AMERICAN BANKRUPTCY INSTITUTE

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CONCURRENT SESSION

Business Session

Health Care Bankruptcy Update

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Healthcare Bankruptcy Update

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Hypothetical – Virgil Health System

Virgil Health System is a not-for-profit corporation that owns six hospitals in the State of Krameria. All of the hospitals are of long-standing, and all serve economically disadvantaged and under-served populations. VHS's board of directors, faced with multi-million dollar annual losses and no solutions, decided to enter into an agreement with a management company to take over the operations of the hospitals in 2015, but when the Attorney General approved that transaction, the office imposed significant financial and operational conditions which make a turn-out impossible.

Other financial hurdles include:

1. Payer mix – predominately Medicare and Medicaid
2. Significant underfunded pension liabilities
3. Above market collective bargaining agreements
4. Below market agreements with health plans
5. $500 million of secured debt.

After years of attempting to resuscitate operations VHS's board of directors has chosen to sell its assets through bankruptcy in 2019.

What Comes Next?

1. Options for selling the assets of VHS
   a. Out of court sale
   b. Section 363 sale

2. Stalking horse bidder considerations
   a. Board of directors has a duty to maintain a charitable mission but also to pay creditors
   b. Due diligence
   c. Certainty of closing
   d. Financing
   e. Ability to operate a hospital
   f. Experience with employee and CBA issues, negotiating with physicians and medical staff, local politics, etc.

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The Sale Process - Continued

3. Bid procedures
4. Selecting the winning bidder
5. Role of the patient care ombudsman
6. Transferring Medicare and Medicaid provider agreements
7. Obtaining new licenses and OTA
8. Rejection of collective bargaining agreements
9. Addressing governmental oversight (AG, Medicare, Medicare, etc.)
10. Rejecting medical contracts
11. Assessing medical malpractice claims
12. Investigating potential fraud claims

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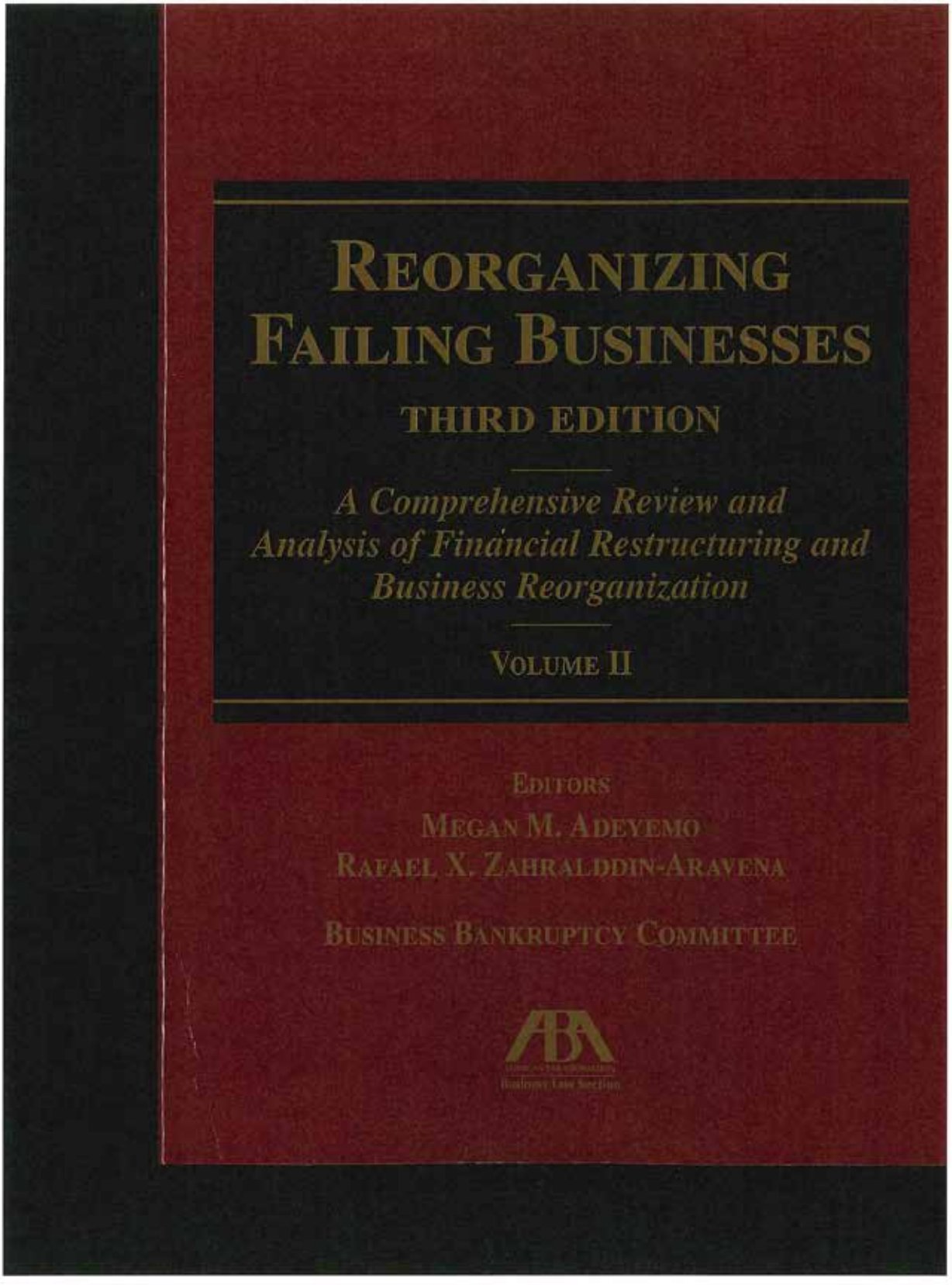

