy to let HHS adjudicate those claims in the first instance. The Supreme Court explained in *Illinois Council* that the review provisions of § 405(h) and (g) give HHS a greater opportunity to "apply, interpret, or revise policies, regulations, or statutes without possibly premature interference by different individual courts." *See* 529 U.S. at 13.

Indeed, the bankruptcy court's actions here illustrate the kind of "premature interference" that *Illinois Council* had in mind. While the bankruptcy court went to great length to deny that it was reviewing the merits of HHS's findings or decisions (*see e.g. In re Bayou Shores SNF*, 525 B.R. at 168), that is effectively what the bankruptcy court did. After holding an evidentiary hearing on the

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provider's financial need to be subsidized for the care of its Medicare patients is only incidental to the purpose and design of the (Medicare) program.") (internal quotation marks and citations omitted).

[50] This assumes of course that Bayou Shores will be successful in regaining the provider agreements in the administrative appeals process. That in turn is a dubious proposition as an administrative law judge in that appeal has already granted summary judgment against Bayou Shores on the issue of the termination of the provider agreements. *See* Bankr. ECF No. 261-1, Administrative Law Judge Ruling on Motion for Partial Summary Judgement (Dec. 16, 2015).

conditions at Bayou Shores' facility, the bankruptcy court apparently decided that the three deficiencies Bayou Shores was cited for were not particularly serious. *Id.* at 163. The court also decided that Bayou Shores had corrected each of the deficiencies it was cited for and provided adequate assurances that it would be in compliance with the Medicare regulations in the future. *Id.* at 170-171. Notwithstanding HHS's determination to the contrary, the bankruptcy court deemed the health and safety of Bayou Shores' patients free of immediate jeopardy. The practical outcome of the bankruptcy court's decision was thus a reversal of HHS's decision: the bankruptcy court rolled back the termination, gave Bayou Shores back its provider agreements, and effectively prevented HHS from terminating Bayou Shores from the Medicare/Medicaid program for its repeated deficiencies. That was functionally a decision on the merits of the underlying HHS decision, and an interference with HHS's role in deciding who is eligible to participate in Medicare/Medicaid.[51]

The Government for its part disputes the bankruptcy court's version of the facts. With respect to the three violations, the picture painted by the Government suggests far more serious issues with the care provided by Bayou Shores to its

[51] We have explained previously that where both parties to a Medicare claim dispute "engage in extensive discovery and presentation of their whole cases on the merits, the district court does exactly what [HHS] is expected to do," and therefore "[i]t is simply not realistic to say that the district court in such a case does not address and decide the merits of the case." *V.N.A. of Greater Tift Cty., Inc. v. Heckler*, 711 F.2d 1020, 1032 (11th Cir. 1983). Such a merits-review is contrary to the policy embodied by the Medicare Act's limited judicial review provisions. *See id.*

patients. Federal Appellee Br. at 14-16; State Appellee's Br. at 3-4.[52] Moreover, the Government argues that simply coming back into compliance after each violation was not the issue. Rather, terminating repeat offenders like Bayou Shores was a key part of Congress's overhaul of nursing home regulations, and was intended to stop "instances in which substandard providers had avoided termination from Medicare by claiming that they had cured serious violations of safety standards, only to lapse back into noncompliance after the threat of administrative sanction was removed." Federal Appellee's Br. at 50-51.

In any event, we do not need to decide whose version of the facts is correct, nor do we need decide whether the bankruptcy court's decision on the merits of HHS's action was correct. HHS, not the bankruptcy court, has been charged by Congress with administering the Medicare Act and regulating Medicare providers. Indeed, the bankruptcy court's action here stymied the direct statutory mandate from Congress to HHS to take appropriate action (including potentially terminating a provider agreement) when, as here, a survey determines that a nursing home's condition "immediately jeopardize[s] the health or safety of its residents." *See* 42

[52] Most disturbingly perhaps, the bankruptcy court's opinion describes the result of the second incident somewhat innocuously: "[T]he patient with the history of abuse—who was in the facility for less than 24 hours—did not touch or otherwise harm the other resident." *In re Bayou Shores SNF*, 525 B.R. at 163. But the Government contends that the "patient with the history of abuse" "sexually molest[ed]" his roommate during those 24 hours. Federal Appellee Br. at 14-16; State Appellee's Br. at 3-4. According to the underlying report, the roommate reported in an interview that the patient with the history of abuse "put his hand under the curtain and moved his hand on the sheet to about ¼ inch from my private parts." *See In re Bayou Shores*, Bankr. ECF No. 42-2 at 17.

U.S.C. § 1395i-3(h)(2).[53] And though charged with broad jurisdiction to deal with issues related to a debtor's bankruptcy estate, bankruptcy courts generally lack the institutional competence or technical expertise of HHS to oversee the health and welfare of nursing home patients or to interpret and administer a "massive, complex health and safety program such as Medicare." *See Illinois Council*, 529 U.S. at 13. Or at least, that is the judgment of Congress we derive from the enactment of § 405(h) in 1939 (and the recodification in 1984).

4. § 405(h) clearly requires administrative exhaustion

Finally, while much of the above dispute concerns the third sentence of § 405(h) and whether it completely bars bankruptcy jurisdiction under § 1334, we do not overlook the effect of the first two sentences as well. The bankruptcy court dismissed the second sentence as merely limiting "the ability of federal courts to review the findings of fact or an agency decision." *In re Bayou Shores SNF*, 525 B.R. at 167. Though correct in a minimalist sense, we think that is an overly narrow understanding of the statute. The Supreme Court made clear in *Salfi* that the first two sentences of § 405(h) "assure that administrative exhaustion will be required" and "prevent review of decisions of the Secretary save as provided in the

[53] If the deficiencies immediately jeopardize the health and safety of a facility's residents, "the Secretary *shall take immediate action* to remove the jeopardy and correct the deficiencies through the remedy specified in subparagraph (B)(iii), *or terminate the facility's participation under this subchapter* and may provide, in addition, for one or more of the other remedies described in subparagraph (B))." 42 U.S.C. § 1395i-3(h)(2) (emphasis added).

Act, which provision is made in § 405(g)." 422 U.S. at 757. The third sentence, according to the Court in *Salfi*, means that no action may be brought pursuant to any jurisdiction other than § 405(g), even where administrative remedies have been exhausted. *Id.*; *see also Illinois Council*, 529 U.S. at 13.

Bayou Shores does not dispute that its claims have not been administratively exhausted; in fact, as of the date of the oral argument, Bayou Shores' administrative appeal was still pending in front of an administrative law judge at HHS. *See* Oral Argument, March 29, 2016. Putting aside the jurisdictional question then, neither Bayou Shores nor the bankruptcy court has explained why standard principles of administrative exhaustion should not prevent a district court from hearing Bayou Shores' case. *See e.g. In re Rodriquez*, No. 09-93431-JB, 2010 WL 2035733, at *3-5 (Bankr. N.D. Ga. Mar. 23, 2010) (relying on § 405(g) and (h) to hold that bankruptcy court would not entertain non-administratively exhausted Social Security claims). Bayou Shores has also not shown that any exception to standard administrative exhaustion principles should apply here. *See McCarthy v. Madigan*, 503 U.S. 140, 146-149 (1992) (explaining the "three broad sets of circumstances" in which exceptions to administrative exhaustion may apply).

Thus, even if we were to assume that § 405(h) does not bar jurisdiction under § 1334, the bankruptcy court erred by not dismissing Bayou Shores' claim for failure to exhaust Bayou Shores' administrative remedies first.

IV. OTHER ARGUMENTS

Bayou Shores raises a number of other issues that it contends warrant reversal of the district court's Order. For the reasons below, we do not find these arguments persuasive.

A. Mootness

Bayou Shores argues that this dispute is either constitutionally moot or equitably moot. With respect to constitutional mootness, Bayou Shores contends that because the bankruptcy court's injunction and automatic stay have been dissolved, no live controversy between the parties remains. The Government contends that at least two live issues remain. First, the bankruptcy court's stay and injunction (even if now dissolved) prevented the Government from stopping payments to Bayou Shores during the pendency of the bankruptcy case. The Government argues that it intends to seek recoupment of these payments if the bankruptcy court's orders are found to be invalid. Second, contrary to Bayou Shores' contention that the injunction and stay have dissolved, the Government

contends that the bankruptcy court's Confirmation Order continues to indefinitely enjoin the Government from terminating the provider agreements.[54]

A case is constitutionally moot when "when the issues presented are no longer 'live' or the parties lack a legally cognizable interest in the outcome." *Powell v. McCormack*, 395 U.S. 486, 496 (1969). Put another way, "[a] case is moot when it no longer presents a live controversy with respect to which the court can give meaningful relief." *Florida Ass'n of Rehab. Facilities, Inc. v. State of Fla. Dep't of Health & Rehab. Servs.*, 225 F.3d 1208, 1216-17 (11th Cir. 2000) (internal quotations and citations omitted). Here, a holding that the bankruptcy court lacked subject matter jurisdiction would allow the Government to go forward with its efforts to terminate Bayou Shores from the Medicare/Medicaid program, as well as allow the Government to try and recover payments made to Bayou Shores since the filing of the bankruptcy court action.[55] Meaningful relief is thus available, and this case is not constitutionally moot.

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[54] For example, we note that the Confirmation Order contains the following: "Nothing set forth in the Amended Plan or this Order shall limit the power and authority of AHCA to take action related to the renewal or revocation of the Debtor's license necessary to protect public health, safety and welfare, ***provided however, that any such actions related to the renewal or revocation of the license may not be based upon the termination of the Medicare and Medicaid provider agreements that have been assumed by the Debtor***." *In re Bayou Shores*, Bankr. ECF No. 285 at 14. At oral argument, Bayou Shores conceded that this second issue was not constitutionally moot.

[55] Bayou Shores argues that the Government has no claim to damages because the Government "would be required to pay for the care of Bayou's patients, if not at Bayou, somewhere, because the vast majority of Bayou's patients are indigent." Appellant's Reply Br. at 28. That argument misses the mark though. The Government is not seeking to claw back the money merely to pocket the funds or to avoid paying for the care of Bayou Shores' patients. Rather, the

Bayou Shores argues alternatively that the case is equitably moot because its Chapter 11 plan has been substantially consummated. Equitable mootness is a discretionary doctrine that permits courts sitting in bankruptcy appeals to dismiss challenges (typically to confirmation plans) when effective relief would be impossible. *See In re Nica Holdings, Inc.*, 810 F.3d 781, 786 (11th Cir. 2015). Central to a finding of mootness is a determination by an appellate court that it cannot grant effective judicial relief. *Id.* (quoting from *First Union Real Estate Equity & Mortg. Invs. v. Club Assocs. (In re Club Assocs.)*, 956 F.2d 1065, 1069 (11th Cir.1992)). The equitable mootness doctrine seeks to avoid an appellate decision that "would knock the props out from under the authorization for every transaction that has taken place and create an unmanageable, uncontrollable situation for the Bankruptcy Court." *Id.* at 787 (citing *Miami Ctr., Ltd. P'ship v. Bank of NY*, 838 F.2d 1547, 1555 (11th Cir.1988)).

Here however, we are reviewing whether the district court was correct in dismissing for lack of subject matter jurisdiction. "Subject-matter jurisdiction properly comprehended … refers to a tribunal's power to hear a case, *a matter that can never be forfeited or waived.*" *See Union Pac. R. Co. v. Bhd. of Locomotive*

Government (as required by statute) will not pay a facility such as Bayou Shores that fails to comply with health and safety regulations. In other words, while the Government may be required to pay for the care of Bayou Shores' patients, it reasonably wants to pay someone other than Bayou Shores for that service.

Engineers & Trainmen Gen. Comm. of Adjustment, Cent. Region, 558 U.S. 67, 81, 130 (2009) (internal quotation marks omitted; citations omitted; emphasis added). Because we agree with the district court that the bankruptcy court lacked subject matter jurisdiction over the assumption of Bayou Shores' provider agreements, that must end the inquiry. When the lower court "lack[s] jurisdiction, we have jurisdiction on appeal, not of the merits but merely for the purpose of correcting the error of the lower court in entertaining the suit." *See Bender v. Williamsport Area Sch. Dist.*, 475 U.S. 534, 541 (1986). "Without jurisdiction the court cannot proceed at all in any cause. Jurisdiction is power to declare the law, and when it ceases to exist, the only function remaining to the court is that of announcing the fact and dismissing the cause." *Steel Co. v. Citizens for a Better Env't*, 523 U.S. 83, 94 (1998). The Supreme Court in *Steel Co.* characterized this threshold inquiry as "inflexible and without exception." *See id.* at 94-95 (quoting from *Mansfield, C. & L.M.R. Co. v. Swan*, 111 U.S. 379, 382 (1884)).

Thus, even assuming for the sake of argument that Bayou Shores is correct that this situation justifies the application of equitable mootness, the absence of jurisdiction precludes the exercise of that discretionary authority. Our only role

here is to correct the bankruptcy court's error by affirming the district court's Order.[56]

B. Bayou Shores' claims "arise" under the Medicare Act

Bayou Shores additionally argues that its claims do not "arise" under the Medicare Act, and thus are not subject to the § 405(h) jurisdictional bar. According to Bayou Shores, "[n]either the September 5 Order nor the Confirmation Orders had anything to do with recovering a claim (a right to payment) arising under the Medicare Act." Appellant's Br. at 58.

Bayou Shores' position however has already been rejected by the Supreme Court. In *Illinois Council* the Court rejected the argument that claims "arising under" the Medicare Act were limited to monetary claims:

> Nor can we accept a distinction that limits the scope of § 405(h) to claims for monetary benefits. Claims for money, claims for other benefits, *claims of program eligibility*, and *claims that contest a*

[56] Of course, we are addressing only the issue of the bankruptcy court's authority to adjudicate Bayou Shores' claim to ownership of the provider agreements terminated by the Government. To the extent Bayou Shores has other property in its bankruptcy estate, nothing in this opinion addresses or reaches the bankruptcy court's actions with respect to that property.

