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Health Care and Nonprofits in Crisis: Is Bankruptcy the Cure? How to Properly Diagnose and Treat Troubled Health Care Businesses and Nonprofits

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Bankruptcy Court Jurisdictional Issues in Healthcare Cases

Clash of the Titans: 28 U.S.C. § 1334 vs. 42 U.S.C. § 405

Article I of the Constitution assigns to Congress the "Power * * * [t]o establish * * * uniform Laws on the subject of Bankruptcies throughout the United States." U.S. Const. art. I, § 8, cl. 4. Pursuant to that authority, Congress has granted federal courts "original and exclusive jurisdiction of all cases under title 11." 28 U.S.C. § 1334(a). A "critical feature" of every bankruptcy [case] is the bankruptcy court's "exercise of exclusive jurisdiction over all the debtor's property." *Cent. Va. Cmty. Coll. v. Katz*, 546 U.S. 356, 363-64 (2006); *see also* 28 U.S.C. § 1334(e)(1). Congress provided this comprehensive grant of jurisdiction "to ensure adjudication of all claims in a single forum and to avoid the delay and expense of jurisdictional disputes." *N. Pipeline Constr. Co. v. Marathon Pipe Line*

Co., 458 U.S. 50, 87 n.40 (1982) (citing H.R. Rep. No. 95-595, at 43-48 (1977); S. Rep. No. 95-989, at 17 (1978)).

The bankruptcy system includes several provisions in furtherance of those goals. The automatic stay prohibits commencement or continuation of certain actions against the debtor, 11 U.S.C. § 362(a); a debtor may assume its executory contracts after curing any default, 11 U.S.C. § 365; bankruptcy courts may issue all relief "necessary or appropriate" to carry out the bankruptcy process, 11 U.S.C. § 105(a); and bankruptcy courts may confirm a debtor's plan of reorganization, vesting all property of the estate in the debtor, free and clear of all claims, 11 U.S.C. § 1141. In 11 U.S.C. § 106, Congress abrogated the federal government's sovereign immunity with respect to the foregoing provisions, submitting the United States to the jurisdiction of the bankruptcy courts.

In 2005, Congress passed BAPCPA, which incorporated specific provisions into the Bankruptcy Code relating to health care businesses.[1] BAPCPA granted a special administrative priority to the winding-up of health care businesses, 11 U.S.C. § 503(b)(8), and authorized the compensation of a patient care ombudsman from property of the estate, 11 U.S.C. § 330(a). Congress also provided that HHS need not seek relief from the automatic stay to "exclude" (as distinguishable from "terminate") a bankrupt health care business from participation in Medicare.

Although bankruptcy courts have comprehensive jurisdiction to deal with all matters connected with a debtor's estate, and possess "exclusive jurisdiction" over "all cases under title 11" and "all property of the estate," 28 U.S.C. § 1334(a), (e)(1), the Medicare Act limits a party's ability to pursue claims arising under the Act in federal court. In 42 U.S.C. § 405(g), Congress provided for judicial review

[1] The term "health care business" is broadly defined in 11 U.S.C. § § 101(27)(A) and includes hospitals, ambulatory care facilities, hospices, home health agencies, long-term care facilities like nursing homes and assisted-living facilities.

following a final decision by the agency. Congress then limited review of the agency's decision as follows:

> The findings and decision of the [Secretary] after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the [Secretary] shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the [Secretary], or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28, to recover on any claim arising under this subchapter.
>
> 42 U.S.C. § 405(h).

Section 405 was enacted in 1939 as part of the Social Security Act. As originally drafted, it barred actions brought "under section 41 of Title 28 to recover on any claim arising under sections 401-09 of this chapter." 42 U.S.C. § 405(h) (1939). At the time, "§ 41 contained all of that title's grants of jurisdiction to United States district courts," *Weinberger v. Salfi*, 422 U.S. 749, 756 n.3 (1975), including "all matters and proceedings in bankruptcy," 28 U.S.C. § 41(19) (1934). In 1948, however, Congress revised the U.S. Code, extracting the various jurisdictional grants from Section 41 and re-codifying some of them as 28 U.S.C. § 1331 to 1348 (1948). When Congress rewrote Section 41, it did not update Section 405(h), which continued to refer to then-defunct 28 U.S.C. § 41, not the new 28 U.S.C. § 1334.

The Supreme Court noted this in *Salfi*, 422 U.S. at 756 n.3. The next year, the Office of Law Revision Counsel[2] removed the reference to Section 41 and replaced it with references to 28 U.S.C. § 1331 and 1346—the jurisdictional grants

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

for federal questions and suits against the United States, respectively. A codification note acknowledged that the amended statute no longer referenced all of the jurisdictional provisions that formerly comprised Section 41. *See* 42 U.S.C.A. 405 (West 1982).

Eight years later, Congress enacted the Law Revision Counsel's changes. *See* Deficit Reduction Act of 1984 ("DRA"), Pub. L. No. 98-369, § 2663(a)(4)(D), 98 Stat. 494, 1162 ("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 . . . ."). In enacting the DRA, Congress stated that its amendments should not "be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date." *Id.*, § 2664(b), 98 Stat. at 1171-72.

The omission of any mention of Section 1334—the federal subject-matter statute governing bankruptcy claims—from Section 405(h) has become increasingly relevant as the administrative process under the Medicare Act has proven impractical for health care companies facing a financial crisis upon termination of their provider agreements by the government. While facilities terminated from Medicare theoretically have access to expedited administrative review, 42 U.S.C. § 1395cc(h)(1)(B), in reality this process is not available to a health care provider facing imminent insolvency. Severe backlogs prevent appeals from being heard in a timely manner. In 2015, the Office of Medicare Hearings and Appeals ("OMHA") reported that the average adjudication took 572 days, and that this time frame "will continue to increase until receipt levels and adjudication capacity are brought into balance." *See Creating a More Efficient and Level Playing Field: Audit and Appeals Issues in Medicare: Hearing Before the S. Comm. On Finance*, 114th Cong. 38 (2015) (prepared statement of Nancy J. Griswold, Chief A.L.J., OMHA). "This is a huge problem in healthcare

bankruptcy cases because the Medicare program's appeal process is simply broken. Staffed to handle approximately 70,000 appeals annually, it currently has more than 700,000 appeals pending.[3]" [cite Maizel book chapter].