CHAPTER TWENTY-NINE

Unique Issues That Arise in Healthcare Business Bankruptcies

Samuel R. Maizel[1]

This chapter provides some guidance on the unique issues that arise in a healthcare business bankruptcy and the specific provisions of the Bankruptcy Code that govern issues particular to healthcare bankruptcy cases. Over the past decade, many healthcare businesses have sought bankruptcy protection. Counsel handling healthcare business bankruptcies will encounter high-profile cases with difficult and unique issues that arise from the intersection of bankruptcy law, various federal and state statutes and regulations, and public interest and concern. Such cases frequently garner a great deal of high-profile publicity and public scrutiny, which may affect strategic management of the case. The unique legal issues arise, in part, from the fact that the healthcare industry is one of the most heavily regulated industries in the United States. Many of those regulations relate only to care or services provided to Medicare or Medicaid patients. Healthcare businesses are governed by intricate statutes and regulations,[2] which vary in scope. Some relate only to care and services

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1. Dentons US, LLP. The author thanks Carole Neville, David Gordon, and Robert Richards, Dentons US, LLP; Kate Harmon, Elliott Greenleaf, P.C.; and Karen Gebbia, Golden Gate University, for their helpful comments in the preparation of this chapter.

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

provided to Medicare or Medicaid patients;[3] others apply more broadly. This chapter provides a roadmap to the unique issues these complications present in healthcare business bankruptcy cases.

DEALING WITH THE FEDERAL AND STATE GOVERNMENTS

Issues related to the resolution of disputes with the Centers for Medicare and Medicaid Services (CMS)[4] (which runs the Medicare program[5]) and the various state agencies that run the individual state Medicaid programs[6] can frequently be the most important issues in the case. This is due to the relative importance in the healthcare industry of the federal and state governments, both as a payors and regulators.

The United States can be expected to argue that bankruptcy courts do not have jurisdiction over any dispute regarding Medicare payments or decisions unless and until the debtor exhausts its administrative remedies under the Medicare rules. 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.[7] If the federal government's position is sustained, it effectively denies meaningful bankruptcy protection to healthcare businesses forced into bankruptcy by a dispute with the Medicare program. This issue is usually litigated early in the bankruptcy case. A loss on this issue can eliminate the usefulness of the bankruptcy filing by effectively denying a healthcare debtor any bankruptcy relief.

To support its position, the federal government relies on 42 U.S.C. § 405(h), which expressly states that federal courts may take jurisdiction over Medicare

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

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

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

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

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

disputes only after a party exhausts applicable appeal processes within the Medicare system. A complete discussion of this issue would be too lengthy to include here. It should be noted, however, that there is currently a split among the circuits regarding whether bankruptcy courts are barred by this provision from adjudicating disputes with CMS.[8] In short, the controversy is based on the plain language of section 405(h). This provision expressly restricts courts from taking jurisdiction under U.S. Code title 28 sections 1331 and 1336. It does not expressly refer to title 28 section 1334, which grants federal bankruptcy court jurisdiction. The plain language of the statute[9] supports the argument that the debtor need not exhaust its administrative remedies before a bankruptcy court may take jurisdiction in order to rule on non-Medicare-specific classic bankruptcy issues. For purposes of this chapter, such determinations specifically include whether the debtor can assume and assign an executory contract under section 365 of the Bankruptcy Code[10] and/or sell debtor assets free and clear of liens, claims, and interests under section 363. (As discussed later herein, these are two essential issues for healthcare business bankruptcy cases.) Nevertheless, 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.[11]