Further, while we do not rule on the equitable mootness issue, we note that the limited factual record in front of us suggests it would not be appropriate to do so in this situation. Although the Government did not obtain a stay, it appears from our review of the record that it was not for lack of trying. *See In re Nica Holdings*, 810 F.3d at 787 ("On this record, we cannot fault [appellant] for not getting a stay."). Moreover, the simplicity of the transactions and amounts of money involved here appear more akin to the "simpler" transactions in *In re Nica Holdings*, 810 F.3d at 788 (no equitable mootness) than in the complex multi-million dollar transactions that justified equitable mootness in *In re Club Assocs.*, 956 F.2d 1065 and *Miami Ctr., Ltd. P'ship v. Bank of NY*, 820 F.2d 376 (11th Cir.1987). Finally, the reliance interests of Bayou Shores' creditors, who we must presume understood they were lending money to a nursing home that the Government was attempting to shut down for violating health and safety regulations, also do not weigh much in favor of applying equitable mootness.

> *sanction or remedy* may all similarly rest upon individual fact-related circumstances, may all similarly dispute agency policy determinations, or may all similarly involve the application, interpretation, or constitutionality of interrelated regulations or statutory provisions. *There is no reason to distinguish among them in terms of the language or in terms of the purposes of § 405(h)…* Nor for similar reasons can we here limit those provisions to claims that involve "amounts."

Id. at 14 (emphasis added).

Here, the determination of whether Bayou Shores is allowed to keep its provider agreements could be characterized as either a "claim[] of program eligibility" (*i.e.* whether Bayou Shore is eligible to participate in Medicare) or a "claim[] that contest[s] a sanction or remedy" (*i.e.* the sanction of terminating Bayou Shores from the Medicare program). In either case, the Supreme Court made clear in *Illinois Council* that Bayou Shores' claims fall within the ambit of § 405(h)'s "claim[s] arising under" the Medicare Act.

C. Bayou Shores' Medicaid claims rise and fall with its Medicare claims

The parties also dispute whether the termination of Bayou Shores' Medicare provider agreement resulted in the termination of Bayou Shores' Medicaid provider agreement. In its briefing, Bayou Shores contends that AHCA failed to use the required procedures under Florida state law to terminate a Medicaid agreement. The Government argues that Medicaid agreements terminate by operation of law when Medicare agreements terminate. *See* 42 U.S.C. § 1396a(a)(39).

Without resolving this dispute, we note that the only issue necessary to decide is whether the bankruptcy court was barred by § 405(h) from taking jurisdiction over Bayou Shores' Medicaid provider agreements. Courts have held that the Medicare and Medicaid statutory and regulatory provisions "provide that when a dually certified facility challenges a determination that it is not in substantial compliance with the common Medicaid and Medicare regulations and a termination of its participation in both programs, the facility must seek review of this determination through the Medicare administrative appeals procedure." *Cathedral Rock of N. Coll. Hill, Inc. v. Shalala*, 223 F.3d 354, 366 (6th Cir. 2000); *see also Michigan Ass'n of Homes & Servs. for Aging, Inc. v. Shalala*, 127 F.3d 496, 503 (6th Cir. 1997) ("The Medicaid Act's inclusion of § 405(g) is clear textual support for the proposition that Congress intended the exhaustion of administrative remedies to apply in cases [involving dual Medicare/Medicaid providers]); *Health Equity Res. Urbana, Inc. v. Sullivan*, 927 F.2d 963, 967 (7th Cir. 1991).

Bayou Shores cannot avoid the jurisdictional bar in § 405(h) by attempting to re-characterize its claim to the Medicaid provider agreement as separate from its claim to the Medicare provider agreement. *See Cathedral Rock*, 223 F.3d at 366-67. Indeed, it can hardly be said that Bayou Shores has a separate Medicaid claim, notwithstanding the two separate provider agreements: the sole reason for termination of Bayou Shores' Medi*caid* provider agreement was the termination of

its Medi*care* provider agreement for Bayou Shores' failure to comply with Medi*care* laws and regulations. Allowing Bayou Shores to go forward with only its Medicaid claims would thus put the bankruptcy court in the untenable position of adjudicating a dispute fundamentally about Medicare laws and regulations (*i.e.* whether Bayou Shores was in compliance with the relevant Medicare laws and regulations), despite being barred from adjudicating Bayou Shores' Medicare claims. *See Rhode Island Hosp. v. Califano*, 585 F.2d 1153, 1162 (1st Cir. 1978) ("Were we to assume § 1331 jurisdiction over the Hospital's Medicaid claim we would find ourselves in the peculiar posture of hearing a case that consists entirely of a challenge to the limits promulgated under [the Medicare Act], when we are expressly barred by [the Medicare Act] from entertaining that challenge at this time.").

Accordingly, Bayou Shores "cannot avoid the Medicare Act's administrative channeling requirement simply because as a dual Medicare and Medicaid provider, its claims also fall under Medicaid Act." *Cathedral Rock*, 223 F.3d at 367.[57]

D. Termination of the provider agreements

On appeal, the parties continue to dispute whether the provider agreements in question terminated before or after the filing of Bayou Shores' bankruptcy petition. Because we have determined that the bankruptcy court lacked jurisdiction

[57] We do not need to decide here whether a different result would accrue in a case where a party presents only Medicaid claims to a bankruptcy court.

over the termination of the provider agreements, we decline to rule on the issue of whether or not the agreements terminated prior to the filing of the bankruptcy petition.

V. Conclusion

We agree with the district court that the bankruptcy court erred as a matter of law when it exercised subject matter jurisdiction over the provider agreements in this case. 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.

Thus, finding no reversible error in the district court's June 26, 2015, Order (*In re Bayou Shores*, 533 B.R. at 343) we AFFIRM.

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

ELBERT PARR TUTTLE COURT OF APPEALS BUILDING
56 Forsyth Street, N.W.
Atlanta, Georgia 30303

David J. Smith
Clerk of Court

For rules and forms visit
www.ca11.uscourts.gov

July 11, 2016

MEMORANDUM TO COUNSEL OR PARTIES

Appeal Number: 15-13731-FF
Case Style: Agency for Health Care Adminis, et al v. Bayou Shores SNF LLC
District Court Docket No: 8:14-cv-02816-JSM
Secondary Case Number: 8:14-bk-09521-MGW

This Court requires all counsel to file documents electronically using the Electronic Case Files ("ECF") system, unless exempted for good cause. Enclosed is a copy of the court's decision filed today in this appeal. Judgment has this day been entered pursuant to FRAP 36. The court's mandate will issue at a later date in accordance with FRAP 41(b).

The time for filing a petition for rehearing is governed by 11th Cir. R. 40-3, and the time for filing a petition for rehearing en banc is governed by 11th Cir. R. 35-2. Except as otherwise provided by FRAP 25(a) for inmate filings, a petition for rehearing or for rehearing en banc is timely only if received in the clerk's office within the time specified in the rules. Costs are governed by FRAP 39 and 11th Cir.R. 39-1. The timing, format, and content of a motion for attorney's fees and an objection thereto is governed by 11th Cir. R. 39-2 and 39-3.

Please note that a petition for rehearing en banc must include in the Certificate of Interested Persons a complete list of all persons and entities listed on all certificates previously filed by any party in the appeal. See 11th Cir. R. 26.1-1. In addition, a copy of the opinion sought to be reheard must be included in any petition for rehearing or petition for rehearing en banc. See 11th Cir. R. 35-5(k) and 40-1 .

Counsel appointed under the CRIMINAL JUSTICE ACT must file a CJA voucher claiming compensation for time spent on the appeal no later than 60 days after either issuance of mandate or filing with the U.S. Supreme Court of a petition for a writ of certiorari (whichever is later).

Pursuant to Fed.R.App.P. 39, costs taxed against appellant.

The Bill of Costs form is available on the internet at www.ca11.uscourts.gov

For questions concerning the issuance of the decision of this court, please call the number referenced in the signature block below. For all other questions, please call Janet K. Mohler, FF at (404) 335-6178.

Sincerely,

DAVID J. SMITH, Clerk of Court

Reply to: Jeff R. Patch
Phone #: 404-335-6161

OPIN-1A Issuance of Opinion With Costs

UNITED STATES BANKRUPTCY COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

In re:

BEAM MANAGEMENT, LLC d/b/a HARMONY HEALTHCARE AND REHABILITATION CENTER OF SARASOTA

CASE NO. 8:10-bk-08580-KRM

Chapter 11

_____/

PATIENT CARE OMBUDSMAN INITIAL WRITTEN REPORT

Frank P. Terzo, the duly appointed Patient Care Ombudsman ("PCO") in this matter, pursuant to 11 U.S.C. §333 (b)(2), hereby files with this Court the PCO's Initial Written Report ("Report") on the status of quality of patient care being provided by the Debtor.

I. BACKGROUND:

A. Procedural Summary

Commenced by petition on April 13, 2010, this proceeding is an involuntary Chapter 11 bankruptcy for the Debtor, Beam Management, LLC ("Beam" or "Debtor") filed by its creditors. A Chapter 11 bankruptcy proceeding allows a debtor to stay in business through a plan of reorganization, which includes adjusting its debts.

Beam does business as Harmony Healthcare and Rehabilitation Center of Sarasota ("Harmony" or "Facility"), a Florida licensed nursing home with 120 beds. Harmony has been operating as a nursing home under Beam's management since 2006.

According to pleadings in this proceeding, Beam was formed as a Delaware limited liability company in 2000 and has been operating since 2004. The company is owned by Rivka Gelbtuch, Sara Ellman and Abby Baruch. The members' husbands, Ben Gelbtuch, Neil Ellman and Elliot Baruch, comprise Beam's Board of Directors. One of the owners of the Debtor, Elliot

Baruch, also served as Beam's manager from 2004 to late 2008 (officially noticed under filings with the Florida Division of Corporations in May, 2009). The other owners in this bankruptcy assert that Beam under Mr. Baruch's leadership "experienced serious financial difficulties," such as a significant tax liability (about $ 1.8 million from employee payroll taxes) owed to the Internal Revenue Service and considerable delinquencies to a number of its vendors, including a number of judgments against Beam.

The Court on May 25, 2010 found that the nursing home is a "health care business" and ordered the U.S. Trustee[1] to appoint a "Patient Care Ombudsman" ("PCO") in accordance with Section 333(a)(1) of the Bankruptcy Code. The obligation of the PCO under the Court's order and the applicable law is "to monitor the quality of patient care, to the extent necessary under the circumstances, and to represent the interests of the patients of the health care business." The Court's order also granted the PCO the right to review the confidential records of all Harmony patients. The US Trustee officially appointed Frank Terzo as PCO on May 27, 2010. The PCO gave an interim report at a hearing on June 17, 2010, which was noticed to all patients and their surrogate decision-makers, some of whom attended by telephone. The instant Report is the mandated full report required by law within sixty days of the appointment of the PCO.

On May 28, 2010, pursuant to the motion of the Debtor, the Court approved, on an interim basis, the retention of Michael Bokor, President and owner of Southern SNF Management, Inc. ("Southern") as Debtor's management company, effective retroactively to the date of commencement of this proceeding. On July, 23, 2010, however, Southern through Mr. Bokor gave notice of Southern's resignation as Harmony's manager. Simultaneously, Andrea

[1] The United States Trustee Program is the component of the Department of Justice responsible for overseeing the administration of bankruptcy cases. The U.S. trustee (Donald F. Walton is the United States Trustee for Region 21) plays a major role in monitoring the progress of chapter 11 cases and supervising their administration.

Pankhurst tendered her resignation as the Nursing Home Administrator for Harmony, both effective August 5, 2010.

The resignation of Southern and Ms. Pankhurst with such short notice created serious concerns on the part of the PCO and his team because the Agency for Health Care Administration ("AHCA") was due to survey the Facility before the end of July, 2010. The PCO and his team increased the onsite visits after Southern's resignation to ensure that the clinical supervisors involved in the Facility were prepared for the pending survey.

B. PCO and his team

The PCO possesses both bankruptcy and healthcare legal and operational experience. The following summarizes the background of the PCO and the team he has assembled to assist him:

> Frank P. Terzo: Mr. Terzo is AV -rated and is the Managing Director of the Restructuring and Creditor Rights Department at GrayRobinson. Prior to practicing law, Mr. Terzo spent eighteen years in the health care industry. He has a broad range of management experiences in the health care field, including clinical laboratory, hospitals and physician practices. In the six years prior to entering law school in 1998, he co-founded two public health care companies; one that performed comprehensive home healthcare services and another that offered hospital staffing services. Most recently he has used his healthcare experience in representing various constituents in healthcare insolvency cases and healthcare litigation matters
>
> Mark Levine: President of Levine & Associates, Mark Levine completed his Bachelors Degree at S.U.N.Y. at Cortland and later earned a Masters Degree in Health Care Administration from Cornell University. Concurrent with his formal education, Mr. Levine served in the U.S. Army Reserves as a Field Medic where he received clinical training and provided direct patient care. Mr. Levine started his career at Miami Jewish Home and Hospital, an organization with a national reputation for quality of care and innovation. He went on to manage senior care organizations, both as a licensed administrator and as a senior member for non-profit multi-level senior care providers. Mr. Levine now operates a multifaceted company geared to supporting the long term care industry.
>
> Jack P. Hartog: Prior to becoming of counsel to Gray Robinson in 2008, Mr. Hartog worked as an Assistant County Attorney for Miami-Dade County with Jackson Health

System (the Public Health Trust of Miami-Dade County) as his principal client. The Jackson Health System at that time owned and operated numerous hospital and other health care facilities, including two nursing homes. As counsel for over two decades to the largest health system in Florida and one of the largest and busiest hospitals in the country, Mr. Hartog has extensive experience in nearly all aspects of health care law. Mr. Hartog received his B.A. from Cornell University and law degree from Stanford University.