Making these delays more problematic, CMS can institute recoupment against a provider's ongoing payments while the provider's appeal is pending. This loss of revenue creates a very high risk of insolvency. *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, 29 (2015). Against this backdrop, health care businesses have increasingly resorted to bankruptcy courts, with varied success, depending, in part, upon the circuit in which the case is filed, and how the circuit interprets the jurisdictional interplay between 28 U.S.C. § 1334 vs. 42 U.S.C. § 405. There is currently a circuit split[4] regarding whether bankruptcy courts are barred by Section 405(h) from adjudicating disputes with CMS. "*Compare Florida Agency For Health Care Admin, et al. v. Bayou Shores, SNF, LLC* (*In re Bayou Shores, SNF, LLC*), 828 F.3d 1297, 1331 (11th Cir. 2016) ("The bankruptcy court was without § 1334 jurisdiction under the § 405(h) bar to issue orders enjoining the termination of the provider agreements and to further order the assumption of the provider agreements.") *with Do Sung Uhm v. Humana, Inc.*, 620 F.3d 1134, 1140 n.11 (9th Cir. 2010) (noting the "special status" of bankruptcy court jurisdiction over

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

[4] Courts have routinely recognized the circuit split; *Nurses' Registry & Home Health Corp. v. Burwell (In re Nurses' Registry & Home Health Corp.)*, 533 B.R. 590, 595 (Bankr. E.D. Ky. 2015) (noting that its view has been "embraced by two circuits and acquiesced to by Congress for over twenty years," while acknowledging "a number of courts" disagree); *U.S. Dep't of Health & Human Servs. v. James*, 256 B.R. 479, 481-82 (W.D. Ky. 2000) (noting that "courts have split on this issue" and "the arguments for and against jurisdiction have been well developed by circuits ruling in favor of each").

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

Nevertheless, when squarely presented with this split of authority, on June 5, 2017, the United States Supreme Court declined to grant certiorari in order to address whether (i) Section 405(h) strips bankruptcy courts of jurisdiction over claims arising under the Medicare Act; and whether (ii) Section 405(h) requires a debtor to exhaust administrative remedies prior to pursuing the relief available under the Bankruptcy Code. With the denial of certiorari by the Supreme Court, the questions of whether Section 405(h) strips bankruptcy courts of jurisdiction over claims arising under the Medicare Act and whether Section 405(h) requires a debtor to exhaust administrative remedies prior to pursuing the relief available under the Bankruptcy Code are unresolved.

The plain language of Section 405(h)[5] supports the argument that the debtor need not exhaust its administrative remedies before a bankruptcy court may take jurisdiction in order to rule on core bankruptcy issues, including whether the debtor can assume and assign an executory contract under section 365 of the Bankruptcy Code[6] and/or sell debtor assets free and clear of liens, claims, and interests under section 363. Regardless, the government has argued with some success that the absence of a reference to section 1334 of title 28 is a "scriveners error," and therefore, the statute should be read as if a reference to section 1334 were expressly included.[7] In *Bayou Shores*, the government successfully argued (at the District Court and Circuit Court levels) against a plain language interpretation of 405(h) by injecting an ambiguity where none resides by pointing to a proviso directing that amendments, including those to 405(h), should not "be construed" to change or affect any previously existing rights, liabilities, statuses, or interpretations. *See* DRA § 2664(b), 98 Stat. 474, 1171–72). However, courts need not "construe" unambiguous texts. *See United States v. Fisher*, 6 U.S. (2 Cranch) 358, 386 (1805) (where a statute "is plain, nothing is left to construction"). The plain language of 42 U.S.C. § 405(h) – "[n]o action against the United States, the [Secretary of Health and Human Services], 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"— does not include a bar on actions brought under

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

[6] Unless otherwise noted, all references in this chapter to "section" are to the U.S. Bankruptcy Code, 11 U.S.C. § §§ 101-1531, as amended.

[7] *See, e.g*., Bayou Shores, 828 F.3d at 1304 ("we conclude that the lack of reference to section 1334 in section 45(h) is the result of a codification error").

Section 1334 of Title 28, which provides "exclusive jurisdiction" to district courts over bankruptcy cases.

Section 405(h) plainly expressly restricts courts from taking jurisdiction under 28 U.S.C. § 1331 (diversity) and 1336 (mandamus), but not 1334 (bankruptcy). When Congress amended Section 405(h), it omitted 28 U.S.C. § 1334 from the list of affected jurisdictional provisions, knowing that Section 1334 had previously been affected. Yet, the Eleventh Circuit found Congress's intent unclear because Congress did not explain its decision in legislative history. However, courts do not "require Congress to state in committee reports . . . that which is obvious on the face of the statute." *Harrison v. PPG Indus., Inc.*, 446 U.S. 578, 592 (1980) ("In ascertaining the meaning of a statute, a court cannot, in the manner of Sherlock Holmes, pursue the theory of the dog that did not bark.").

Regarding the second question the Supreme Court declined to address – whether Section 405(h) requires a debtor to exhaust administrative remedies prior to pursuing the relief available under the Bankruptcy Code, unlike the Eleventh Circuit, the Third and Ninth Circuits have held that the exhaustion requirements of Section 405(h) do not apply where there is an independent grant of jurisdiction to the federal courts. This makes sense: if one is not invoking the jurisdiction of courts under Section 405(g), one need not fulfill the jurisdictional prerequisites to 405(g) found in 405(h). The Supreme Court has never reached this question—something the Eleventh Circuit acknowledged. In *Weinberger v. Salfi*, 422 U.S. 749 (1975), the Court considered whether the third sentence of Section 405(h) barred jurisdiction under 28 U.S.C. § 1331. Its decision turned on the "sweeping and direct" bar on actions brought under 1331. *Id.* at 757. There is no such bar on 1334 proceedings. That rule was affirmed in *Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1 (2000), another 1331 case. In *Heckler v. Ringer*, 466 U.S. 602 (1984), the plaintiffs based jurisdiction on Sections 1331, 1361

(mandamus), and 405(g) itself. *Id.* at 609. The Supreme Court found 1331 and 405(g) jurisdiction barred by the third sentence of 405(h), but assumed without deciding that mandamus jurisdiction was *not* foreclosed; Section 1361, unlike 1331 but *like* 1334, does not appear in the third sentence. Ultimately, mandamus was not viable because the plaintiffs had not exhausted *as required by the law governing mandamus*, not pursuant to 405(h). *Id*. at 616-17. But there is no analogous exhaustion requirement for 1334 proceedings. Ergo, the Eleventh Circuit's ruling is inconsistent with the reasoning in *Ringer*.