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8. *Compare* Florida Agency For Health Care Admin., et al v. Bayou Shores, SNF, LLC (*In re* Bayou Shores, SNF, LLC), 828 F.3d 1297, 1331 (11th Cir. 2016) ("The bankruptcy court was without § 1334 jurisdiction under the § 405(h) bar to issue orders enjoining the termination of the provider agreements and to further order the assumption of the provider agreements.") *with* Do Sung Uhm v. Humana, Inc., 620 F.3d 1134, 1140 n.11 (9th Cir. 2010) (noting the "special status" of bankruptcy court jurisdiction over bankruptcy issues); 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 Home Nursing Services, Inc.), 963 F.2d 1146, 1155 (9th Cir. 1992) ("Section 405(h) only bars actions under 28 U.S.C. §§ 1331 and 1346; it in no way prohibits an assertion of jurisdiction under section 1334."); and Nurse's Registry & Home Health Corp. v. Burwell (*In re* Nurses' Registry & Home Health Corp.), 533 B.R. 590, 593 (Bankr. E.D. Ky. 2015) (Court holds that "the statutory bar on federal jurisdiction over unexhausted Medicare Act disputes ... did not apply to bankruptcy jurisdiction".); *see also* Samuel R. Maizel & Michael B. Potere, *Killing the Patient to Cure the Disease: Medicare's Jurisdictional Bar Does Not Apply to Bankruptcy Courts*, 32 EMORY BANKR. DEV. J. 1 (2015).

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

10. 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.

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

THE PROVIDER AGREEMENT AS A LICENSE OR CONTRACT?

The relationship between the Medicare or Medicaid programs and the providers of healthcare goods and services is captured in a document commonly referred to as a "provider agreement." The treatment of provider agreements in a bankruptcy proceeding is often vital to the success of a bankruptcy case involving a sale of assets, but it can present difficult legal issues. Inside of bankruptcy proceedings, the government takes the position that the provider agreement is an executory contract that must be assumed by the debtor and assigned to the buyer under section 365. If the provider agreement is an executory contract, the debtor must cure existing defaults in the Medicare relationship (i.e., pay any existing prepetition obligations). Moreover, the buyer must take successor liability for the debtor's prior overpayments from Medicare and perhaps even for damages resulting from federal False Claims Act lawsuits.[12] What makes this issue controversial is that, outside of bankruptcy proceedings, the government argues, with success, that the Medicare provider agreement is not a contract.[13] The government does this to avoid giving Medicare providers contract-based rights and remedies. The Bankruptcy Code does not define the word *contract*. Instead, applicable nonbankruptcy law defines the nature of the debtor's property and contract rights. Therefore, it is hard to fathom why the filing

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

13. PAMC, Ltd. v. Sebelius, 747 F.3d 1214, 1221 (9th Cir. 2014) ("We have, on occasion, stated that providers and others have contracts with the government in this area, but our decisions have turned on the regulatory regime rather than on contract principles. . . . As the Eleventh Circuit Court of Appeals held when hospitals complained of legislative impairment of their contract rights in this area because they had agreements with the Secretary: 'Upon joining the Medicare program, however, the hospitals received a statutory entitlement, not a contract right.'") (quoting Mem'l Hosp. v. Heckler, 706 F.2d 1130, 1136 (11th Cir. 1983)); Germantown Hosp. & Med. Ctr. v. Heckler, 590 F. Supp. 24, 30–31 (E.D. Pa. 1983), *aff'd*, 738 F.2d 631 (3d Cir. 1984) ("There is no contractual obligation requiring HHS to provide Medicare reimbursement."); *In re* BDK Health Mgmt., Inc., Case Nos. 98-609-B1, Order Authorizing Sale of Assets out of the Ordinary Course of Business, 1998 Bankr. LEXIS 2031 (Bankr. M.D. Fla., Nov. 16, 1998). *But see In re* Univ. Med. Ctr., 973 F.2d 1065, 1075 n.13, 1076 (3d Cir. 1992) (reasoning that the "complexity of the Medicare scheme" does not exclude a provider agreement from the ambit of section 365, and that "a Medicare provider agreement easily fits" within the judicial definition of an executory contract). Lower courts in the Third Circuit have concluded that the decision in *University Medical Center* on this issue is limited. *See, e.g.*, Health Care Fin. Admin. v. Sun Healthcare Grp., Inc. (*In re* Sun Healthcare Grp., Inc.), 2002 U.S. Dist. LEXIS 17868 (D. Del. 2002) (holding that "although the Medicare provider agreement may not be a license in the strictest sense of the word, it is clearly similar to a license for section 525 purposes").