Tamra Hassler: Ms. Hassler is a seasoned Registered Nurse and a Risk manager. She has worked at River Garden, Hebrew Home for the Aged in Jacksonville and as the Director of Nursing for Oak Hammock, a non-profit CCRC sponsored by the University of Florida in which she served as the Director of Nursing. Ms. Hassler, who began her career as a certified nursing assistant, has been a caregiver in long term care for over 20 years. Ms. Hassler has very strong clinical foundation and a expertise in developing clinical systems that are both functional and employee friendly.

C. Skilled Nursing Facilities and Today's Regulatory Environment

Nursing homes provide long term and sub-acute care to persons in need of 24-hour nursing services or significant supportive services. The quality of care and quality of life for residents of nursing homes have been a concern for decades. Nursing home residents are generally frail, physically and psycho-socially compromised, heavily dependent upon others for basic care and sustenance, and in some cases, near the end of their lives. When residents live in an environment where they are totally dependent on others, they are especially vulnerable to abuse.

Due to the recognized vulnerability of their residents, today's skilled nursing home facilities operate in a very intensive regulatory environment. Nursing homes must adhere to extensive, detailed federal and state regulations. Starting in the late 1980s, regulatory oversight has been strengthened in response to public outcry over inadequate or poor care. Nursing facilities are now obligated to assure the proper health and well being of a patient/resident is being provided in accordance with written practice standards and enforcement guidelines regarding such matters as residents' health, memory, hobbies, habits and ability to walk, talk, eat,

dress, bathe and understand and communicate with other people. Facilities must have individualized plans to maintain and potentially improve each resident's condition. These heightened standards were accompanied by enhanced enforcement with associated penalties for non-compliance.

Florida has a particularly rigorous regulatory environment, overseen by the Agency for Health Care Administration ("AHCA"). The Center for Medicare and Medicaid ("CMS") is the federal regulatory body that oversees federal law pertaining to Skilled Nursing Facilities. Florida and federal laws and their accompanying regulations (by AHCA and CMS) subject nursing homes to detailed rules that seek to assure that nursing home residents are provided timely quality care and preserve residents' statutory rights and individual dignity. For example, recent legislation in Florida required nursing homes to implement comprehensive risk management and quality assurance programs, conform to new reporting guidelines, and satisfy increased staffing requirements. *See, e.g.,* §§ 400.147, Fla. Stat. (2009) (risk management and quality assurance) and 400.23, Fla. Stat. (2009) (staffing requirements). Evidence that care at nursing facilities generally has been improving is evidenced by less lawsuits against nursing facilities, less government fines due to noncompliance with regulations, and increased availability of liability insurance policies for nursing facilities.

D. ACHA Surveys/Inspections

To ensure compliance with applicable Florida and federal laws and rules, AHCA conducts standard, unannounced surveys every 9-15 months. For facilities with a history of regulatory non-compliance, AHCA surveys every six months or more often. It also conducts separate and regular fire, life and safety inspections as well as complaint investigations upon the filing of a complaint.

Standard surveys generally have four to five surveyors in the building for approximately five days, evaluating every aspect of residential life. As appropriate during any survey, inspection or investigation, AHCA personnel review clinical records, policies and procedures, and staffing reports. It also conducts interviews with patients/residents, family members, staff, visitors, and volunteers.

AHCA records the results of its reviews in what is called a "Statement of Deficiencies," which cites the facility for any failure to meet applicable regulations. The nursing home's licensed administrator responds to AHCA's statement of deficiencies by attesting that the deficiencies have been corrected, identifies a plan to systematically fix the problem and then develops a quality assurance plan to make sure the plan is working. AHCA performs follow up surveys as needed to ensure that the corrective action is working, reporting whether the facility has corrected the deficiencies. All these reports are public records that can be downloaded from AHCA's website.[2]

To categorize the nature and extent of deficiencies and their impact on residents, AHCA identifies each by a scope (meaning how many residents potentially or actually were affected, ranging from "isolated" to "widespread") and a severity (ranging from no impact and minimal harm to patients, to actual harm and immediate jeopardy, the most severe). See "Scope and Severity Chart," below.

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2 http://www.floridahealthfinder.gov/FacilityLocator/facloc.aspx

SCOPE AND SEVERITY CHART

SCOPE→→→→→→→→ SEVERITY/HARM ↓	ISOLATED (One or a very limited number of residents affected and/or one or a very limited number of staff involved, and /or the situation, occurred only occasionally or in a very limited number of locations.)	PATTERN (More than a limited number of residents affected, and/or more than a limited number of staff involved, and/or the situation occurred in several locations and/or the same resident(s) have been affected by repeated occurrences of the same practice.)	WIDESPREAD (Situation was pervasive throughout the facility or represented a systematic failure that affected a large portion or all of the facility's residents.)
(4) Immediate jeopardy to resident health or safety (Deficiencies practice caused or is likely to cause serious injury, serious harm, serious impairment or death AND there is a reasonable degree of predictability of a similar situation occurring in the future, Immediate corrective action is need.)	J Immediate Jeopardy	K Immediate Jeopardy	L Immediate Jeopardy
(3) Actual harm that is not immediate jeopardy (Deficiencies practice has lead to a negative outcome that has compromised the resident's ability to maintain and/or reach his/her highest practicable physical, mental, and/or psychosocial well-being.	G	H Substandard Quality of Care	I Substandard Quality of Care
(2) No actual harm with potential for more than minimal harm that is not immediate jeopardy (Deficiencies practice has lead to minimal physical, mental, and/or a psychosocial discomfort to the resident and/or a yet unrealized potential for compromising the resident's ability to maintain and/or reach his/her highest practicable level of physical, mental, and/or psychosocial well-being.)	D	E	F Substandard Quality of Care (tags 221-226, 240-258 & 309-333)
(1) No actual harm with potential for more than minimal harm (Deficiencies practice has the potential for causing no more than minor negative impact on residents.)	A Substantial Compliance	B Substantial Compliance	C Substantial Compliance

Under this system, the least serious "deficiencies" are A, B and C, which describe practices that have the potential for causing no more than minor negative impact on patient care. The most serious are I, J and K, termed "Immediate Jeopardy" ("I.J." in common parlance), which are practices that have caused or are likely to cause serious harm, serious impairment or death, and to reoccur absent immediate corrective action. Deficiency statements also are referred to as "tags" with the preface of "F" or "N" corresponding to a federal or state (respectively) requirement denoted by a number that corresponds with listed kinds of specific deficiencies.

When AHCA concludes that residents are at risk, it puts the facility on "Special Focus" status. "Special Focus Facility Designation" is not a sanction but targets non-compliant facilities for more frequent surveys, reflecting AHCA's concern about the welfare of the residents. As evidence of the seriousness of this designation (formerly referred to as a "watch list," terminology which AHCA has stopped using), in 2008, according to the last published data we could find, there were only five Florida nursing homes that were "special focus facilities."

E. PCO's Monitoring Activities:

Our initial monitoring, beyond gathering publicly available data, included tours of the facility; meeting with senior management (both Harmony and Southern), department supervisors and line staff; interviewing residents and following up on calls from guardians and family members; and reviewing document (such as patient charts, quality assurance reviews, weight and skin reports, and life safety records and various meeting minutes). We observed the general functioning of the facility, including mealtimes.

We devoted considerable attention to understanding the functioning, skills and performance of Southern SNF Management Inc. ("Southern"), the management consulting company that contractually assumed responsibility for operating Harmony in February and came

on site in March 2010. Southern, which specializes in long term care and skilled nursing facilities, quickly revamped the leadership structure at Harmony, appointing a new licensed nursing home administrator, assistant director of nursing, director of rehabilitation, nurse manager, staffing coordinator, weekend unit manager, activities director, and an internal admissions coordinator (who helps residents acclimate to facility). Southern made many significant operational changes very quickly. In addition, Southern's management structure gave the licensed nursing home administrator great autonomy.

To gain a better understanding of the operations and the emerging working "culture" of the facility, we were on-site during the day shift, evening shift and night shift. We also monitored and interviewed on the weekends, when most families visit and when the majority of the management team is not typically present. We viewed areas not available to the public, such as the kitchen, laundry rooms, maintenance work areas, bio-hazardous storage area, and medication rooms.

During virtually every on-site visit, we met with the Administrator and usually James Kestler, Chief Operating Officer of Southern. The PCO or his team met with most of the critical department supervisors, including the Director of Nursing, Assistant Director of Nursing, Social Services Director and Maintenance Director. We also met privately with certified nursing assistants (CNAs) and licensed nurses. Finally, we interviewed Robin Bleier, RN, President of RB Health Partners, Inc., licensed nurse and risk manager particularly skilled in assisting nursing facilities in their regulatory compliance activities, who assisted Harmony with its compliance activities following the December 2009 AHCA complaint survey; and Harold Williams, AHCA Area Director for the district where Harmony Healthcare is located.

We reviewed AHCA's survey results, which are summarized below in this Report. We also reviewed existing Harmony policies and procedures and operational systems to support full compliance with issues not related to AHCA findings.

The PCO and his team examined the following core areas:

Administration

Team members reviewed quality assurance and risk management meeting minutes, abuse/ neglect logs, grievances, resident council meetings, and safety committee reports. We examined the clinical systems supporting psychotropic drug reduction attempts, physical restraints, medication management as well compliance with the facility's Plan of Corrections.

Pharmacy

Team members checked medication storage rooms and medication carts (used for securely transporting pharmacy products to residents) for expired medications, appropriate and timely physician signatures, and for conformity of the products with the MAR (Medication Administration Record) for each respective resident. In those areas where Harmony had been cited as deficient (such as F tag 425 and F tag 431), we did a more intensive review. We also reviewed reports from Harmony's pharmacy consultant to ensure attempts were made to reduce use of psychotropic medications.

Building and Fire Safety

We reviewed the tests from the fire monitoring company, including fire sprinkler system, outside testing of alarm systems, reports for dampers and required generator testing. We reviewed internal fire drill reports (one per shift per quarter) and internal and external disaster drill reports. We checked various fire doors for appropriate ratings (30 minute, one hour, four

hour rating) and that doors release when a fire drill is activated. We did a walk through of the entire building to review ongoing and preventive maintenance.

Human Resources

We conducted a review of personnel charts for timely criminal background checks; license verification for nurses and therapists; and current certification for certified nursing assistants, confirming compliance with immigration status review requirements. We looked at whether staff has appropriate levels of mandatory education (all employees working in a SNF must have 12 hours of mandatory education and direct caregivers even more) had been done in a timely manner, including Alzheimer training within appropriate time frames, for changes in compensation inconsistent with policy, and the timeliness of personnel reviews. We reviewed time card reports to verify that facility was providing staffing consistent with minimum state standards for certified nursing assistants (2.9 hours per patient day) and licensed nurses (1 hour per patient per day). We reviewed turnover for the last six months and the last year.

Social Services

We reviewed whether residents were given opportunities to create or change their advanced directives, which are required for all nursing facility residents. We interviewed resident to hear whether their rights were honored and whether they felt that their concerns would be handled timely. We checked whether residents were asked to participate in their mandated plan of care. We reviewed complaint/grievance logs of all residents for the last year. We determined whether residents had reasonable access to their money within their Resident Trust Funds and that statements of the Resident Trust Funds are mailed out on a quarterly basis.

Dietary

We observed all three meals, conducted a sanitation review, and performed a temperature audit to confirm that meats and chickens reach appropriate, safe internal temperature. We evaluated whether the menu conforms to RFDA guidelines in terms of diversity and caloric intake, residents have appropriate eating devices to facilitate autonomy, and residents receive their hot foods and cold foods at the appropriate temperature. We reviewed the facility's weight loss policy under which residents are weighed and which calls for a multidisciplinary approach to weight loss.

MDS/Care Plan

Upon admission for all nursing home patients, Federally mandated "minimum data sets" (MDS) must be filled out and a plan of care completed. We confirmed that the facility develops a complete care plan within seven days of each admission. We reviewed a sample of assessments for accuracy and that they were coordinated by a RN and done and signed by the appropriate director. We reviewed that the care plan met all of the residents needs with timetable and actions that can be measured.

RN/Risk management/Quality Assurance

Tamra Hassler reviewed Harmony's clinical practice and quality assurance programs. She analyzed the Plans of Correction for clinical deficiencies and evaluated whether identified problems were solved such that a system existed to make sure the deficiency did not reappear and that the issue was effectively monitored through the QA process. She analyzed the following information:

- Quality rounds with Director of Nursing
- Chart review of selected charts (selected based on resident complaint or from our observations while touring, including all ventilator care residents)

- Clinical Review (checking systems supporting significant weight loss, skin integrity, medication dissemination and control, and various clinical practices)
- Particular "flagged" items in Deficiencies
- Sentinel Events (reportable incidents)
- Weight Loss Reports
- Decubitus Ulcer Reports
- Quality indicator Report (used to compare Harmony's Health care results to other outcomes across the state and country) (monthly and financial analyses)
- Ventilator patients charts for orders, care plans, omissions in MAR
- Dialysis patients charts for orders, care plans, communication between facility and dialysis center
- Director of Nursing chart audits
- Resident's on psychotropic medications and chemical restraint reductions attempts
- Pharmacy Consultant Recommendations and follow through

Patient/Family Interviews

We met with all the patients that were capable of consenting to their own care, a total of 18 residents, asking for feedback. Because many lack such capacity, guardians/surrogates were contacted. There were several family members that sought us out to make sure we were aware of their concerns and asked for our intervention. We investigated their individual concerns and often were able to crystallize the concern to administration and bring a satisfactory resolution. In total, there were four formal complaints that required us to communicate with administration to address the resident or their guardian/surrogate complaints or concerns. Their concerns all related to resident care issues, resident rights and or problems with their bills.