The issue of an independent grant of jurisdiction does not arise only in the health care context. In *Califano v. Sanders*, 430 U.S. 99 (1977), the plaintiff's claims were brought under the APA, which plaintiff argued was an independent grant to district courts of subject-matter jurisdiction to review agency decisions. *Id*. at 100-101. The Supreme Court could have decided whether 405(h)'s second sentence required exhaustion of claims brought under separate jurisdictional grants, but declined that "shorter route" to decision. *Id.* at 110-11 (Stewart, J., concurring in the judgment). Instead, the Court held the plaintiff was required to exhaust pursuant to 405(h) because the APA did *not* contain an independent jurisdictional grant. *Id*. at 104-06. The Bankruptcy Code *does* contain such a grant, and it contains no corresponding exhaustion requirement. As such, the better ruling, but one the Eleventh Circuit declined to make, is that Section 405(h) does not require exhaustion in bankruptcy cases because of the independent jurisdictional grant supplied in Section 1334.

Recoupment

Recoupment is a common law doctrine that applies when a party to a contract overpays and has a credit balance that can be applied to the contractual arrangement. Recoupment arises from a single contract and occurs when a party

holds a Medicare provider number and has received overpayments. CMS provides payment to a healthcare provider based upon estimated costs of services which can then be recouped based upon actual costs. Recoupment has an impact for both Chapter 11 debtors and buyers of assets because a pre-petition claim may be recouped post-petition based upon the fact that the payments were part of a single contract.

The minority view is that recoupment may only be for a single year under the Medicare contract. *See*, *In re University Medical Center*, 973 F.2d 1065 (3d Cir. 1992). The majority view is that recoupment can be made for the entire time of the contract. *Holyoke Nursing Home, Inc. v. Health Care Financing Administration (In re Holyoke Nursing Home, Inc.)*, 372 F.3d 1 (1st Cir. 2004). *United States v. Consumer Health Services of America, Inc.*, 108 F.3d 390 (D.C. Cir. 1997). *In re TLC Hospitals, Inc.*, 224 F.3d 1008 (9th Cir. 2000).

Recoupment can have a significant impact on cash flow because the debtor's receivables may be subject to recoupment and recoupment, unlike set off is not subject to the automatic stay. *See, University Medical Center* 973 F. 2d at 1079; *Visiting Nurses Association of Tampa Bay Inc.* 121 B.R. 144, 119 (M.D. Fl. 1990), for buyers who are assigned provider agreements there can be successor liability that runs with the agreement. Buyers have attempted to contract around successor liability for recoupment. Courts have held that under applicable law, a buyer becomes primarily liable for recoupment payments when a provider number is assumed and that the buyer cannot contract around applicable law. *See, U.S. v. Vernon Home Health, Inc.* 21 F. 3rd 693 (5th Cir. 1994); *In re Senior Management Services of Treemont, Inc.* Case No. 07-30230-HDH-11.

Regulatory Approvals

Approvals required depend upon the type of healthcare business. The approvals generally include CMS 855 applications, Medicare Enrollment applications, notification and approval to the state licensure agency, applications to the DEA and state boards of pharmacy for licenses. Note that State licensure may take several months, and that licenses are generally nontransferable. As a result most transactions will include an Operations Transfer Agreement ("OTA") or a Management Agreement. The OTA generally will deal with the transfer of employees, collection and allocation of accounts receivable, regulatory filings, proration of operating costs, cost reports, and bank account issues.

It should be noted that when there is a Change of Ownership (CHOW) the Medicare provider agreement is automatically assigned to the buyer along with all of the obligations and liabilities associated with the agreement. The buyer should consider holdbacks or other protections in order to avoid liabilities. Although it is possible for the Medicare agreement to be terminated it practically is not a solution in most cases because it requires 45 days' notice and the buyer will likely be unable to obtain a new provider number in time to operate.

ISSUES RELATED TO HEALTHCARE FRAUD

31 U.S.C. § 3729 – 33 False Claims Act (Criminal Liability)

In the healthcare arena the government has enforced traditionally enforced claims for fraud unless the False Claims Act ("FCA"). Such actions are not stayed under 11 U.S.C. § 362(b)(4) . While the government can continue to prosecute a FCA, it will not be able to collect its damages under the police and regulatory exception to the Automatic Stay.

The False Claims Act provides:

A. Whoever knowingly presents or causes to be presented a false or fraudulent claim for Payment or approval;

B Knowingly makes, uses or causes to be made or used a false record or statement material to a false or fraudulent claim;

C. Conspires to commit a violation of A, B, C, D, E, F, or G

In short, the Plaintiff must show the defendant made a claim, to the United States Government, which is false or fraudulent, knowing of its falsity and seeking payment by the Federal Treasury. United States ex rel. *Makes v. Straud* 274 F. 3rd 687 (2nd Cir. 2001). However, it should be noted that "knowingly" requires no actual intent to defraud and includes those who act in deliberate ignorance or reckless disregard. 31 U.S.C. § 3239(b)(1).

The consequences of both pre-petition and post-petition FCA claims are significant because damages awarded under the FCA are the damages sustained trebled, plus fines of $10,781 to $21,996 per violation. A healthcare entity could be found liable for obviously fraudulent violations such as billing for services that were never rendered. However, a healthcare entity could also be held liable for providing a service in violation of another law or billing the government for a substandard service or a higher level of service than what was actually provided.