of a bankruptcy case would change the essential character of a document from a noncontract to a contract.

Are provider agreements executory contracts, or licenses?[14] The impact of this determination on a healthcare bankruptcy case is profound. A detailed discussion is beyond the scope of this chapter;[15] however, several implications are clear. A license becomes property of the bankruptcy estate[16] and can be sold under section 363, without successor liability passing to the buyer. An executory contract is also property of the estate,[17] but it must be transferred under section 365, and the buyer must assume the contract *cum onere*.[18] Such a transfer could result in the party taking the assignment of the Medicare provider agreement subject to successor liability.[19] Thus, an assignment of the provider agreement under section 365 is likely to generate significantly less value than a sale of the provider agreement under section 363 as a license.

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

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

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

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

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

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

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

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

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

SETOFF AND RECOUPMENT BY THE GOVERNMENT

Outside of bankruptcy, the federal government and its contractors routinely withhold Medicare and Medicaid payments when they determine that a healthcare provider has been overpaid.[22] Section 362 automatically stays creditors' efforts to exercise control over property of the estate or collect on the debtor's prepetition obligations.[23]

Medicare and Medicaid withholdings might be characterized either as setoff or recoupment. Simply stated, *recoupment* is the assertion against the debtor of a claim or defense that arises from the same contract (or transaction or relationship), whereas *setoff* is the assertion of a claim that arises between the same parties but under a different contract (or transaction or relationship). Outside of bankruptcy, the distinction may be insignificant; inside of bankruptcy it can be key. The Bankruptcy Code strictly limits creditors' setoff rights but does not restrict creditors' recoupment rights.[24] For example, the Bankruptcy Code allows setoff only with respect to mutual prepetition

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

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

22. 42 U.S.C. § 1395(g)(a).

23. 11 U.S.C. § 362(a)(7).

24. *See, e.g.*, University Med. Ctr., 973 F.2d at 1079-80 (discussing the differences between setoff and recoupment in bankruptcy).

obligations; however, precedent uniformly holds that recoupment is not so limited.[25] Additionally, while setoff is subject to the automatic stay and requires a creditor to obtain court approval, recoupment is not subject to the automatic stay and does not require court approval.[26] Consequently, in bankruptcy cases the government argues that its withholding of Medicare payments to recover prior overpayments constitutes recoupment. While a complete discussion of this issue is beyond the scope of this chapter,[27] it should be noted that there is a split in the circuits on whether the withholding is recoupment or setoff.[28]

The same arguments that apply to federal Medicare recoupments/setoffs also generally apply to state governments' efforts to recover prior Medicaid overpayments from ongoing Medicaid programs. There are, however, differences arising from the different approaches states have applied to the provider agreements. As with Medicare, courts are split on the issue.[29]

IMPACT OF HEALTHCARE BUSINESS BANKRUPTCY ON HEALTHCARE FRAUD CASES

One of the most powerful statutes that addresses fraud against the United States is the federal False Claims Act.[30] The government has vigorously applied this law against the healthcare industry over the past two decades. Although most litigation is subject to the automatic stay imposed by section 362(a), section 362(b)(4) exempts from the

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25. 11 U.S.C. § 553(a); *see, e.g.*, *In re* Holford, 896 F.2d 176, 179 (5th Cir. 1990).

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

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

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

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

30. 31 U.S.C. §§ 3729–3733. Many states also have false claims acts. *See, e.g.*, Cal. Gov't Code §§ 12650–12655 (1992).

stay acts by the government to enforce police or regulatory powers. Cases arising under the False Claims Act are generally thought to be exempt from the automatic stay as an exercise of a police or regulatory power.[31] Nevertheless, the exemption extends only to prosecution of the case, not to recovery of any damage award. Despite the inapplicability of the automatic stay, the filing of a bankruptcy petition is not without benefits for a healthcare business facing a False Claims Act case.