II. Harmony Healthcare and Rehabilitation Center

A. Description:

Harmony Healthcare is a 120 bed skilled nursing facility, certified by Medicare and Medicaid. It is licensed pursuant to Chapter 400, Part II, Florida Statutes.

It has 18 rooms that are private and 51 rooms that are shared. The facility is located in a largely residential neighborhood. The physical facility itself follows a "medical model" environment (giving the appearance more like a hospital than a residential setting), and has been

tastefully updated. It has common areas for the residents to congregate or use with visitors (three dining areas, TV and recreation room, sitting rooms and conference rooms).

The census fluctuates on a daily basis, usually in the 90s; as of July 24, 2010, for example, the resident population totaled 97. Shortly before the filing of this bankruptcy action, resident census was in the 70s. There are currently approximately 104 employees (both full and part time).

The facility cares for residents who primarily are frail and dependent. According to the Resident Census and Condition Form (an AHCA mandated form) dated July 9, 2010:

- 78% of the residents are bedfast or in a chair all or most of the time.
- 65% are incontinent.
- 48% have chronic loss of joint motion due to structural changes in non-bony tissue.
- 50% have a documented psychiatric diagnosis.
- 43% have a type of dementia.
- 7-8% are currently in Hospice.

In late July, 2010, the Facility housed four ventilator-dependent patients, with several others receiving ventilator care; the facility in the past has had double digit ventilator-dependent patients. A ventilator mechanically assists patients to breathe who are physically insufficiently able to breathe for themselves. Harmony is the only facility from Naples to St. Petersburg providing this high acuity service. Discontinuance of such service would result in long drives for visiting families or friends as well as creating dissatisfaction among those Patients currently receiving ventilator care at Harmony.

Most of the ventilator care residents are currently paid through Medicaid. Unlike several other states, Florida's Medicaid program offers providers no appreciable financial difference for the intense care of residents on ventilators, paying a set rate for all nursing home residents, regardless of the intensity of medically necessary care.

In May of 2010, there were approximately ten residents on Medicare and four private pay patients. The remaining residents are on Medicaid, meaning they have very little, if any, income or assets.

Complicating matters at Harmony Healthcare, most residents lack any routine visits from family or have no active family involvement to effectively advocate for them when care issues arise, which unfortunately is common for Medicaid nursing home patients. Several residents who do have families actively sought out the PCO to seek to improve their loved one's care in a timely manner.

B. Facility History: Opened in 1987, the facility has always been known as "Harmony"). Harmony Healthcare at one time had a licensed capacity of 180 beds, which included a separate, 60 bed, secured Alzheimer's patient unit. The facility was "mothballed" for about 4 years – the timing of closing the facility coincided with the "insurance crises" that caused many operators to leave the state due to runaway insurance premiums or the inability to secure insurance. Beam Management purchased the Facility in 2005 and submitted an application to CMS for Medicare and Medicaid certification on December 29, 2005. The opening of the Facility in 2006 required the coordination of several local, state and federal governing bodies and careful administrative coordination. This coordination did not occur causing a delay in the approval of Harmony's application. Adding further delay and expense were the hurricanes that hit the area in 2005 causing the owners to conform to new building standards and placing significant unanticipated financial pressures. Ultimately, the initial application to CMS was approved in December, 2005 but payments did not begin until March, 2008 when the AHCA certification was formally completed.

C. AHCA Surveys of Harmony

AHCA surveys of Harmony show its regulatory compliance problems date back to its first survey under the Debtor's management in 2007. The AHCA Survey reports demonstrate that year after year Harmony has incurred deficiencies in the same categories: Quality of Care, Resident Assessments, Resident Rights, Pharmacy, and Administration.

In response to a family/resident complaint, AHCA from December 21- 23, 2009, surveyed Harmony, issuing a 100 plus page statement of deficiencies (an unusually lengthy survey report) that included four Immediate Jeopardy ("I.J.") deficiencies, AHCA's most serious level of deficiency. An I.J. deficiency is not common; it is issued only in the most egregious situations. To get more than four at one time demonstrates a serious system breakdown and absent clinical standards. The four I.J.s were[3]:

- Failure to give each resident care and services to get or keep the highest quality of care.
- Failure to give professional services that meet professional services that meet a professional standard of quality.
- Failure to administer services in a way that leads to the highest possible level of well being for each resident.
- Failure to choose a Doctor to be the Medical Director.

Some examples of the conduct involved included:

- Failure to follow physician order: A physician wrote an order that a patient on a ventilator was to be suctioned and assessed every two hours; this was not done and the resident died.

- Failure to follow physician order: A resident had a tracheotomy and physician order indicated nothing to be fed by mouth. The resident was fed solid food, such as cookies and fruit. The resident aspirated and died.

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3. Note that several incidents are repeated under a more than one IJ (for instance, failure to tell the doctor immediately on a change of condition and listed under failure to keep the highest quality of life possible):

- Failure to follow physician order: Ventilator settings were to be checked every 4 hours per doctor and tracheotomy care each shift and changed every 30 days. These orders were not carried over on the month to month so that physician orders for trach and related care were not being followed.

- Other serious problems: 12 out of 15 sampled residents showed physician orders not followed; 7 out of 7 respiratory therapists were providing care without physician orders or direction in the ventilator unit; 7 out of 13 licensed nurses had no required training on how to use a central line to administer medications; several nurses administering care had no verifiable license.

Harmony also had two level 3 deficiencies (G, H or I), which means actual harm compromising a resident's ability to maintain and/or reach his/her highest practicable physical, mental, and/or psychosocial well-being. These deficiencies related to failing to give residents proper treatment to prevent new bed sores and a failure to tell the doctor, resident and family member if there is a major change in a residents condition.

The Facility submitted and AHCA approved a plan of corrections on February 4, 2010 for these deficiencies, but a regularly scheduled routine survey dated February 12 revealed significant additional deficiencies. These were:

- failing to give residents care to keep highest quality of life;
- an actual harm deficiency related to improper treatment;
- failure to use licensed or registered staff;
- Employed nurses that were working under expired licenses, had a police record (including narcotic diversions), with an inadequate system to do criminal background checks;
- no reliable mandatory staff training programs;
- failure to develop timely, accurate measurable care plans;
- poor medication management (given too many doses or for too long of narcotics or psychoactive medications).

The Facility submitted a plan of correction for these deficiencies, certifying it had a system in place to prevent similar problems. The follow up resurvey on March 23, however, identified that

the last two bulleted deficiencies above remained uncorrected. These deficiencies were finally cleared on another follow up survey on May 7, 2010.

AHCA reported that from January 1, 2009 through March 31, 2010, Harmony had incurred 20 separate deficiencies, a number well above the state annual average of eight deficiencies. On-site visits from AHCA are summarized in the following chart:

AHCA Inspection Reports of Harmony

	Inspection Type	Document Type	Visit Date	Pages	Inspection Status
Select	Standard	Statement of Deficiencies	5/7/2010	4	Deficiencies Corrected
Select	Complaint	Statement of Deficiencies	4/5/2010	2	No Deficiency Cited
Select	Standard	Statement of Deficiencies	3/23/2010	10	Deficiencies Cited
Select	Fire/Life/Safety	Statement of Deficiencies	2/19/2010	4	No Deficiency Cited
Select	Standard	Statement of Deficiencies	2/12/2010	29	Deficiencies Cited
Select	Complaint	Statement of Deficiencies	2/4/2010	5	Deficiencies Corrected
Select	Complaint	Statement of Deficiencies	12/23/2009	116	Deficiencies Cited

D. Comparison With Other Nursing Facilities:

Harmony does not compare favorably with other nursing facilities in the country, both presently and in the recent past.

Each federally certified nursing home must complete a standardized assessment of each resident (Minimum Data Set – MDS) at the time of the resident's admission, whenever a significant change in condition occurs, and each calendar quarter. The MDS is used to identify resident conditions and produce "Quality Indicators" for each nursing home. Quality Indicators are used during inspections and monitoring visits to target areas of potential concern. For

example, if a resident is considered "low-risk" for the development of pressure sores, but develops a pressure sore while in the nursing home, the care would be reviewed as a potential concern.

The Quality Indicator Report from January 1, 2010 to June 30, 2010 (from the "Minimum Data Set" that every skilled nursing facility must use, thereby allowing comparisons of nursing homes throughout the country) indicates that Harmony is at the bottom 10% percent in residents with pressure ulcers. It is in the bottom 5% for resident who may be unnecessarily on a catheter, residents without a toileting plan, residents who have moderate to severe pain, residents who spend most of their time in a bed or chair and residents who are on 9 or more medications.

A non-clinical specific example is the percentage of long stay residents who spend most of their time in a chair or bed. The state and national average of all nursing homes were 4%; at Harmony it is 20% -- 5 times higher.

A "star rating" system of one to five (with one being the worst and five the best) is also used nationally to rate nursing homes. It considers a number of factors—the level of staffing in the building, regulatory compliance averaged over three years and quality indicator reports. Harmony's overall rating is one star, demonstrating a "much below average" rating.

Finally, as a result of its adverse surveys, Harmony presently is a Special Focus facility, subject to standard surveys every six months. There is better news on the horizon, however. On July 26- July 30, Harmony had its first unannounced survey under its Special Focus status. The results of this survey demonstrated significant improvement in the quality of care Harmony is delivering. Most of the deficiencies were "isolated" and none of the deficiencies observed by AHCA adversely impacted residents' health. There were deficiencies related to housekeeping, kitchen sanitation, medication management, medication control, and incomplete charting in the

medical records. Prior to this survey, an internal "mock survey" identified several of these areas as being vulnerable to becoming a deficiency at a formal survey. In addition, four out of the five deficiencies in the July survey were previously identified in prior surveys, meaning the facility still failed to follow its own plan of correction.

E. Harmony Management

In part as response to its troubles with AHCA, in February, 2010 Beam decided to hire a health care and skilled nursing facility management services company, Southern SNF Management Inc., to manage the Facility's day-to-day operations. Southern has provided some degree of improved management services. During its tenure, Southern was able to streamline Harmony's operations, increase the resident census, conduct a mock survey, and in many respects enhanced resident care.

The PCO has expressed two concerns over Southern's management services. First, Southern was managing over 17 skilled nursing facilities throughout the State of Florida and had limited ability to provide Beam with oversight and support capabilities in the areas of physical therapy, quality assurance, risk management, and pharmaceutical delivery. Second, Beam's Management Agreement with Southern paid Southern a percentage of gross revenue. As it relates to Southern's oversight of the marketing efforts to admit Medicaid and Medicare patients, this method of payment raised legal concerns relative to anti-kickback laws.

Due to disagreements that developed between Beam and Southern, Southern announced on July 23, 2010 its decision to terminate its Management Agreement with Beam. Simultaneously with Southern's termination, Ms. Andrea Pankhurst also resigned. Both Southern and Ms. Pankhurst provided only a two-week notice of termination requesting that they be relieved of their duties by no later than Thursday, August 5, 2010.

III. FINDINGS AND CONCLUSIONS:

A. FINDING: Harmony has had several AHCA surveys since 2007 with below average results, the most serious occurring in December 2009, which caused Harmony to become a "special focus facility" subject to additional oversight. Cumulatively, these surveys reflect a lack of developed, enforced and dependable clinical and operational systems, and have generated for Harmony consistent federally recognized ratings in the bottom 10% of all nursing facilities. New management needs to continue improving and strengthening these systems.

Harmony has a "one star" facility rating because for its last three years its surveys, staffing ratio and its quality indicator reports have consistently been worse than its peers. Its last annual standard survey (February 12, 2010) resulted in a finding of 20 deficiencies, well above the state average of 8. While many of its most severe problems stem from the challenges of operating a ventilator program (at least two of its four I.J. citations stemming from the December 29, 2010 AHCA complaint survey involved ventilator patients), its low ratings also consistently reflect inadequate clinical systems and poor management.

Since Southern and Ms. Pankhurst assumed management responsibility, we have witnessed more accountability of and teamwork among staff, an improving customer service mentality and progress in the development of systems. These advances in turn have improved overall care.

The latest survey that occurred in the last week of July indicated five deficiencies. They involved the following federal tags:

- F253 (Failure to provide) Housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior (pattern)

- F371(Failure to) Store, prepare, distribute and serve food under sanitary conditions (widespread)
- F425 (Failure to) Provide routine and emergency drugs (isolated)
- F431(Failure to) Label drugs and biologicals in accordance with currently accepted professional principles (pattern)
- F514--(Failure to) Keep accurate and medical records (isolated)

It is disconcerting that four out of five deficiencies were previously cited in recent AHCA surveys. These repeat deficiencies reinforce our perception that operational management systems to prevent deficiencies either are not in place or are unreliable. Strong management oversight can stop these preventable deficiencies. Nonetheless, the July survey was a much improved survey; all cited deficiencies were generally isolated with no negative impact on patient care.

B. FINDING: Harmony has shown it can correct deficiencies. Its response in several cases, however, reveals the clinical and operational systems that led to the deficiencies were not corrected, so that similar problems can reappear.

We are concerned about regulatory compliance, even when the Facility has corrected a deficiency. For example, our observations and conversations with staff indicate there still is no reliable system to hire properly and conduct appropriate background checks of new employees, who start at the facility without mandatory education, criminal background checks and verification of licenses, even though this was a repeat deficiency in the immediate past.