The FCA provides that a private individual known as a Qui Tam Relator (whistleblower) can bring a FCA Claim on behalf of the government. 31 U.S.C. § 3730. The action is filed under seal and the Government has sixty days to intervene in the action. However, this time is routinely extended in six month increments for years. The relator will receive between 25 and 30 percent of the recovery plus attorney's fees if the government does not intervene and up to 25 percent if the government does intervene. The relator can bring the litigation

whether or not the individual has actual damages. 31 U.S.C. § 3730. Liability under the FCA is for federal claims. In the healthcare area this means billings for Medicare, Medicare Part D and Tricare, and a host of other claims.

What does this mean for a Chapter 11 debtor or buyer of assets?

It should be noted that FCA claims may be non dischargeable. 1141 (d)(6)(A) excludes from discharge a debt owed to a person as a result of an action filed under the FCA or similar statute or owed to a governmental unit due to fraud related acts.

Debts owed to a relator, *i.e.*, attorneys' fees and percent of recovery, are likely non dischargeable under § 1141(d)(c)(A). The government's portion is likely not covered under that section because the "person" definition does not include governmental unit See, 11 U.S.C. § 101(41) "person" does not include governmental entity. For the government portion of the claim for damages § 523(A)(2)(a) will apply and the government will have to meet its burden of proof to demonstrate false pretenses, a false representation or actual fraud in order to establish a non dischargeable debt.

A buyer should be concerned about successor liability for false claims and or a systemic problem in the operations that they are buying giving rise to FCA liability. In order to deal with successor liability the sale order can provide for a sale specifically free and clear of such liability, however the free and clear order may not be effective if it is not permitted by law. *See*, *U.S. v Vernon Mane Merton, Inc.*, 211 F.3d at 693.

A buyer's other option is to wait until after the governmental bar date has past so that the extent and nature of the government claims are known. The government must file a proof of claim by the governmental claims bar date to

recover damages for false claims. In addition, the APA can provide for holdbacks from the purchase price.

Although the False Claims Act is the most common federal statute for the imposition of liability against a healthcare entity there are other statutes to consider.

Stark Law (aka Physician Self-Referral Act)

42 U.S.C. § 1395nn (civil penalties)

As a general proposition, a Physician may not refer Medicare or Medicaid patients for so-called "designated health services" to an entity with which the physician **or** an immediate family member that has a "financial relationship," unless an exception applies. This federal statute is known generally as the Physician Self-Referral Act. Penalties for violation of the Act range from denial of payment or refunds of payments received to civil monetary fines.

Key provisions of the Self-Referral Act are as follows:

(a) Prohibition of certain referrals

(1) In general

Except as provided in subsection (b) of this section, if a physician (or an immediate family member of such physician) has a financial relationship with an entity specified in paragraph (2), then—

(A) the physician may not make a referral to the entity for the furnishing of designated health services for which payment otherwise may be made under this subchapter, and

(B) the entity may not present or cause to be presented a claim under this subchapter or bill to any individual, third party payor, or other entity for designated health

services furnished pursuant to a referral prohibited under subparagraph (A).

(2) Financial relationship specified

For purposes of this section, a financial relationship of a physician (or an immediate family member of such physician) with an entity specified in this paragraph is—

(A) except as provided in subsections (c) and (d) of this section, an ownership or investment interest in the entity, or

(B) except as provided in subsection (e) of this section, a compensation arrangement (as defined in subsection (h)(1) of this section) between the physician (or an immediate family member of such physician) and the entity.

An ownership or investment interest described in subparagraph (A) may be through equity, debt, or other means and includes an interest in an entity that holds an ownership or investment interest in any entity providing the designated health service.

(b) General exceptions to both ownership and compensation arrangement prohibitions.

Subsection (a)(1) of this section shall not apply in the following cases:

(1) Physicians' services

. . .

(2) In-office ancillary services

. . .

(3) Prepaid plans

. . .

(4) In the case of any other financial relationship which the Secretary determines, and specifies in regulations, does not pose a risk of program or patient abuse.

(5) Electronic prescribing

. . .

(g) Sanctions

(1) Denial of payment

No payment may be made under this subchapter for a designated health service which is provided in violation of subsection (a)(1) of this section.

(2) Requiring refunds for certain claims

If a person collects any amounts that were billed in violation of subsection (a)(1) of this section, the person shall be liable to the individual for, and shall refund on a timely basis to the individual, any amounts so collected.

(3) Civil money penalty and exclusion for improper claims

Any person that presents or causes to be presented a bill or a claim for a service that such person knows or should know is for a service for which payment may not be made under paragraph (1) or for which a refund has not been made under paragraph (2) shall be subject to a civil money penalty of not more than $15,000 for each such service. The provisions of section 1320a-7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a

civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

…

Anti-Kickback Statute – 42 U.S.C. § 1320a–7b (criminal law)

The Anti-Kickback Statute makes it a felony for anyone to knowingly and willfully offer, pay, solicit or receive remuneration (in cash or in kind) to induce, directly or indirectly, the referral, purchasing, ordering or recommending of any goods or services reimbursable with federal money. Key provisions of the statute are as follows:

(a) Making or causing to be made false statements or representations

Whoever–

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program (as defined in subsection (f) of this section),

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or

payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized,

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

(5) presents or causes to be presented a claim for a physician's service for which payment may be made under a Federal health care program and knows that the individual who furnished the service was not licensed as a physician, or

(6) for a fee knowingly and willfully counsels or assists an individual to dispose of assets (including by any transfer in trust) in order for the individual to become eligible for medical assistance under a State plan under subchapter XIX of this chapter, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1396p(c) of this title, shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under the program, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, conversion, or provision of counsel or assistance by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than

$10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a Federal health care program is convicted of an offense under the preceding provisions of this subsection, the administrator of such program may at its option (notwithstanding any other provision of such program) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b) Illegal remunerations

(1) whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind–

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person–

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

...

(c) False statements or representations with respect to condition or operation of institutions.

Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution, facility, or entity in order that such institution, facility, or entity may qualify (either upon initial certification or upon recertification) as a hospital, critical access

hospital, skilled nursing facility, nursing facility, intermediate care facility for the mentally retarded, home health agency, or other entity (including an eligible organization under section 1395mm(b) of this title) for which certification is required under subchapter XVIII of this chapter or a State health care program (as defined in section 1320a-7(h) of this title), or with respect to information required to be provided under section 1320a-3a of this title, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Illegal patient admittance and retention practices

Whoever knowingly and willfully–

(1) charges, for any service provided to a patient under a State plan approved under subchapter XIX of this chapter, money or other consideration at a rate in excess of the rates established by the State (or, in the case of services provided to an individual enrolled with a Medicaid managed care organization under subchapter XIX of this chapter under a contract under section 1396b(m) of this title or under a contractual, referral, or other arrangement under such contract, at a rate in excess of the rate permitted under such contract), or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under subchapter XIX of this chapter, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)–

(A) as a precondition of admitting a patient to a hospital, nursing facility, or intermediate care facility for the mentally retarded, or

(B) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(e) Violation of assignment terms

Whoever accepts assignments described in section 1395u(b)(3)(B)(ii) of this title or agrees to be a participating physician or supplier under section 1395u(h)(1) of this title and knowingly, willfully, and repeatedly violates the term of such assignments or agreement, shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $2,000 or imprisoned for not more than six months, or both.

Criminal Forfeiture and the Bankruptcy Code

Criminal forfeiture allows the government to obtain property used in a crime or the proceeds of criminal activity. The issues related to the criminal Medicare or insurance fraud in the bankruptcy context are complex. The bankruptcy court has exclusive jurisdiction over all property of the debtor as of the commencement of the case. 28 U.S.C. § 1334(e)(1). Under criminal forfeiture law, the forfeited property becomes property of the government as of the date of the crime. *See In Re Chapman* 264 B.R. (9th Cir. B.A.P. 2001). However, criminal forfeiture is not

determined until there is a conviction. Thus, in the case of healthcare fraud, receivables are property of the estate so long as there is no forfeiture order. Upon the entry of an order of forfeiture the receivables would no longer be property of the estate due to the relation back of the forfeiture order. *Id.* The cloud of a potential forfeiture has implications for the use of cash collateral and for a plan because it is possible that it could ultimately be determined that assets are not property of the estate.

Further, in some circumstances, criminal forfeiture can defeat the interests of secured creditors, subsequent purchasers, or other entities with an interest in forfeited property. The criminal forfeiture statute only directly sets out two circumstances under which a third party can petition to have their interest in forfeited property protected: (i) if the petitioner's right, title or interest "was superior to any right, title, or interest of the defendant at the time of the commission of the acts which gave rise to the forfeiture of the property" or (ii) if "the petitioner is a bona fide purchaser for value of the right, title, or interest in the property and was at the time of purchase reasonably without cause to believe that the property was subject to forfeiture under this section[.]" 21 U.S.C. § 853(n)(6). The criminal forfeiture statute does not directly include the "innocent owner" defense available to third parties in civil forfeiture proceedings. *See* 21 U.S.C. § 983(d). At least one circuit court has held that lienholders who took their liens for value can be protected under the bona fide purchaser defense. *See United States v. Huntington National Bank*, 682 F.3d 429 (6th Cir. 2012).

Patient Care Ombudsman in Bankruptcy

Code Provision

- 11 U.S.C. § 333

(a) (1) If the debtor in a case under chapter 7, 9, or 11 is a health care business, the court shall order, not later than 30 days after the commencement of the case, the appointment of an ombudsman to monitor the quality of patient care and to represent the interests of the patients of the health care business unless the court finds that the appointment of such ombudsman is not necessary for the protection of patients under the specific facts of the case.

(2) (A) If the court orders the appointment of an ombudsman under paragraph (1), the United States trustee shall appoint 1 disinterested person (other than the United States trustee) to serve as such ombudsman.

(B) If the debtor is a health care business that provides long-term care, then the United States trustee may appoint the State Long-Term Care Ombudsman appointed under the Older Americans Act of 1965 for the State in which the case is pending to serve as the ombudsman required by paragraph (1).

(C) If the United States trustee does not appoint a State Long-Term Care Ombudsman under subparagraph (B), the court shall notify the State Long-Term Care Ombudsman appointed under the Older Americans Act of 1965 for the State in which the case is pending, of the name and address of the person who is appointed under subparagraph (A).

Applicability and Purpose

- The requirement for a PCO only applies in a "health care business" (as defined in 11 U.S.C. § 101(27A) – "any public or private entity . . . that is primarily engaged in offering to the general public facilities and services for – the diagnosis or treatment of injury, deformity, or disease; and surgical, drug treatment, psychiatric, or obstetric care").
- Monitor the quality of patient care and represent the interests of the patients.

Appointment Process

- Section 333 requires that a PCO "shall" be appointed "unless the court finds that the appointment of such ombudsman is not necessary for the protection of patients under the specific facts of the case."
- Rule 2007.2 requires the appointment "unless the court, on motion of the United States trustee or a party in interest file[s] no later than 21 days after the commencement of the case . . . finds that the appointment of a [PCO] is not necessary under the specific circumstances of the case for the protection of patients."
- The appointment of a PCO can occur even after the court has previously found the appointment was not necessary (*see* Rule 2007.2(b)). Alternatively, the court can terminate the appointment of a PCO after previously determining the PCO was necessary (*see* Rule 2007.2(d)).

Avoiding the Appointment of a PCO

- The Tenth Circuit Court of Appeals has not adopted a specific test to determine when a PCO is unnecessary.
- Courts in various other jurisdictions make the determination by "examin[ing] the totality of the circumstances surrounding the bankruptcy

filing and the operations of the debtor." *In re Alternative Family Care*, 377 B.R. 754, 758 (Bankr. S.D. Fla. 2007).