First, False Claims Act lawsuits are usually filed under seal by *qui tam* relators.[32] While the case is still under seal, the United States can decide whether to intervene. During this process, the debtor/defendant is not aware that a lawsuit is pending against it. Nevertheless, if the United States wants to recover in the bankruptcy case any damages that might be awarded in the False Claims Act case, the government must file a proof of claim by the applicable bar date. This requirement provides the debtor with knowledge of and the ability to address what may have been unknown litigation prepetition. Moreover, the United States may be required to defend that claim in the bankruptcy court, which it may view as a less favorable forum than the district court. The time for doing so may be much shorter than the time allowed outside of bankruptcy. Finally, section 502(c) permits a bankruptcy court to estimate claims for the purposes of (1) allowance of the claim as to amount, (2) voting on a plan, (3) feasibility of a plan, and (4) distributions under a plan.[33] The court may also estimated a claim in order to determine the amount to be paid as "cure" when the Medicare and or Medicaid Provider Agreements are assumed by a debtor and/or assigned to a buyer.[34] The key question in determining whether a court should estimate a claim otherwise pending in another forum is "whether the liquidation of that claim" outside of bankruptcy "would unduly delay the . . . reorganization."[35] If so, a debtor could employ a bankruptcy case estimation proceeding to compel the government to assert claims otherwise pending in a False Claims Act case.

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31. *In re* Commonwealth Cos., 913 F.2d 518 (8th Cir. 1990) (holding that suits for violation of False Claims Act not subject to automatic stay); *In re* Selma Apparel Corp., 132 B.R. 968 (S.D. Ala. 1991) (same). Nevertheless, some courts have held that automatic stay applies if the action could be considered analogous to a lawsuit for contract damages. *See* Commonwealth Cos., 913 F.2d at 525; *see generally In re* Corporacion de Servicios Medicos Hospitalarios de Fajardo, 805 F.2d 440, 445–47 (1st Cir. 1986) (holding that that section 362(b)(4) does not apply to an action by a governmental unit to enforce contractual rights).

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

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

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

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

This strategy has the potential benefit of forcing a resolution much more quickly than could be obtained outside of bankruptcy.

IMPACT OF BAPCPA ON HEALTHCARE BUSINESS BANKRUPTCIES

Until 2005, the Bankruptcy Code did not define, or contain any provisions that applied exclusively to, healthcare businesses. In 2005, the Bankruptcy Abuse Prevention and Consumer Protection Act (BAPCPA)[36] amended the Bankruptcy Code to address certain issues that arise in healthcare provider bankruptcies. Many of these amendments arose from specific cases that this chapter will identify where appropriate.

NOT-FOR-PROFIT HEALTHCARE BUSINESS RULES

Many healthcare businesses are not-for-profit entities.[37] Three provisions of the Bankruptcy Code address the sale of not-for-profit assets. Those provisions arise out of and are frequently invoked in healthcare business bankruptcies.[38] *In re Allegheny Health Education and Research Foundation* provided the catalyst for these BAPCPA provisions. In *Allegheny*, the bankruptcy court rejected the Pennsylvania Attorney General's attempt to intervene in the chapter 11 sale of not-for-profit hospitals.[39] BAPCPA amended section 363 to require the trustee to comply with all applicable nonbankruptcy laws governing the transfer, sale, or lease of not-for-profit entities' property. Under newly added section 1129(a)(16), the court cannot confirm a plan of reorganization without a finding that all transfers of not-for-profit assets comply

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36. Pub. L. No. 109-8, 119 Stat. 23 (2005).

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

38. For a more detailed discussion of the sale of not-for-profit healthcare assets in bankruptcy proceedings, see Samuel R. Maizel & Mary D. Lane, *The Sale of Nonprofit Hospitals through Bankruptcy: What BAPCPA Wrought*, 30(5) Am. Bankr. Inst. J. (June 2011).

39. *In re* Bankruptcy Appeal of Allegheny, Health, Educ. & Res. Found., Appeal of Order Staying/Enjoining Orphans Court Proceedings, 252 B.R. 309 (W.D. Pa. 1999). These provisions had their genesis in the Business Bankruptcy Reform Act of 1998, S. 1914, introduced by Sen. Grassley (R.-Iowa), and its counterpart in the House of Representatives, the Consumer Bankruptcy Reform Act of 1998, H.R. 3150, introduced by Rep. Gekas (R.-Pa.). Those statutes were never enacted, but many of their concepts were incorporated into BAPCPA.

with applicable nonbankruptcy law. Similarly, newly added section 541(f) allows a not-for-profit healthcare business to transfer property to a for-profit entity, but only under the same conditions that would apply if the debtor were not in bankruptcy.