Some clinical systems are still not reliable, resulting in care not compliant with regulations and in some cases causing avoidable adverse impact. Prior to the July 26 ACHA survey, two examples from our own review of patient records showed: a failure to send information to a provider in a timely manner for a patient undergoing dialysis, and nurses failing

to follow a physician orders, which ultimately resulted in a preventable hospitalization. While we were pleased to see that the facility was encouraging an alert and oriented resident to take medication without assistance, this was done without the benefit of a physician's approval, which is against regulations. All the foregoing examples had been cited as deficiencies in 2010 by AHCA, yet they are being repeated.

A noteworthy exception to this finding is the respiratory therapy department, particularly its current director. It has significantly improved its clinical management ensuring that physician orders for those receiving ventilator care are followed.

C. FINDING: Although management has shown it will respond to problems brought to its attention, Harmony's Quality Assurance program is not sufficiently proactive either in identifying problems or in implementing follow up systems that solve or prevent the identified problem from recurring.

It is the PCO's belief that all too often the Facility fixes its shortcomings without repairing its underlying systems, which repairs are then enforced; this is the responsibility of Harmony's quality assurance ("QA") program. Through the QA program, interdisciplinary teams are supposed to analyze problems, come up with solutions, develop system to resolve, and then do ongoing monitoring to ensure they are followed. Examples where this process is to be applied include clinical processes to address significant weight loss, chemical restraint reduction or lessen the number of decubitus.

The repeat deficiencies are evidence that an effective quality assurance program is not in place. Early on in the PCO's monitoring of the QA function, he brought to management's attention the lack of coordination regarding significant weight loss among residents, but to date we have seen no system response to this fairly obvious problem. Another example is

management's response to a patient complaint about selection of an outside physician. While this individual complaint was noted, no system was put in place to honor resident's right to choose licensed health care providers. The facility has demonstrated, however, good success in having very few residents on restraints.

D. FINDING: Cutbacks to save expenditures on employees have resulted in a reduction in employee hourly compensation rates, benefit packages and hours worked, which cuts can lead to morale issues, which consequently may affect quality of care. Extensive staff turnover at Harmony also can negatively affect patient care.

Southern implemented a plan that reduced the hourly rates of line staff and shortened their scheduled work week. It remains to be seen what effect this reduction will have on turnover and employee satisfaction. It has been demonstrated that facilities with low turnover have better quality of care. In addition there is a direct correlation between staff satisfaction and nursing home resident satisfaction.

All certified nurse assistants had their workday reduced from a 8 hours to 7 ½ hours a day. This reduction precludes the CNAs from sharing information during working time about the residents from one shift to another. While there are no regulations requiring crossover time between CNA shifts, it is the prevailing standard among better care providers to allow for crossover to assure 24 hour nursing care. Although there is crossover among the licensed nurses, we believe this change for CNAs may have a deleterious effect on quality patient care as it relates to informing the next shift of changes in resident care.

Our analysis of Harmony reports to AHCA shows that 61 out of its 104 employees were employed for less than one 1 year. This represents an annual turnover rate of 58%. High turnover rates can have a negative impact on resident care.

E. FINDING: Harmony's physical plant is well maintained and its general presentation is clean, positive, and attractive. Its residents appear well dressed, are treated respectfully and participate in a vibrant activity program and for the most part speak favorably about the facility, its staff and management.

Many of the residents indicated that they were satisfied with care and many were complimentary to staff and management. Some of the higher functioning residents expressed concern with turnover and more recently were worried that Southern's rapid departure meant their home would be closing. Several of the residents were at the Facility the last time it was closed and remembered how difficult relocation can be.

After the last serious deficiency in December, 2009, ACHA noted that Harmony needed to honor residents' requests for different types of activities and activities that are tailored to individual resident desires. Since then, an activity consultant was brought on and programmatically, the activity program has improved. The PCO toured the facility several times and saw that few residents were in their room—a sign of a vibrant activity program.

F. FINDING: Harmony needs to continue improving its culture of caring.

During our visits we witnessed employees walking past residents obviously in some distress who could easily have been calmed down through behavioral based interventions. While we can understand that the bankruptcy and new management has been a turbulent time for Harmony employees, we recognize there is more work to be done in changing a culture to one that promotes positive staff–resident interaction.

We also see problems, particularly in social services, which among its many duties is acting to champion resident rights in bringing problems to closure. We were made aware of three resident complaints regarding transfer issues and timely discharge planning. Families made

their needs known, but the facility did not move on this timely. There were two complaints about the accuracy of a resident's bill. There were meritorious complaints about failure to choose a doctor, provide individualized care, and pain management protocols. Two family members expressed that if they were not present, the care of their loved one was not assured. These issues should be addressed by social services directly, without the need for a PCO to convey these concerns and issues.

In addition, resident grievance logs were not done in a clear manner and follow up with residents is problematic both in its documentation and level of resident satisfaction. Additional education and training for the social services director is necessary immediately so that he can more effectively advocate for the residents and document his interventions. For example, one of the residents complained that the facility did not try to find outside placement. The social services director produced a sheet of places of six places he tried and the patient's admission was turned down. Placement was however immediately identified when the PCO became involved.

G. FINDING: **Despite the need for ventilator care in Sarasota, Harmony's ventilator care program is currently managed in a way making it a financial drain.**

Harmony's ventilator program is challenged economically by Medicaid's funding all nursing home patients at a set rate, regardless of the actual costs of their care. Offering a ventilator care program can become cost effective through expanding and managing a minimum number of Medicare and private pay residents. In fact, several well-respected operators, including Miami Jewish Home and Hospital provide the community ventilator care and have found a way to make this economically viable through carefully accessing and balancing several payer types. Preservation of the ventilator program is important to area residents.

IV. RECOMMENDATIONS

A. Strengthening of Quality Assurance practices and continued education and support for the Director of Nursing are necessary.

Care is improving as evidenced by findings of fewer deficiencies by AHCA. Some existing systems, however, either fail to capture the benefits of the entire interdisciplinary care team, are not viable or are not consistently implemented because staff is not always held accountable. Interdepartmental communication is a problem and many challenges have occurred because the different departments are not always working together.

B. Education for staff on resident rights and Alzheimer's is required. In an effort to bolster resident rights, the social services director needs additional education.

These issues have either been the subject of deficiencies or directly observed. Our monitoring shows a lack of pro-active activity in social services areas.

C. It is a mandatory priority that a progressive and experienced management company be retained to supervise Harmony.

The departure of Southern has made essential the finding of a new manager for the Facility as soon as possible.

D. The Court should allow the PCO to remain in its role for an additional 60 days to monitor the effects on the quality of patient care by the introduction of a new management company and licensed nursing home administrator to operate the Facility.

V. CONCLUSION

This report is the initial report of the Patient Care Ombudsman and is a summarization of numerous interviews, meetings and document reviews conducted with management at all levels, staff and patients. Management at all levels, staff and patients have been cooperative in

providing information, producing data and reports and responding to questions in an honest and open fashion. The PCO has made a best effort, within the time constraints, to conduct a comprehensive review and assessment of the quality of care at Harmony as set forth in this Report.

I HEREBY CERTIFY that a true copy hereof was furnished via electronic mail to all parties on the Court's CM/ECF list maintained by the Court, and by U.S. mail to any parties who have requested a copy, on this 3rd day of August, 2010.

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The Medicare Provider Agreement: Is It a Contract or Not? And Why Does Anyone Care?

*By Samuel R. Maizel and Jody A. Bedenbaugh**

The article first considers the conflicting positions taken by the United States Government regarding whether the Medicare Provider Agreement is an executory contract in and outside of bankruptcy court. It examines whether the Government's positions can be reconciled, and if the Government should be barred by preclusion and estoppel principles from asserting in bankruptcy court that a Provider Agreement is an executory contract. The article then discusses whether the Provider Agreement should be treated as an executory contract in bankruptcy, and the implications of such treatment on a bankrupt provider's ability to transfer its Provider Agreement to a purchaser under the Bankruptcy Code and related issues, such as the Government's setoff and recoupment rights and successor liability.

INTRODUCTION

For thirty years, the United States Government[1] has successfully argued in federal district and circuit courts nationwide that the Health Insurance Benefit Agreement (commonly referred to, and referred to herein, as a "Medicare Provider Agreement") between the Government, on the one hand, and various providers of healthcare services or goods on the other hand, *is not* a contract between the United States and the provider.[2] Rather, the Government has argued that the Medicare Provider Agreement grants the provider a statutory entitlement.[3] However, during that same period of time, the United States has also successfully

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1. The authors use the terms "United States" and "Government" extensively and interchangeably in this article to refer to the federal government and its component agencies, which enter into Medicare Provider Agreements with the various healthcare entities that provide goods and services to Medicare beneficiaries. The primary agency involved in this "transaction" is the Centers for Medicare and Medicaid Services ("CMS"), which is a federal agency within the United States Department of Health and Human Services. Until 2001, CMS was known as the Health Care Financing Administration or "HCFA." *See* 66 Fed. Reg. 35437 (July 5, 2001).

2. *See infra* notes 24, 26, 28–30 & 33–35 and accompanying text.

3. *See infra* note 29.

argued, in federal bankruptcy courts, that the Medicare Provider Agreement is a contract.[4] How the Medicare Provider Agreement could be a contract inside of bankruptcy and not a contract outside of bankruptcy is hard to fathom, because the Bankruptcy Code does not define the term "contract" and precedent holds that applicable non-bankruptcy law controls the property rights held by a debtor in bankruptcy.[5] Presumably, then, the non-bankruptcy interpretation of whether a Medicare Provider Agreement is a contract governs in a bankruptcy case.

This inconsistency in treatment is complicated even further by the impact of the Government's argument in bankruptcy, because it means that the Medicare Provider Agreement is, therefore, subject to treatment under section 365 of the Bankruptcy Code. Section 365 of the Bankruptcy Code describes how debtors and trustees in bankruptcy cases deal with executory contracts.[6] The precedent in this area of bankruptcy law is, at best, complicated; courts dealing with issues related to executory contracts have described it as a "thicket . . . where . . . lurks a hopelessly convoluted and contradictory jurisprudence"[7] and referred to this area of law as "psychedelic."[8] Unfortunately, the Medicare provisions of the Social Security Act[9] are similarly complicated; courts have referred to it as "the most completely impenetrable texts within human experience."[10] The result when the two collide is, as one would imagine, difficult for judges, confusing to lawyers, and impossible to sort out for healthcare industry participants.

This article discusses the applicable law on both sides of the issue and concludes that the Medicare Provider Agreement is not a contract for bankruptcy purposes. It discusses why the Government chooses to make these inconsistent arguments and the possible implications if bankruptcy courts hold that Medicare Provider Agreements are not contracts in bankruptcy cases.[11]

4. *See infra* note 68 and accompanying text.

5. *See, e.g.*, Raleigh v. Ill. Dep't of Revenue, 530 U.S. 15, 20 (2000) ("The 'basic federal rule' in bankruptcy is that state law governs the substance of claims, Congress having generally left the determination of property rights in the assets of a bankrupt's estate to state law."); Butner v. United States, 440 U.S. 48, 55 (1979) (noting the determination of property rights is generally governed by state law); Tyler v. DH Capital Mgmt., Inc., 736 F.3d 455, 461 (6th Cir. 2013) ("The nature and extent of property rights in bankruptcy are determined by the 'underlying substantive law.'"); Am. Bankers Ins. Co. v. Maness, 101 F.3d 358, 363 (4th Cir. 1996) (finding that while federal law creates the bankruptcy estate, the determination of property rights is generally governed by applicable state law).

6. 11 U.S.C. § 365 (2012).

7. *In re* Drexel Burnham Lambert Grp., Inc., 138 B.R. 687, 690 (Bankr. S.D.N.Y. 1992) (quoting Michael T. Andrew, *Executory Contracts Revisited: A Reply to Professor Westbrook*, 62 U. COLO. L. REV. 1, 1 (1991)).

8. *Id.* at 690 (quoting Jay Lawrence Westbrook, *A Functional Analysis of Executory Contracts*, 74 MINN. L. REV. 227, 228 (1991)).

9. *See* 42 U.S.C. §§ 1395 *et seq.* (2012).

10. Rehab. Ass'n of Va. v. Kozlowski, 42 F.3d 1444, 1450 (4th Cir. 1994) ("There can be no doubt but that the statutes and provisions in question, involving the financing of Medicare and Medicaid, are among the most completely impenetrable texts within human experience. Indeed, one approaches them at the level of specificity herein demanded with dread, for not only are they dense reading of the most tortuous kind, but Congress also revisits the area frequently, generously cutting and pruning in the process and making any solid grasp of the matters addressed merely a passing phase.").

11. Prior articles dealing with this issue include: Ted A. Berkowitz & Veronique A. Urban, *Medicare Issues in Bankruptcies*, AM. BANKR. J., Aug. 2012, at 28; Frank A. Oswald & Howard P. Magaliff,

Medicare Provider Agreements

To be able to bill the Medicare program[12] for either providing services to Medicare beneficiaries or selling goods to Medicare beneficiaries, an entity or person must apply to the Government.[13] As one would expect, applying to participate in the Medicare program is complicated. First, the party concerned must file an application for a National Provider Identifier ("NPI"). The NPI is a ten-digit number that the entity or person will use to identify itself in future transactions with the Medicare program. The application is then usually submitted via the CMS's Internet-based Provider Enrollment, Chain and Ownership System ("PECOS"). This method can be used by physicians, non-physician practitioners, provider organizations, and supplier organizations. Each kind of applicant must complete a different kind of form.[14]

Once the applicant has an NPI, the party or person concerned must submit a form and supporting documents (usually online) to the appropriate Medicare fee-for-service contractor[15] serving the appropriate state or region, which then checks the application for completeness and accuracy. If applicable, a physical inspection of the facility is included in the review process. Once the verification and inspection is complete, the packet is forwarded to the Government for final approval.[16]

If the agreement is approved, the applicant will receive a Health Insurance Benefit Agreement (CMS Form 1561, commonly referred to as a "Medicare Provider Agreement") from the Government. The Medicare Provider Agreement's operative language for hospitals follows in its entirety:

Transfer of Medicare Provider Numbers in Bankruptcy: Executory Contract or Saleable Asset, Am. Bankr. J., May 2009, at 18; Samuel R. Maizel & Debra I. Grassgreen, *Selling Relationships with Governmental Entities*, Am. Bankr. J., Sept. 1999, at 10; Sarah Robinson Borders & Rebecca Cole Moore, *Purchasing Medicare Provider Agreements in Bankruptcy: The Case Against Successor Liability for Prepetition Overpayments*, 24 Cal. Bankr. J. 253 (1998).