- The court in *Alternate Family Care* introduced the most comprehensive and widely accepted test for evaluating whether the specific facts of a case make the appointment of a PCO unnecessary. *See* 3-333 Collier on Bankruptcy ¶ 333.02[2] (Bender 16th ed. 2015).
- In *Alternative Family Care*, the court set forth a nonexclusive list of nine factors surrounding the bankruptcy filing and the debtor's operations to be examined in considering the totality of the circumstances:
    - (1) the cause of the bankruptcy; (2) the presence and role of licensing or supervising entities; (3) the debtor's past history of patient care; (4) the ability of the patients to protect their rights; (5) the level of dependency of the patients of the facility; (6) the likelihood of tension between the interests of the patients and debtor; (7) the potential injury to the patients if the debtor drastically reduced its level of patient care; (8) the presence and sufficiency of internal safeguards to ensure appropriate level of care; (9) the impact of the cost of an ombudsman on the likelihood of a successful reorganization. *Alternative Family Care*, 377 B.R. at 758.
- Additional factors that other courts have considered include:
    - (1) the high quality of the debtor's existing patient care; (2) the debtor's financial ability to maintain high quality - patient care; (3) the existence of an internal ombudsman program to protect the rights of patients; and/or (4) the level of monitoring and oversight by federal, state, local, or professional association programs which renders the services of an ombudsman redundant. *In re Valley Health Sys*., 381 B.R. 756, 762 (Bankr. C.D. Cal. 2008).
- Courts in several jurisdictions, including Colorado and Wyoming, have issued orders waiving the requirement that a PCO be appointed. *See, e.g., In re William L. Saber M.D., P.C*., 369 B.R. 631, 637-38 (Bankr. D. Colo. 2007) (declining to appoint ombudsman because (i) debtor's bankruptcy

filing was unrelated to patient care, (ii) it was unlikely that a financial crisis during bankruptcy would impair debtor's ability to provide quality medical care, and (iii) debtor was very experienced and in good professional standing); *In re Powell Valley Health Care, Inc.*, Case No. 16-20326, Order Finding that the Appointment of a Patient Care Ombudsman is Unnecessary in this Case [Docket No. 147] (Bankr. D. Wyo. June 23, 2016); *In re Barnwell Cnty. Hosp*., No. 11-06207-DD, 2011 WL 5443025, at *6 (Bankr. D. S.C. Nov. 8, 2011); *Valley Health Sys*., 381 B.R, at 765 (waiving appointment of a patient care ombudsman where there was no "evidence to suggest that the quality of patient care . . . [wa]s an issue at any of the [debtor's] facilities, or that the [debtor would] be unable to maintain the highest quality of patient care given its extensive and redundant internal policies and procedures and the current level of oversight by federal, state, local, and private entities"); *Alternate Family Care*, 377 B.R. at 758 (same); *In re Med. Assoc. of Pinellas, LLC*, 360 B.R. 356 (Bankr. M.D. Fla. 2007) (same); *In re Total Woman Healthcare Ctr., P.C*., No. 06-52000, 2006 WL 3708164, at *2-3 (Bankr. M.D. Ga. Dec. 14, 2006) (declining to appoint ombudsman because patients had not been adversely affected by bankruptcy filing and debtor understood its record-keeping and reporting obligations); *see also In re Divine Dedication, Inc*., Case No. 15-16878, [Doc. 40] (Bankr. D. Colo. July 15, 2015); *In re ALC Holdings LLC*, Case No. 11-13853 (MFW) (Bankr. D. Del. Jan. 6, 2012); *In re Fairview Ministries, Inc*., Case No. 11-04386 (SPS) (Bankr. N.D. Ill. Mar. 3, 2011); *In re Hingham Campus, LLC*, Case No. 11-33912 (Bankr. N.D. Tex. July 28, 2011).

Advantages and Disadvantages of the PCO

- Ensure quality care for patients.

- Identify serious matters that arise with patient care and inform the court.
- Assist the debtor in moving the case forward by building consensus.
- Assist in maintaining patient levels at the facility.
- Assist in maintaining strong relationships with state and federal agencies.
- Friend or foe.
- Expense
  - PCO's reasonable compensation and actual, necessary expenses are to be paid by the bankruptcy estate.
  - Section 333 does not expressly authorize a PCO to hire professionals, but some courts have relied on section 105(a) to authorize a PCO to hire professionals. *See, e.g., In re Synergy Hematology-Oncology Med. Assocs.*, 433 B.R. 316 (Bankr. C.D. Cal. 2009).
  - Typical duties of a professional hired by a PCO would include assisting with filing and serving documents (*see* section 333(b)(2)), and assist the PCO with understanding their duties under the bankruptcy code or health care laws.
  - Expenses for PCO may be avoidable if State Long-Term Care Ombudsman is appointed.

Absolute Priority Rule – Nonprofit Exclusion

Code Provision

- **11 U.S.C. § 1129**

  (b)(1) Notwithstanding section 510(a) of this title, if all of the applicable requirements of subsection (a) of this section other than paragraph (8) are met with respect to a plan, the court, on request of the proponent of the plan, shall confirm the plan notwithstanding the requirements of such paragraph if the plan does not discriminate

unfairly, and is fair and equitable, with respect to each class of claims or interests that is impaired under, and has not accepted, the plan.

(2) For the purpose of this subsection, the condition that a plan be fair and equitable with respect to a class includes the following requirements:

(B) With respect to a class of unsecured claims—

(i) the plan provides that each holder of a claim of such class receive or retain on account of such claim property of a value, as of the effective date of the plan, equal to the allowed amount of such claim; or

(ii) the holder of any claim or interest that is junior to the claims of such class will not receive or retain under the plan on account of such junior claim or interest any property, except that in a case in which the debtor is an individual, the debtor may retain property included in the estate under section 1115, subject to the requirements of subsection (a)(14) of this section.

- **Summary of the APR**
  - When an unsecured creditor is not paid the full amount of its claim under the debtor's plan of reorganization, no equity holder junior to that unsecured creditor may receive or retain any property on account of its equity interest.[8] The APR enables unsecured creditors to challenge a plan of reorganization when the plan allows holders of

[8] A limited exception may apply based on "new value" contributed by equity holders. *See, e.g., Coones v. Mutual Life Ins. Co. (In re Coones)*, 168 B.R. 247 (D. Wyo. 1994); *contra, In re Drimmel*, 135 B.R. 410 (D. Kan. 1991).

equity in the debtor to retain their equity interest, but fails to pay all unsecured creditors in full.