It is important to note two sections of BAPCPA that were not codified into the U.S. Code but that are still binding and relate to the sale of not-for-profit assets in bankruptcy.[40] First, BAPCPA section 1221(d) states that "the court shall not confirm a plan . . . without considering whether this section[41] would substantially affect the rights of a party in interest. . . . The parties who may appear and be heard in a proceeding under this section include the attorney general of the State in which the debtor is incorporated, was formed, or does business." Second, BAPCPA section 1221(e) states that "[n]othing in this section [which is now section 363(d)(1)] shall be construed to require the [bankruptcy] court in which a case under [the Bankruptcy Code] is pending to remand or refer any proceeding, issue, or controversy to any other court or to require the approval of any other court for the transfer of property." These provisions make clear both that the state Attorney General has standing to appear on issues related to the sale of not-for-profit assets and that the bankruptcy court need not defer to a state court to decide issues related to the transfer of assets.

DEFINITION OF HEALTHCARE BUSINESS

BAPCPA amended section 101 of the Bankruptcy Code by defining, for the first time, a *healthcare business*.[42] Under this definition, a healthcare business:

> (A) means any public or private entity . . . that is primarily engaged in offering to the general public facilities and services for (i) the diagnosis or treatment of an injury, deformity, or disease; and (ii) surgical, drug treatment, psychiatric, or obstetric care; and

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

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

42. Pub. L. No. 109-8, § 1101(A), 119 Stat. 23, 189 (codified at 11 U.S.C. § 101(27A)).

> (B) includes (I) general or specialized hospital; (II) ancillary ambulatory emergency, or surgical treatment facility; (III) hospice; (IV) home health agency; and (IV) other health care institution that is similar to an entity referred to in subclause (I), (II), (III), or (IV); and (ii) any long-term care facility, including any (I) skilled nursing facility; (II) intermediate care facility; (III) assisted living facility; (IV) home for the aged; (V) domiciliary care facility; and (VI) health care institution that is related to a facility referred to in subclause (I), (II), (III), (IV), or (V), if that institution is primarily engaged in offering room, board, laundry, or personal assistance with activities of daily living and incidentals to activities of daily living.[43]

BAPCPA also added definitions of *patient* (section 101(40A))[44] and *patient record* (section 101(40B)).[45] A patient means "any individual who obtains or receives services from a health care business." A patient record means any written or electronic record relating to a patient.[46] These definitions are rarely discussed and never litigated. In contrast, the parties not infrequently dispute whether an entity is a healthcare business.

EXCLUSION FROM PARTICIPATION IN THE MEDICARE PROGRAM

Outside of bankruptcy, the Office of Inspector General[47] may exclude an individual or entity from future participation in all federal healthcare programs and all state healthcare programs. BAPCPA added section 362(b)(28), which provides that the automatic stay does not apply to "the exclusion by the Secretary of Health and Human Services of the debtor from participation in the Medicare program or any other Federal health care program." This provision is not as broad as it may seem, in part because the conditions for exclusion are limited.[48] Counsel should be careful to draw a distinction between suspension and exclusion with regard to the Medicare program. While section 362(b)(28) expressly exempts exclusion from the automatic

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43. 11 U.S.C. § 101(27A).
44. Pub. L. No. 109-8, § 1101(b), 119 Stat. 23 (codified at 11 U.S.C. § 101(40A)).
45. Pub. L. No. 109-8, § 1101(c), 119 Stat. 23 (codified at 11 U.S.C. § 101(40B)).
46. 11 U.S.C. § 101(40B).
47. The Office of Inspector General, which is part of the U.S. Department of Health and Human Services (HHS), is responsible for protecting the integrity of HHS programs.
48. For a more in-depth discussion of this issue, see Samuel R. Maizel & Rachel Caplan, *Chicken Little Comes to Roost in Bankruptcy*, 25(6) Am. Bankr. Inst. J. (July/Aug. 2006).

stay, it does not expressly exempt suspensions. The courts are split concerning whether the automatic stay bars suspension.[49]

PATIENT CARE OMBUDSMAN

BAPCPA added section 333, which requires the appointment of a patient care ombudsman (PCO). The PCO represents the interests of patients and serves as the "eyes and ears" of the bankruptcy court to ensure that the healthcare business maintains appropriate levels of patient care.[50] Section 333 requires the bankruptcy court to order the appointment of a PCO, within 30 days after the commencement of a bankruptcy case, unless the court reviews and facts and determines that the appointment is not necessary for the protection of the patients. If the court orders the appointment of a PCO, the U.S. Trustee must appoint a disinterested person (which can include a corporation) as the PCO. If the healthcare business provides long-term care services, the U.S. Trustee may appoint the state long-term care ombudsman as the PCO.