12. Medicare is a federal program that funds health insurance primarily for the elderly and disabled, and it was created under Title XVIII of the Social Security Act. Approximately 55 million Americans participate in the Medicare program, which accounts for approximately $600 billion paid out in benefits annually, or 20 percent of all national health expenditures. *See, e.g.*, *The Facts on Medicare Spending and Financing*, Henry J. Kaiser Fam. Found., http://kff.org/medicare/fact-sheet/medicare-spending-and-financing-fact-sheet/ (last visited July 30, 2016); Sims v. HHS (*In re* TLC Hosps., Inc.), 224 F.3d 1008 (9th Cir. 2000) (describing statutory and regulatory framework of Medicare reimbursement).

13. *See* 42 U.S.C. § 1395cc.

14. The forms include but are not limited to: CMS-855A, Medicare Enrollment Application for Institutional Providers; CMS-855B, Medicare Enrollment Application for Clinics, Group Practices and Certain Other Suppliers; CMS-855I, Medicare Enrollment Application for Physicians and Non-Physician Practitioners; CMS-855S, Medicare Enrollment Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers; and CMS-855POH, Medicare Enrollment Application for Physician Owned Hospitals.

15. Also referred to as "carrier," "fiscal intermediary," "Medicare Administrative Contractor," or the "National Supplier Clearinghouse."

16. *See* 42 C.F.R. §§ 488.1, 488.3, 489.1, 489.2, 489.10 (2016) (describing how a new provider must apply for initial certification). The certification process enables CMS to determine, among other things, that the provider is qualified to provide healthcare services to patients. *See id.* §§ 489.10–489.12 (grounds for denying a Provider Agreement to a new provider).

> In order to receive payment under title XVIII of the Social Security Act, [fill in name of provider] D/B/A . . . as the provider of services, agrees to conform to the provisions of section . . . 1866 of the Social Security Act and applicable provisions in 42 CFR. This agreement, upon submission by the provider of services of acceptable assurance of compliance with title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 as amended, and upon acceptance by the Secretary of Health and Human Services, shall be binding on the Provider of services and the Secretary. In the event of a transfer of ownership, this agreement is automatically assigned to the new owner subject to the conditions specified in this agreement and 42 CFR 489, to include existing plans of correction and the duration of this agreement, if the agreement is time limited. ATTENTION: read the following provision of federal law carefully before signing. Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent representation or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than 5 years or both (18 U.S.C. § 1001).

Thus, the Medicare Provider Agreement itself expressly states that the provider only has to "conform" to the provisions of the Medicare Act. It does not state that the provider is obligated to provide any medical services or supplies.[17] Furthermore, the Medicare Provider Agreement does not mention any obligations imposed on the Government.

The transfer of a Medicare Provider Agreement is strictly controlled by federal regulations. Medicare Provider Agreements can only be assigned if there is a "change of ownership" (commonly referred to as a "CHOW").[18] Most importantly to buyers of healthcare entities, when the Government determines that a CHOW has occurred, the Medicare Provider Agreement is automatically assigned to the new owner,[19] and the new owner becomes liable for liabilities created or incurred by the prior owner.[20] As one circuit court has observed, "[i]f the new owner elects to take an assignment of the existing Medicare Provider Agreement, it receives an uninterrupted stream of Medicare payments but assumes successor liability for overpayments and civil monetary penalties asserted by the Government against the previous owner."[21] In other words, assuming the Medicare Provider Agreement generally means assuming successor liability.[22]

17. The reference in the Medicare Provider Agreement to the "Secretary" is to the Secretary of the United States Department of Health and Human Services.

18. 42 C.F.R. § 489.18 (2016).

19. *Id.* § 489.18(c); United States v. Vernon Home Health, Inc., 21 F.3d 693, 696 (5th Cir. 1991).

20. *See Vernon Home Health*, 21 F.3d at 696 (citing 42 C.F.R. § 489.18(a), (d)).

21. *In re* Charter Behavioral Health Sys., LLC, 45 F. App'x 150, 151 (3d Cir. 2002).

22. 42 C.F.R. § 489.18(d); Deerbrook Pavilion, LLC v. Shalala, 235 F.3d 1100, 1103 (8th Cir. 2000) (assignment of Provider Agreement to new owner of a skilled nursing facility made new owner liable for penalties assessed on the basis of former owner's actions); *Vernon Home Health*, 21 F.3d at 696 (assignment to new owner of Medicare Provider Agreement results in liability for overpayments received by prior owner); Eagle Healthcare, Inc. v. Sebelius, 969 F. Supp. 2d 38, 40 (D.D.C. 2013) ("An assigned Provider Agreement is subject to all of the terms and conditions under which it was originally issued.").

Government Arguments that Medicare Provider Agreements Are Not Contracts

Although it is beyond dispute that the United States has the inherent right to use contracts in carrying out its obligations and exercising its powers,[23] for more than thirty years, the United States has argued, with success, in federal litigation nationwide that the Medicare Provider Agreement is *not* a contract.[24] These cases often arise after a regulatory or statutory change to applicable reimbursement schemes. These changes are challenged by providers in courts on contract law grounds.[25] The Government argues against these suits on the basis that unilateral changes to the applicable law do not constitute an impermissible taking because the Medicare Provider Agreements do not create contractual rights.[26] In addition, this issue also arises in False Claims Act[27] cases where the Government is the plaintiff. In such cases, the Government takes the position that it has equitable, rather than contractual, claims.[28]

23. United States v. Tingey, 30 U.S. 115 (1831); United States v. Maurice, 26 F. Cas. 1211 (C.C.D. Va. 1823) ("Contract is one of the means necessary to accomplish the objects of the institution of the government, and the capacity of the United States to contract is coextensive with the powers and duties of government.").

24. *See, e.g.*, Mem'l Hosp. v. Heckler, 706 F.2d 1130, 1136 (11th Cir. 1983) ("Upon joining the Medicare Program, however, the hospitals received a statutory entitlement, not a contractual right."); United States *ex rel.* Roberts v. Aging Care Home Health, Inc., 474 F. Supp. 2d. 810, 820 (W.D. La. 2007) ("Medicare Provider Agreements create statutory, not contractual, rights."); Maximum Care Home Health Agency v. HCFA, No. 3-97-CV-1451-R, 1998 WL 901642, at *5 (N.D. Tex. Apr. 14, 1998) ("[A] Medicare service provider agreement is not a contact in the traditional sense. It is a statutory entitlement created by the Medicare Act.").

25. The Contract Clause of the United States Constitution prohibits states from enacting laws that retroactively impair contract rights. U.S. Const. art. 1, § 10, cl. 1. However, this applies only to state legislation, not federal legislation or court decisions. The Fifth Amendment of the U.S. Constitution is the limitation on the power of Congress to enact laws impairing the obligation of contracts. *See generally* Lynch v. United States, 292 U.S. 571, 579 (1934) ("The Fifth Amendment commands that property be not taken without making just compensation. Valid contracts are property, whether the obligor be a private individual, a municipality, a state or the United States."); Cienega Gardens v. United States, 331 F.3d 1319, 1330 (Fed. Cir. 2003) ("There is . . . ample precedent for acknowledging a property interest in contract rights under the Fifth Amendment."); Elmer W. Roller, *The Impairment of Contract Obligations and Vested Rights*, 6 Marq. L. Rev. 129 (1922).

26. *See, e.g.*, Greater Dallas Home Care Alliance v. United States, 10 F. Supp. 2d 638, 647 (N.D. Tex. 1998) (holding that the provider's "participation agreements are not contracts, for the right to receive payments under the Medicare Act is a manifestation of Government policy and, as such, is a statutory rather than a contractual right"); Home Care Ass'n of Am. Inc. v. United States, No. CIV-98-193-R, 1998 U.S. Dist. LEXIS 20515, at *17 (W.D. Okla. 1998) (noting the plaintiff providers failed to dispute the Government's "assertion that neither the provider agreements nor the Medicare Act provide contractual rights to a particular method or amount of payment" (internal citations omitted)), *rev'd on other grounds*, No. 98-6364, 2000 U.S. App. LEXIS 23220 (10th Cir. 2000).

27. 31 U.S.C. §§ 3729–3733 (2012). In 2008, 40 percent of False Claims Act recoveries were related to healthcare industry fraud. James B. Helmer, Jr., *False Claims Act: Incentivizing Integrity for 150 Years for Rogues, Privateers, Parasites and Patriots*, 81 U. Cin. L. Rev. 1261, 1281 (2013).

28. *See, e.g.*, United States v. Villaspring Health Care Ctr., Inc., No. 3:11-43, 2011 U.S. Dist. LEXIS 145534, at *7 (E.D. Ky. Dec. 19, 2011) (declining to dismiss unjust enrichment claim because Medicare Provider Agreements create statutory, not contractual, rights); United States v. Medica-Rents Co., 285 F. Supp. 2d 742, 777 (N.D. Tex. 2003) (agreeing with Government's argument, declining to grant summary judgment for provider, and holding that "a contract did not exist between [the provider] and the government").

For example, in 2005 litigation in the United States District Court for the Central District of California, the United States made the following argument:

> The Provider Agreements referenced by defendants are one-page documents that do no more than notify providers of the statutory and regulatory provisions of the Medicare program and do not in themselves convert the [G]overnment's statutory and common law remedies into contractual ones. Under those Agreements, providers "agree[] to conform to the provisions of . . . the Social Security Act and applicable provisions in [the Code of Federal Regulations]." . . . The Agreements impose no duties upon the United States or the Department of Health and Human Services. . . . Importantly, a Provider Agreement imposes no additional duties upon a provider that are not also embodied in the Social Security Act and regulations. Any "breach" of the Agreement by a provider would necessarily be a violation of the Social Security Act and/or the regulations because to determine what duties the provider had breached, one would have to turn to the statute and the regulations. . . . Medicare providers, upon joining the Medicare program, "receive[] a statutory entitlement, not a contractual right." Although the hospitals entered into an "agreement" with the Secretary that they would abide by the rules of the Medicare program, that agreement did not obligate the Secretary to provide reimbursement for any particular expenses.[29]

In another case, in the United States District Court for the District of Columbia, the United States similarly argued that the Medicare Provider Agreement was not a contract between the Government and the provider:

> Second, [the] argument that the parties enjoyed express contractual relationships is untenable. The overwhelming weight of authority rejects any notion that providers participating in Government Health Care Programs have contractual relationships with them. Although provider enrollment applications and materials are often referred to as "agreements," these materials do not establish a contractual relationship—instead providers' rights to reimbursement are statutory in nature. . . . [The defendant's] sole argument in opposition to the Government Parties' unjust enrichment claim is an erroneous contention that the Government Parties' cause of action must be styled as a breach of contract count . . . . This form over substance argument, however, is incorrect as a matter of law. . . . Courts have rejected attempts to characterize Medicare provider "agreements" as contracts. In the context of the Medicare program, the Medicare statute requires providers to enter into an agreement, commonly referred to as a provider agreement, with the Secretary of HHS in order to receive Medicare reimbursement. While the provider "agreement" is a condition for reimbursement, it does not establish a contractual relationship between providers and the United States.[30]

Further, in *United States ex rel. Drakeford v. Tuomey Healthcare System, Inc.*,[31] the United States sued a hospital, the Tuomey Regional Medical Center, for

29. United States' Sur-Reply to Tenant's Reply to its Motion for Summary Adjudication (Statute of Limitations) at 2, United States v. Tenant Healthcare Corp., Nos. CV-03-206, CV-04-857, CV-04-859, 2005 WL 3784642 (C.D. Cal. Dec. 22, 2005) (internal citations omitted).

30. Government Parties' Reply in Further Support of Their Motion for Partial Summary Judgment at 2, 4, United States v. Malik, No. 12-1234, 2013 WL 3948074 (D.D.C. June 13, 2013).

31. This long and complicated case involved two jury verdicts and two appeals to the Fourth Circuit. Its history is described in 675 F.3d 394 (4th Cir. 2012) and 792 F.3d 364 (4th Cir. 2015).

violations of the Ethics in Patient Referrals Act,[32] also known as the Stark Law. Tuomey provided services to Medicare beneficiaries pursuant to its Medicare Provider Agreement. The Government asserted alternative causes of action for equitable theories (unjust enrichment and payment by mistake), not for breach of contract. In describing the Medicare Provider Agreement in its second amended complaint, the Government referred to the Medicare Provider Agreement as an "application for participation."[33] Even more directly, in its Opposition to Tuomey's Motion for Summary Judgment on Government's Equitable Claims, the Government distinguished certain cases cited by Tuomey by stating the "two Northern District of Illinois cases cited by Tuomey similarly involved contracts, in contrast to the present case, *which does not.*"[34] In another filing in the same case, the Government went on to state:

> Further, Tuomey erroneously argues that the Provider Agreement it signed constituted a "contract" with the government. This argument misconstrues the nature of the Medicare program. The program is a social benefit program for individuals, and the Provider Agreement is the hospital's certification that it will comply with all applicable requirements. As explained by the Seventh Circuit in *United States v. Rogan*, 517 F.3d 449, 453 (7th Cir. 2008), the government does not receive any benefit from the services provided to Medicare beneficiaries; no "service" or "product" is provided directly to the government.[35]

The above arguments are typical of those consistently made by the United States in lawsuits throughout the nation with regard to whether the Medicare Provider Agreement is a contract. Moreover, these arguments are generally successful.