- **Applicability of the APR to a Nonprofit Debtor**
  - Many "health care businesses" are organized as nonprofit entities.
  - Nonprofit entities do not have private owners, issue stock or pay dividends.
  - Issue: Can the pre-petition board or members maintain their interests in the debtor (*i.e.*, their control of the debtor) post-plan confirmation if unsecured creditors are not paid in full?
- **Representative Cases**
  - *In re Wabash Valley Power Ass'n Inc.*, 72 F.3d 1305 (7th Cir. 1995).
    - The court stated that "while Wabash's member cooperatives obtain some economic benefit as customers from their participation on Wabash's Board, they do not improperly retain property 'on account of' either their patronage capital accounts (which are mere refunds of overpayments) or their control over Wabash. Control of the cooperative provides no opportunity, either currently or in the future, for the Members to obtain profits or any equity in Wabash's assets and control itself is not an equity interest. Further, control of Wabash's Board provides the Members with no opportunity to benefit at [objecting creditor's] expense." *Wabash*, 72 F.3d at 1320.
  - *In re Whittaker Memorial Hosp. Ass'n*, 149 B.R. 812, 816 (Bankr. E.D. Va. 1993).
    - The court ultimately found that the retention of control over the nonprofit hospital by the same individuals that controlled the hospital prior to the bankruptcy filing did not violate the APR

(even though other creditors less junior were not paid in full) because "the present group retaining control over the debtor entity does not give them anything, certainly not a favored position over [the objecting creditor]. . . . Clearly there is no distribution to this group and nothing beyond control that passes to it." *Whittaker*, 149 B.R. at 816.

- *See also, In re General Teamsters, Warehousemen and Helpers Union, Local 890*, 265 F.3d 869 (9th Cir. 2001); *In re Indian Nat'l Finals Rodeo*, 453 B.R. 387 (Bankr. D. Mt. 2011).

HIPAA Concerns in Bankruptcy

Statutes & Rules

- 42 U.S.C. § 1302d, *et seq.*, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").
  - HIPAA and its accompanying regulations, including 45 C.F.R. §§ 164.502 and 160.103, address the use and disclosure of "protected health information" ("PHI") by a "covered entity."[9]
  - HIPAA prohibits the "wrongful disclosure" of "individually identifiable health information."
    - "individually identifiable health information" is defined as any information relating to (a) the individual's past, present or future physical or mental health or condition, (b) the provision of health care to the individual, or (c) the past, present, or future payment for the provision of health care to the individual, and that also (x) identifies the individual or (y) for which there is a reasonable basis to believe that the information can be used to identify the individual. *See* 45 C.F.R. § 160.103. Generally speaking (with some exceptions), this information is "protected health information," or PHI. *See id.*
    - "wrongful disclosure" means "knowingly" (a) using or causing to be used a unique health identifier, (b) obtaining individually identifiable health information relating to an individual, or (c)

[9] *Covered entity* means:

(1) A health plan.

(2) A health care clearinghouse.

(3) A health care provider who transmits any health information in electronic form in connection with a transaction covered by this subchapter.

See 45 C.F.R. § 160.103.

disclosing individually identifiable health information to another person. *See* 42 U.S.C. § 1320d-6(a).

- 11 U.S.C. § 521(a)(1)(A): "The debtor shall file a list of creditors."
  - Fed. R. Bankr. P. 1007(a) requires the debtor to file with the court "a list containing the name and address of each entity included or to be included on Schedules D, E/F, G, and H . . . ."

Using First Day Motions to Address Tension Between HIPAA and Bankruptcy Laws

- Certain patients of health care providers may have claims against the debtor, which would require the debtor to list information about those claimants—including names and addresses—in the Schedules and creditor matrix.
- 45 CFR § 164.512(e) allows PHI to be disclosed in a judicial or administrative proceeding "in response to an order of a court or administrative tribunal, provided that the covered entity discloses only the protected health information expressly authorized by such order."
- To balance the need to protect PHI with the need to disclose meaningful information in the bankruptcy case, a debtor can use first day motions to seek court approval to procedures for disclosing certain information.
  - For example, the debtor could (a) seek permission to omit any reference to current or former patients from the creditor matrix and any certificate of service, (b) file a Supplemental Schedule and Patient Matrix containing PHI under seal, and (c) identify current or former patients in the Schedules and Statements solely by a code number, such as "Patient 1," "Patient 2," and so forth (while making unredacted copies available to the court and the US Trustee, upon request, or to other interested parties after court approval).

- The debtor would then maintain a "Patient List" and would note on certificates of service as having served the Patient List without disclosing on the certificate of service the names or addresses of the patients (while making that information available to interested parties after court approval).

Using Business Associate Agreements to Make Disclosures of PHI

- 45 C.F.R. §§ 164.502 allows a health care provider to disclose PHI to "business associates," "as permitted or required by its business associate contract or other arrangement pursuant to § 164.504(e) or as required by law."
- Business associate functions and activities include: claims processing or administration; data analysis, processing or administration; utilization review; quality assurance; billing; benefit management; practice management; and repricing. Business associate services are: legal; actuarial; accounting; consulting; data aggregation; management; administrative; accreditation; and financial.
- Examples of business associates:
  - A third party administrator that assists a health plan with claims processing.
  - A CPA firm whose accounting services to a health care provider involve access to protected health information.
  - An attorney whose legal services to a health plan involve access to protected health information.
  - A consultant that performs utilization reviews for a hospital.
  - A health care clearinghouse that translates a claim from a non-standard format into a standard transaction on behalf of a health care provider and forwards the processed transaction to a payer.

- An independent medical transcriptionist that provides transcription services to a physician.
- A pharmacy benefits manager that manages a health plan's pharmacist network.

- To disclose PHI to a business associate, the covered entity/health care provider must enter into a written agreement with the business associate.
  - In the Business Associate Agreement the health care provider must obtain satisfactory assurances from the business associate that (a) the business associate will appropriately safeguard the PHI it receives or creates on behalf of the health care provider, (b) the business associate will use the information only for the purposes for which it was engaged by the covered entity, and (c) the business associate will help the covered entity comply with some of the covered entity's duties under HIPAA.