The PCO is required to monitor the quality of patient care and report on it to the court within 60 days of being appointed. Reports are required every 60 days thereafter. The PCO is authorized to file a motion or written report (other than the regular report) if it observes that the quality of patient care is declining significantly or otherwise being materially compromised. The PCO will almost certainly have to review medical records in the course of monitoring patient care. The PCO must comply with applicable nonbankruptcy law, including federal law that strictly controls access to medical records.[51] Usually, PCOs obtain express authorization to review patient records as well.

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

50. Pub. L. No. 109-8, § 1104, 119 Stat. 23 (codified at 11 U.S.C. § 333). It is generally thought that this provision, as well as the provision dealing with the transfer of patients, resulted from the publicity surrounding the closure of a skilled nursing facility in bankruptcy in southern California. *See* Julie Tamaki & Julie Marquis, *Judge Assails Shutdown of Nursing Home*, L.A. TIMES (Sept. 30, 1997); Sharon Bernstein & Barry Stavo, *County Asks for Warning of Care Home Shutdowns*, L.A. TIMES (Oct. 1, 1997).

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

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

DISPOSAL OF MEDICAL RECORDS

BAPCPA added a provision dealing with the destruction of medical records.[52] This provision was necessary because federal and state regulations require most medical records to be stored for years and for some medical records to be stored for more than 20 years.[53] This storage can be very expensive. Section 351 preempts such nonbankruptcy rules and provides a mechanism by which a debtor or trustee who does not have sufficient funds to comply with nonbankruptcy storage standards may destroy medical records rather than pay for storing them.[54] It requires the trustee to publish notice in appropriate newspapers, stating that patient records will be destroyed if they are not claimed by the patient or an insurance provider within 365 days of publication of the notice. In the 180 days after publication, the trustee must promptly attempt to notify each patient with patient records being held, and any appropriate insurance carrier, of how and when they may obtain the medical records. If records remain unclaimed after the 365-day period expires, section 351 requires the trustee to mail a request to an "appropriate" federal agency before destroying the records. No such agency is identified, however, and it is not clear that any such agency exists. Oddly, there are state agencies that are available to take on the storage of medical records, but the statute makes no mention of contacting the appropriate state agency. If no federal agency accepts the request to take on storage of the records, the trustee is authorized to destroy the records by shredding or burning paper records, or by "otherwise" destroying magnetic, optical, or electronic records.

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52. Pub. L. No. 109-8, § 1102, 119 Stat. 23, 189–90 (codified at 11 U.S.C. § 351).

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

54. Samuel R. Maizel and Michael R. Maizel, *Revising § 351: Dealing with Unwanted Medical Records*, ABI Journal, Vol. XXXVI, No. 5 (May 2017).

DUTY OF A TRUSTEE TO TRANSFER PATIENTS

BAPCPA amended section 704 to create rules applicable to the transfer of patients when a healthcare business is closing.[55] The trustee must transfer patients to a facility that (1) is in the vicinity of the healthcare business being closed, (2) provides the patient with services that are substantially similar to those provided by the healthcare business that is being closed, and (3) maintains a reasonable quality of care.

COSTS OF CLOSING A HEALTHCARE FACILITY

In the *Allen Care Center* case,[56] the court denied the state's request to be paid the costs it incurred in closing a healthcare business that no longer had any funds.[57] BAPCPA amended the Bankruptcy Code to provide that the costs and expenses a trustee, federal agency, or state or local government department incurs in closing a healthcare business are administrative expenses. These expenses include but are not limited to those related to disposing of patient records (but not storing patient records) or the transfer of patients as necessary.

DISCRIMINATION AGAINST HEALTHCARE BUSINESS BY GOVERNMENTAL ENTITIES

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

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55. Pub. L. No. 109-8, § 1105, 119 Stat. 23, 192 (codified at 11 U.S.C. § 704(a)(12)).