Federal circuit courts regularly agree with the Government and lower courts that Medicare Provider Agreements create statutory, rather than contractual, rights. Perhaps the earliest case to address the nature of the Medicare relationship was *Harper-Grace Hospitals v. Schweiker.*[36] In *Harper-Grace*, the United States Court of Appeals for the Sixth Circuit dealt with a situation where a hospital chain claimed it was entitled to reimbursement under the Medicare Act for a percentage of the costs that it incurred because of certain obligations that it had assumed upon receiving federal funds under the Hill-Burton Act.[37] Because the law on this issue had changed while the appeal was pending, the hospitals argued that the change in law was unconstitutional as a violation of the Due Process Clause of the Fifth Amendment.[38] Central to the hospitals' argument was

32. 42 U.S.C. § 1395 (2012).

33. Second Amended Complaint at para. 14, Drakeford *ex rel.* United States v. Tuomey Healthcare System, Inc., No. 3:05-cv-2858-MBS (D.S.C. Nov. 12, 2008).

34. United States' Opposition to Defendant's Motion for Summary Judgment on Government's Equitable Claim at 10, Drakeford *ex rel.* United States v. Tuomey Healthcare System, Inc., No. 3:05-cv-2858-MBS (D.S.C. Apr. 15, 2010) (emphasis added).

35. Reply in Support of United States' Motion for Entry of Judgment on Counts IV and V of the Amended Complaint, Drakeford *ex rel.* United States v. Tuomey Healthcare System, Inc., No. 3:05-cv-2858-MBS (D.S.C. July 12, 2013).

36. 708 F.2d 199 (6th Cir. 1983).

37. *Id.* at 200.

38. *Id.*

the alleged existence of a "vested contractual right to reimbursement." The Sixth Circuit rejected this argument, holding that the hospitals had not "shown that the Medicare program established a contractual relationship between the hospital and the federal Government."[39]

Three years later, in *Hollander v. Brezenoff*,[40] the United States Court of Appeals for the Second Circuit also characterized the Medicare Provider Agreement as something other than a contract. Confronted with the issue of whether New York's six-year statute of limitations on contracts applied to a dispute between the Government and a nursing home operator, or whether its three-year statute of limitations applied, the Second Circuit ruled that the three-year statute was applicable.[41] Central to its determination was the characterization of the relationship as a "statutory business relationship."[42] As for the Medicare Provider Agreement, the Second Circuit treated it as incidental to the broader relationship.[43]

More recently, the United States Court of Appeals for the Ninth Circuit drew similar conclusions in *PAMC, Ltd. v. Sebelius*, in which it stated the following about the Medicare Provider Agreement:

> Especially is that true when we consider that the whole notion of importing contract doctrines into an area that is a complex statutory and regulatory scheme is problematic. 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 contractual right."[44]

This is consistent with prior holdings from the Third and Eleventh Circuits.[45]

This position has been repeatedly reaffirmed by federal district courts as well. For example, in *United States ex rel. Roberts v. Aging Care Home Health, Inc.*,[46] the United States District Court for the Western District of Louisiana determined that a breach-of-contract cause of action was not available to recoup losses for Medicare fraud because the Medicare statute did not create contractual rights. Similarly, in *United States ex rel. Academy Health Center, Inc. v. Hyperion Founda-*

39. *Id.* at 201.
40. 787 F.2d 834 (2d Cir. 1986).
41. *Id.* at 839.
42. *Id.*
43. *Id.*
44. 747 F.3d 1214, 1221 (9th Cir. 2014) (internal citations omitted).
45. *See* Mem'l Hosp. v. Heckler, 706 F.2d 1130, 1136 (11th Cir. 1983) ("Upon joining the Medicare Program . . . the hospitals received a statutory entitlement, not a contractual right."); Germantown Hosp. & Med. Ctr. v. Heckler, 590 F. Supp. 24, 30–31 (E.D. Pa. 1983) ("There is no contractual requirement requiring [CMS] to provide Medicare reimbursement. Rather, upon joining the Medicare program, providers gain a statutory entitlement to reimbursement."), *aff'd*, 738 F.2d 631 (3d Cir. 1984).
46. 474 F. Supp. 2d 810, 820 (W.D. La. 2007).

tion, Inc.,[47] the United States District Court for the Southern District of Mississippi sustained the Government's claim for unjust enrichment because the remedy of breach of contract was not available in the context of Medicare recovery. Relying upon *Roberts*, the district court held that Medicare Provider Agreements were not contracts and, instead, were creatures of statute.[48]

Further, the United States District Court for the Eastern District of Arkansas, in *Southeast Arkansas Hospice, Inc. v. Sebelius*, explained why a Medicare Provider Agreement is not a contract as follows:

> [T]he Secretary [of the United States Department of Health and Human Services] argues first that the provider agreement is a statutory entitlement and not a contract. . . . The Supreme Court has long "maintained that absent some clear indication that the legislature intends to bind itself contractually, the presumption is that a law is not intended to create private contractual or vested rights but merely declares a policy to be pursued until the legislature shall ordain otherwise." "This well-established presumption is grounded in the elementary proposition that the principal function of a legislature is not to make contracts, but to make laws that establish the policy of the state." The party asserting the creation of a contract must overcome this well-founded presumption. The language and circumstances of the statute must evince a clear intent by the legislature to create contractual rights so as to bind the state. . . . The Secretary cites several cases in this area as to Medicare provider agreements, all of which support the Secretary's position that the agreement with SEARK is not a contract. SEARK has cited no legal authority on this issue. Indeed, SEARK makes no argument to overcome the presumption that the law at issue was not intended to create a contract. . . . The Court cannot say that SEARK is likely to succeed on the merits of its unconscionable contract claim. The weight of authority supports a finding that the provider agreement is not a contract.[49]

Thus, outside of bankruptcy, it seems to be settled law that the Medicare Provider Agreement is not a contract between the provider of goods or services and the United States, but merely a license allowing the provider to bill the Medicare program pursuant to the statutory and regulatory scheme when it provides goods or services to Medicare beneficiaries.

Discussion of Section 365 as Applied to the Medicare Provider Agreement

The Bankruptcy Code has a specific provision, section 365, that deals with the rights and obligations of debtors and trustees in bankruptcy with regard to "executory contracts."[50] Under this provision, trustees and debtors in possession in bankruptcy generally may decide to assume an executory contract or unexpired lease, assume and assign an executory contract or unexpired lease to a third party, or reject an executory contract or unexpired lease, subject to a number

47. No. 3:10-CV-552, 2014 U.S. Dist. LEXIS 93185, at *163–64 (S.D. Miss. July 9, 2014).
48. *Id.* at *163.
49. 1 F. Supp. 3d 915, 925–26 (E.D. Ark. 2014) (quoting Nat'l R.R. Passenger Corp. v. A.T. & S.F. R. Co., 470 U.S. 451, 465–66 (1985) (quoting Dodge v. Bd. of Educ., 302 U.S. 74, 79 (1937))).
50. 11 U.S.C. § 365 (2012).

of requirements and exceptions which are outside the scope of this article. The Bankruptcy Code does not define "executory contract," but most courts have adopted this definition: "a contract under which the obligation of both the bankrupt and the other party to the contract are so far unperformed that the failure of either to complete performance would constitute a material breach excusing the performance of the other."[51] However, that definition establishes only which contracts are "executory"; it does not establish what constitutes a contract. The definition of "contract" comes from applicable non-bankruptcy law.[52] Fortunately, this is consistent with the federal law outside of bankruptcy:

> [T]he creation and modification of a contractual relationship between the Government and a contractor is, for the most part, determined by common law legal rules. As these rules have been applied to Government contract cases, a body of federal law has developed as the primary source of law in this area. This federal law is generally consistent with the legal rules summarized in the Restatement of Contracts.[53]

Non-bankruptcy federal contract law therefore determines whether the Medicare Provider Agreement is a contract under the Bankruptcy Code. The elements of a contract with the United States are "a mutual intent to contract including offer, acceptance, and consideration; and authority on the part of the government representative who entered or ratified the agreement to bind the United States."[54] The federal law of contracts is "generally consistent" with the rules set out in the *Restatement (Second) of Contracts*.[55]

The *Restatement (Second) of Contracts* defines a contract as "a promise or a set of promises for the breach of which the law gives a remedy, or the performance of which the law in some way recognizes as a duty."[56] "Promise" is defined as a

51. Vern Countryman, *Executory Contracts in Bankruptcy: Part I*, 57 MINN. L. REV. 439, 460 (1973); *see also In re* Murexco Petroleum, Inc., 15 F.3d 60, 62–63 (5th Cir. 1994); *In re* Texscan Corp., 976 F.2d 1269, 1271–72 (9th Cir. 1992); Lubrizol Enters., Inc. v. Richmond Metal Finishers, Inc. (*In re* Richmond Metal Finishers, Inc.), 756 F.2d 1043, 1045 (4th Cir. 1985).

52. *See supra* note 5.

53. JOHN CIBINIC, JR. & RALPH C. NASH, JR., FORMATION OF GOVERNMENT CONTRACTS 151 (2d ed. 1986) (citing Priebe & Sons v. United States, 332 U.S. 407, 411 (1947) ("It is customary, where Congress has not adopted a different standard, to apply to the construction of government contracts the principles of general contract law.")); *see also* United States v. Standard Rice Co., 323 U.S. 106, 111 (1944) ("Although there will be exceptions, in general the United States as a contractor must be treated as other contractors under analogous situations. When problems of the interpretation of its contract arise the law of contracts governs."); Lynch v. United States, 292 U.S. 571, 579 (1934) ("When the United States enters into contract relations, its rights and duties therein are governed generally by the law applicable to contracts between private individuals."); Torncello v. United States, 681 F.2d 756, 762 (Ct. Cl. 1982) ("While it is true that the government has the power to abrogate common-law contract doctrines by specific legislation . . . , the general rule must be that common-law doctrines limit the government's power to contract just as they limit the power of any private person.").

54. Hoag v. United States, 99 Fed. Cl. 246, 253 (2011); *see also* Allen v. United States, 100 F.3d 133, 134 (Fed. Cir. 1996).

55. *See, e.g.*, Pac. Gas & Elec. Co. v. United States, 73 Fed. Cl. 333 (2006) (applying *Restatement (Second) of Contracts* to resolve government contract case); Nat'l By-Products, Inc. v. United States, 405 F.2d 1256, 1263 (Ct. Cl. 1969) (same).

56. RESTATEMENT (SECOND) OF CONTRACTS § 1 (AM. LAW INST. 1981).

"manifestation of intention to act or refrain from acting in a specified way."[57] In determining whether the Medicare Provider Agreement is a contract, one must look at whether the parties to the agreement are manifesting an intention to act in a specified way.

Earlier this article quoted the Government as arguing that the Medicare Provider Agreement "impose[s] no duties upon the United States or the Department of Health and Human Services,"[58] as well as arguing that the Medicare Provider Agreement "did not obligate the Secretary to provide reimbursement for any particular expenses."[59] What then is the "promise" made by the Government when it enters into the Medicare Provider Agreement, if that agreement imposes no duties on the Government, including no duty to pay for the goods and services obtained for Medicare beneficiaries through the relationship between the provider and the Government?

Additionally, the *Restatement (Second) of Contracts* recognizes that a party's statements may affect whether a contract is formed: "Neither real nor apparent intention that a promise be legally binding is essential to the formation of a contract, but a manifestation of intention that a promise shall not affect legal relations may prevent the formation of a contract."[60] Earlier, this article quoted Government arguments that the Medicare Provider Agreement does not affect the legal relations between the provider and the Government; it does no more than "notify providers of the statutory and regulatory provisions of the Medicare program."[61] That the Government expressly argues that the Medicare Provider Agreement is not a contract is a clear expression by the Government that the Medicare Provider Agreement does not affect legal relations.

The *Restatement (Second) of Contracts* also states that "the formation of a contract requires a bargain in which there is a manifestation of mutual assent to the exchange and a consideration."[62] However, as shown earlier through the Government's arguments in many cases, the Government has consistently repudiated

57. *Id.* § 2; *see also* Fifth Third Bank of W. Ohio v. United States, 52 Fed. Cl. 264, 270 (2002) ("A promise may be express or implied, but it is to be distinguished from mere statements of intention, opinion or prediction.").

58. Government Parties' Reply in Further Support of Their Motion for Partial Summary Judgment at 2, 4, United States v. Malik, No. 12-1234, 2013 WL 3948074 (D.D.C. June 13, 2013).

59. United States' Sur-Reply to Tenant's Reply to Its Motion for Summary Adjudication (Statute of Limitations) at 2, United States v. Tenant Healthcare Corp., Nos. CV-03-206, CV-04-857, CV-04-859, 2005 WL 3784642 (C.D. Cal. Dec. 22, 2005) (internal citations omitted).

60. RESTATEMENT (SECOND) OF CONTRACTS § 21.

61. *See supra* note 59.