Healthcare Sales – Section 363

Code Provision

- **11 U.S.C. § 363**

(b)(1) The trustee, after notice and a hearing, may use, sell, or lease, other than in the ordinary course of business, property of the estate . . .

. . .

(f) The trustee may sell property under subsection (b) or (c) of this section free and clear of any interest in such property of an entity other than the estate, only if—

(1) applicable nonbankruptcy law permits sale of such property free and clear of such interest;

(2) such entity consents;

(3) such interest is a lien and the price at which such property is to be sold is greater than the aggregate value of all liens on such property;

(4) such interest is in bona fide dispute; or

(5) such entity could be compelled, in a legal or equitable proceeding, to accept a money satisfaction of such interest.

- **Standard for Approving Sale**
  - Generally speaking, the following four factors must be met:
    - a sound business reason exists for the sale;
    - there has been adequate and reasonable notice to interested parties, including full disclosure of the sale terms and the debtor's relationship with the buyer;
    - the sale price is fair and reasonable; and
    - the proposed buyer is proceeding in good faith
  - Fair and reasonable sale price/"highest and best" standard in non-profit context
    - Where the debtor is a non-profit health care entity, a "highest and best" standard may take into consideration non-monetary factors. These factors include the continuance of the non-profit's charitable mission or protecting the interests of patients and employees.
    - Examples of courts looking at non-monetary considerations:
      - *In re HHH Choices Health Plan LLC*, 554 B.R. 697 (Bankr. S.D.N.Y. 2016) (holding that financial considerations were not determinative in approving sale and winning bidder's proposal was more consistent with

decision of debtor's board of directors, debtor's non-profit mission, and current residents' interests).

- *In re United Healthcare System, Inc. (Children's Hospital of New Jersey)*, No. 97-1159, 1997 U.S. Dist. LEXIS 5090, 1997 WL 176574 (D.N.J. Mar. 26, 1997) (holding that bankruptcy court erred by voiding sale of non-profit health care provider, stating that court "must not only weigh the financial aspects of the transaction but also look to the countervailing consideration of a public health emergency").

- **Successor Liability and Assignment of Healthcare Related Contracts**
  - A "Provider Agreement" is an agreement between the healthcare entity and government agencies (Medicare/Medicaid) which allows the healthcare entity to provide—and to be paid for—healthcare services. Provider Agreements are the primary source of revenues for many hospitals and other healthcare providers.
  - If the Provider Agreement is classified as an executory contract under Section 365, it cannot be assumed without curing monetary defaults and the assignee of the contract would be liable for obligations related to the agreement, thus limiting the effect of a "free and clear" sale.
  - If the Provider Agreement is <u>not</u> considered to be an executory contract, then potentially the liabilities related to the Provider Agreement could be washed away through a free and clear sale.
  - Not surprisingly, the federal government (Health & Human Services and Department of Health) takes the position that Provider Agreements are executory contracts and therefore the buyer will assume the obligation to repay the government for any of the debtor's

accrued overpayments received from Medicare/Medicaid. Thus, the government will seek to hold the buyer liable under theories of successor liability and/or recoupment.

- A majority of courts treat Provider Agreements as executory contracts. *See, e.g.*, *In re University Medical Center*, 973 F.2d 1065 (3d Cir. 1992) (concluding that, despite the "complexity of the Medicare scheme . . . a Medicare provider agreement easily" fits within definition of executory contract). However, in a non-bankruptcy context the Second Circuit has characterized a Medicaid Provider Agreement with a state government agency as a "statutory business relationship" and not a contract, for statute of limitations purposes. *Hollander v. Brezenoff*, 787 F.2d 834 (2d Cir. 1986) (finding that government's reimbursement liability is imposed by statute, not the provider agreement).
- Even if the court were to find the Provider Agreement was not executory, there are practical issues to consider. For example, if the Provider Agreement is not assumed and assigned, it will cause cash flow disruption while buyer waits for a new agreement (assuming they get one).

- **Regulatory Issues**
  - Section 363(d)(1) provides that the sale of a non-profit company must be done in accordance with applicable nonbankruptcy law. Where the non-profit company is a health care business, this typically requires approval by the state's attorney general.
  - Coordination with federal, state, and local regulatory agencies is required to successfully transfer a healthcare business. Laws

governing licensure changes of ownership (CHOWs) and certificates of need (CONs) must be considered.

- Many states have enacted CON laws, which seek to restrain healthcare facility costs in certain industry segments by avoiding overcrowding in a particular geographic region. Approval must be obtained from the governing agency to transfer the CON to a buyer, and certain notice requirements must be met. Most current CON laws concentrate on outpatient facilities and long-term care.
- Anti-trust issues—Sherman Act and Clayton Act apply to healthcare entities
  - Sherman Act prohibits contracts, combinations and conspiracies that unreasonably restrain trade. *See* 15 U.S.C. § 1.
  - Clayton Act prohibits combinations of entities by merger or acquisition where the effect is to "substantially [] lessen competition" or "to tend to create a monopoly." 15 U.S.C. § 18. For large transactions which meet certain financial thresholds, there is also a pre-merger/acquisition notification and waiting period. *See* 15 U.S.C. § 18a.

- **Closure of Facility/Chapter 7 Issues**
  - Transfer of Patients to New Facility
    - Under Section 704(a)(12) of the Bankruptcy Code, one of the trustee's duties is to "use all reasonable and best efforts to transfer patients from a health care business . . . to an appropriate health care business" that— "(A) is in the vicinity of the health care business that is closing; (B) provides the patient with services that are substantially similar to those

provided by the health care business that is being closed; and (C) maintains a reasonable quality of care."

- Disposal of Patient Records
  - Section 351 of the Bankruptcy Code imposes certain requirements where the estate has insufficient funds to pay for the storage of patient records as required under applicable Federal or State law.
  - The trustee must give notice by publication, and also directly to each patient, that patients have 365 days to claim their patient records or the records will be destroyed. After the 365-day period has expired, and after requesting Federal agencies to accept the records, the trustee may destroy the records if a Federal agency does not agree to accept deposit of the records.