62. *See* RESTATEMENT (SECOND) OF CONTRACTS § 17; *see also* United States v. Travelers Indem. Co., 802 F.2d 1164, 1169 (9th Cir. 1986) (applying *Restatement (Second) of Contracts* § 17); Univ. of V.I. v. Petersen-Springer, 232 F. Supp. 2d 462, 469 (D.V.I. 2002) (same); *see, e.g.*, Lauren E. Miller, *Breaking the Language Barrier: The Failure of the Objective Theory to Promote Fairness in Language-Barrier Contracting*, 43 IND. L. REV. 175, 177–80 (2009) ("The objective theory of contracts states that a party's outward manifestations of assent will bind the party to the contract if the other party could reasonably regard those manifestations as assent. However, a party cannot reasonably regard outward manifestations as assent if he subjectively knows the party making those manifestations means otherwise. Thus, courts apply the objective theory to reach decisions regarding the enforceability of contracts based on the circumstances present between the parties at the time of contracting." (internal citations omitted)).

the notion that the Medicare Provider Agreement is a manifestation of its assent to an exchange because it argues that it promises nothing to the provider in the agreement.[63] Moreover, it has expressly argued that it gets no consideration from the performance by the provider: "the [G]overnment does not receive any benefit from the services provided to Medicare beneficiaries; no 'service' or 'product' is provided directly to the [G]overnment."[64] The Government cannot enter into contracts "under which the government receives nothing."[65]

Additionally, because a contract requires consideration,[66] an agreement such as the Medicare Provider Agreement, which merely requires both parties to adhere to existing statutes and regulations, does not impose legal obligations other than those both parties already owe. The *Restatement (Second) of Contracts* points out that the "[p]erformance of a legal duty owed to a promisor which is neither doubtful nor the subject of an honest dispute is not consideration."[67] Thus, a pre-existing duty is usually not sufficient consideration for a contract. According to the Government, as the Medicare Provider Agreement merely informs the provider to follow applicable rules and statutes, which it has a pre-existing legal duty to do, the Medicare Provider Agreement is not supported by consideration.

Government Position that Medicare Provider Agreements Are Contracts

Despite the seemingly settled proposition that the Medicare Provider Agreement is not a contract but rather creates an entitlement in the provider to provide goods or services to Medicare beneficiaries and then bill the United States, in bankruptcy cases the United States takes the position that the Medicare Provider Agreement is a contract. Notably, the majority of courts have agreed with the Government, but most of these decisions merely state the conclusion without substantive analysis, or the issue otherwise does not appear to have been con-

63. Russell v. Dist. of Columbia, 747 F. Supp. 72, 79–80 (D.D.C. 1990) ("For the parties to have manifested their mutual assent, they must have exchanged promises.").

64. Reply in Support of United States' Motion for Entry of Judgment on Counts IV and V of Amended Complaint at 5, Drakeford *ex rel.* United States v. Tuomey Healthcare System, Inc., No. 3:05-cv-2858-MBS (D.S.C. July 12, 2013).

65. Aviation Contractor Emps., Inc. v. United States, 945 F.2d 1568, 1573 (Fed. Cir. 1991).

66. *See, e.g.*, Gardiner, Kamya & Assocs., P.C. v. Jackson, 369 F.3d 1318, 1322 (Fed. Cir. 2004) ("[t]o be valid and enforceable, a contract must have . . . consideration to ensure mutuality of obligation").

67. Restatement (Second) of Contracts § 73; *see, e.g.*, United States v. Travelers Indem. Co., 802 F.2d 1164, 1167 (9th Cir. 1986) ("Although the rule has been subject to criticism . . . performance of a preexisting legal duty is not sufficient consideration."); Pressman v. United States, 33 Fed. Cl. 438, 444 (1995) ("A promise by a government employee to comply with the law does not transform statutory or regulatory obligations to contractual ones" and therefore cannot provide consideration); Floyd v. United States, 26 Cl. Ct. 889, 890–91 (1992) (federal agency's promise to do what it is required to do under federal regulations is "essentially" merely a restatement of a preexisting legal duty, and therefore is not consideration; "[t]hat which one is under a legal duty to do, cannot be the basis for a contractual promise"); Corneill A. Stephens, *Abandoning the Pre-Existing Duty Rule: Eliminating the Unnecessary*, 8 Hous. Bus. & Tax J. 355, 361 (2008) ("The [pre-existing duty] rule has even been applied where the pre-existing duty was one imposed, not by contract, but by law.").

tested.[68] For example, in *In re Vitalsigns Homecare, Inc.*,[69] the United States Bankruptcy Court for the District of Massachusetts observed that a "majority of bankruptcy courts considering the Medicare provider relationship with the Government conclude that the Medicare provider agreement, with its attendant benefits and burdens, is an executory contract." However, the court did no analysis of the issue itself. Similarly, in *In re University Medical Center*,[70] the United States Court of Appeals for the Third Circuit rejected the contention that the "complexity of the Medicare scheme" excludes a provider agreement from the ambit of section 365. Instead, it concluded that "a Medicare provider agreement easily" fit within the judicial definition of an executory contract.[71] In this decision there is no evidence that the panel considered the Third Circuit's ruling in *Germantown Hospital & Medical Center v. Heckler*,[72] eight years earlier, that the Medicare Provider Agreement created a statutory entitlement rather than a contractual relationship. More recently, in *In re Bayou Shores, SNF, LLC*,[73] the United States Bankruptcy Court for the Northern District of Florida held that the Medicare Provider Agreement was an executory contract. Citing a series of decisions, the court observed that "the majority of courts have concluded that Medicare provider agreements are executory contracts."[74] However, there is no evidence that the bankruptcy court in *Bayou Shores* considered the Eleventh Circuit's ruling in *Memorial Hospital v. Heckler*[75] in 1983 that the Medicare Provider Agreement created a statutory entitlement, and "not a contractual right." The court in *Bayou Shores* employed two approaches in reaching the conclusion that a Medicare Provider Agreement is an executory contract. The first approach examines whether a portion of the contract was unperformed, and whether a party could thus be deemed to be in material breach.[76] The other approach is more of a "functional approach," whereby a court examines the benefits that would run to the estate if the contract were accepted or rejected.[77] Although this is

68. *See, e.g.*, IHS of Ga., Inc. v. Michigan (*In re* First Am. Health Care of Ga., Inc.), 219 B.R. 324, 327–28 (Bankr. S.D. Ga. 1998) (treating state Medicaid Provider Agreement as executory contract without substantive analysis); *In re* Heffernan Mem'l Hosp. Dist., 192 B.R. 228, 231 n.4 (Bankr. S.D. Cal. 1996) ("[A] Provider Agreement is a contract providing for advance payments based on estimates and expressly permitting the withholding of overpayments from future advances. . . . A Medicare [P]rovider [A]greement is an executory contract."); Tidewater Mem'l Hosp., Inc. v. Bowen (*In re* Tidewater Mem'l Hosp., Inc.), 106 B.R. 876, 880 (Bankr. E.D. Va. 1989) (stating without analysis the Medicare Provider Agreement was an executory contract); Advanced Prof'l Home Health Care Inc. v. Bowen (*In re* Advanced Prof'l Home Health Care Inc.), 94 B.R. 95, 96 (Bankr. E.D. Mich. 1988) (treatment of Medicare Provider Agreement as executory was apparently not contested by the debtor); Mem'l Hosp. of Iowa City, Inc., 82 B.R. 478 (Bankr. W.D. Wisc. 1988) (same).

69. 396 B.R. 232, 239 (Bankr. D. Mass. 2008).

70. 973 F.3d 1065, 1076 (3d Cir. 1992).

71. *Id.* at 1075 n.13.

72. 738 F.2d 631 (3d Cir. 1984).

73. 525 B.R. 160, 168 (Bankr. M.D. Fla. 2014), *rev'd*, Case No. 8:14-CV-02816-T-30, 2015 U.S. Dist. LEXIS 83390 (M.D. Fla. June 26, 2015).

74. *Id.*

75. 706 F.2d 1130, 1136 (11th Cir. 1983).

76. *See generally In re* Murexco Petroleum, Inc., 15 F.3d 60, 62–63 (5th Cir. 1994); *see generally In re* Texscan Corp., 976 F.2d 1269, 1271–72 (9th Cir. 1992).

77. *See generally In re* Magness, 972 F.2d 689, 693 (6th Cir. 1992).

an interesting analysis, it presumes the Medicare Provider Agreement is a contract and then only attempts to analyze whether it is executory.

Similarly, in *In re Barincoat*,[78] the United States Bankruptcy Court for the District of Connecticut also seemed to start with the premise that a Medicaid Provider Agreement was a contract and referred to the Second Circuit's contrary holding in *Hollander* as "not entirely on point." The court went on to hold that the Medicaid Provider Agreement was not executory.[79]

Although most bankruptcy courts and appellate courts in bankruptcy cases have merely ignored the issue of whether the Medicare Provider Agreement is a contract at all, those courts that have tried to analyze the requirements under the Medicare Provider Agreement have sometimes held that there are mutual obligations arising under the "contract," namely that the healthcare provider is obligated to provide patient services, while the Government is obligated to reimburse the provider. As the United States District Court for the Western District of Pennsylvania observed in *In re Monsour Medical Center*,[80] "Monsour is obligated to provide services to Medicare patients without charge and HHS is obligated to reimburse Monsour. These mutual obligations may be viewed as growing out of either an express contract . . . or an implied in fact contract." This is an interesting observation, given that the express language of the Medicare Provider Agreement provides no such obligations. Moreover, this observation ignores that the United States denies that the Medicare Provider Agreement creates any obligations for the provider to do anything other than conform to statutory and regulatory obligations and denies that the United States is bound to do anything other than do what is required under the applicable statutes and regulations. In other words, despite the court's observation about mutual obligations arising out of the Medicare Provider Agreement, at least one party to the alleged contract denies either party is obligated to do anything as a result of the signing of the agreement.

Despite that most bankruptcy courts have held the Medicare Provider Agreement is an executory contract, some bankruptcy courts have followed the precedent from cases outside of bankruptcy.[81] Approximately two decades ago, bankruptcy courts in *In re BDK Health Management, Inc.*[82] and *Kings Terrace Nursing Home & Health Related Facility v. N.Y. State Department of Social Services (In re Kings Terrace Nursing Home & Health Related Facility)*,[83] reached a result that is consistent with the courts considering the issue outside of bankruptcy: a Medicare Provider Agreement does not create contractual rights but rather is a statutory license establishing rights that can be sold under the Bankruptcy Code.

78. 2014 Bankr. LEXIS 2752, at *12 (Bankr. D. Conn. June 23, 2014).
79. *Id.* at *12–13.
80. 11 B.R. 1014, 1018 (W.D. Pa. 1981).
81. *See, e.g.*, Saint Joseph's Hosp. v. Dep't of Pub. Welfare, 103 B.R. 643, 656 (Bankr. E.D. Pa. 1989) (rejecting a provider's claim for breach of contract in an adversary action relating to certain reimbursement determinations, and noting the Provider Agreement "seems to be merely a form document envisioned to memorialize a hospital's participation in the Medicaid program").
82. No. 98-609-B1, 1998 Bankr. LEXIS 2031, at *16 (Bankr. M.D. Fla. Nov. 16, 1998).
83. No. 91 B 11478, 1995 Bankr. LEXIS 157, at *26 (Bankr. S.D.N.Y. Jan. 26, 1995).

In *In re BDK Health Management*,[84] the United States Bankruptcy Court for the Middle District of Florida, relying on the Second Circuit decision in *Hollander* and its progeny, held that a Medicare Provider Agreement was not an executory contract but instead was a statutory entitlement.[85] In *BDK Health Management*, the debtors moved to sell their Medicare Provider Agreements free and clear of liens, claims, and encumbrances.[86] The bankruptcy court rejected the Government's argument that the Medicare Provider Agreements are executory contracts that must be assumed under section 365 of the Bankruptcy Code. The court held that the rights and duties of the provider and the Government are not set forth in the Medicare Provider Agreement, but rather in applicable law.[87] "For example, HHS is not obligated to reimburse the Debtors for services provided under the [Medicare] '[P]rovider [A]greements.' Moreover, HHS's entitlement to recoup overpayments is similarly statutory and does not arise under these arrangements."[88] The bankruptcy court in *BDK Health Management* thus concluded that a seller did not have to comply with the terms of section 365 of the Bankruptcy Code to effectuate a transfer of a Medicare Provider Agreement.[89] In discussing the majority of cases that hold otherwise, the court noted they were distinguishable because, in "virtually all instances," the parties agreed that the Medicare Provider Agreements created contracts, without challenge from the providers on the contractual nature of the "agreements."[90] Consequently, the court approved the sale of the Medicare Provider Agreements free and clear of the Government's claims and interests, including its right of recoupment.[91]

Similarly, in construing a Medicaid Provider Agreement under analogous state Medicaid[92] law, the court in *Kings Terrace Nursing Home & Health Related Facility v. New York State Department of Social Services (In re Kings Terrace Nursing Home & Health Related Facility* held that the Medicaid Provider Agreement was not an executory contract because "the Debtor's right to reimbursement and the [Government's] right to recover payments do not arise from any contract, but rather from statutory and regulatory requirements completely independent of a contract."[93] The court relied on the Second Circuit's decision

84. No. 98-609-B1, 1998 Bankr. LEXIS 2031 (Bankr. M.D. Fla. Nov. 16, 1998).
85. *Id.* at *17.
86. 1998 Bankr. LEXIS 2031, at *4.
87. *Id.* at *5.
88. *Id.* (internal citations omitted).
89. *Id.*
90. *Id.* at *6.
91. *Id.*
92. Medicaid is the joint federal and state program that funds health-care benefits for, among others, poor people, which was created under Title XIX of the Medicare Act. *See generally* Ark. Dep't of Health & Human Servs. v. Ahlborn, 547 U.S. 268, 275 (2006); Ravenwood Healthcare, Inc. v. State of Md., Dep't of Health & Mental Hygiene, No. MJG-06-3059, 2007 WL 1657421 (D. Md. June 5, 2007) (both discussing details of the Medicaid program). Although there are similarities between the Medicare Provider Agreement and the Medicaid Provider Agreement sufficient to allow cases dealing with one to be generally applicable to the other, treatment of the Medicaid Provider Agreement is beyond the scope of this article.
93. No. 91B-11478, 1995 Bankr. LEXIS 157, at *26 (Bankr. S.D.N.Y. Jan. 26, 1995).