56. State of Or., Dep't of Human Res. v. Witcosky (*In re* Allen Care Ctrs., Inc.), 96 F.3d 1328 (9th Cir. 1996).

57. Pub. L. No. 109-8, § 1103, 119 Stat. 23, 190 (2005) (codified at 11 U.S.C. § 503(b)(8)).

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

Consequently, it should apply regardless of whether the Medicare provider agreement is deemed to be a contract or a license.[59] Courts have also held that section 525 protects purchasers of assets from a bankruptcy estate.[60] Nonetheless, states have continued to push the limits on these protections. For example, in *In re Gardens Regional Medical Center and Hospital, Inc.*, the California Attorney General imposed a condition of the sale of a not-for-profit that required the debtor or the purchaser of its assets to pay approximately $2.4 million that the debtor owed to the state. The state threatened to deny the purchaser the right to continue to participate in the state's Hospital Quality Assurance Fee program if the amount was not paid, which would have resulted in the purchaser forfeiting millions of dollars. The matter was not litigated, and it is thus unclear how this condition would have been resolved.[61]

CONCLUSION

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

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

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

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

HEALTHCARE

Extent of State's POWER at Issue in Nonprofit Hospital's Asset Sale

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A recent bankruptcy case in Southern California has raised significant questions about the limits, if any, on the power of state governments in approving or rejecting sales of assets of not-for-profit healthcare industry entities. With Congress focused on repealing the Affordable Care Act (ACA), which some experts suggest would reduce revenue to hospitals by more than $165 billion between 2018 and 2026,[1] this issue is likely to arise repeatedly across the country moving forward. Increasing financial distress in the U.S. healthcare industry, which includes more than 2,800 nongovernmental not-for-profit community hospitals, is likely to lead to growing numbers of workouts and restructurings.

Until the U.S. Bankruptcy Code[2] was amended by the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 (BAPCPA),[3] bankruptcy courts frequently determined that they alone decided issues arising in connection with the application of the code to the sale of not-for-profit healthcare businesses.[4] However, the 2005 amendments added provisions in three different places in the code dictating that the sale of not-for-profit assets in bankruptcy cases must be done in accordance with applicable nonbankruptcy law.[5]

There is little legal precedent on these provisions,[6] so the issue of what exactly they mean is unresolved. Do they mean that a state attorney general can impose conditions on the sale of a not-for-profit that effectively gut federal bankruptcy law protecting debtors? Do they mean that a state attorney general can impose conditions on a sale which require that the state, as a creditor owed money, be repaid either by the debtor or the buyer without regard to the effect of the Bankruptcy Code on its claim? Do they mean that a state attorney general's review is beyond the scope of the bankruptcy court's review? These issues have now been squarely raised in the bankruptcy case of Gardens Regional Hospital and Medical Center.[7]

Gardens is a nonprofit public benefit corporation that operates a hospital in California. Gardens has an institutional provider agreement and corresponding hospital enrollment and certification with the state of California, which enables it to receive payments from the state for services provided to Medi-Cal[8] beneficiaries.

Gardens filed for bankruptcy protection under Chapter 11 of the Bankruptcy Code in June 2016 and in July 2016 auctioned off its assets under Section 363 of the Bankruptcy Code for approximately $19.5 million. In addition to cash, the winning bid, among other things, provided for the continuation of the hospital's medical services, including its emergency department; for the continued employment of at least half of the hospital's nearly 300 employees; and for the transfer of the debtor's Medi-Cal relationship to the buyer.

Because this was a sale of not-for-profit assets, under California law it was subject to review and approval by the state attorney general.[9] In accordance with Section 363(d)(1), Gardens prepared and submitted an application to the attorney general seeking permission to close

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the sale, as required by applicable nonbankruptcy law. Eventually, the attorney general approved the sale but imposed numerous obligations on the buyer as conditions to the sale.

Among the conditions were requirements that the buyer (a) continue to participate in the state's Hospital Quality Assurance Fee (HQAF)[10] program by "assuming all known and unknown monetary obligations under the Medi-Cal program" owed by Gardens, and (b) sign a financial responsibility agreement with the state, which also imposed successor liability on the buyer. Gardens allegedly owed approximately $2.4 million in unpaid prepetition fees related to the HQAF to the state.[11]

During the case the state timely filed a claim in an "undetermined" amount against the Gardens' estate. The sole basis asserted for the state's claim was described as "overpayment of Medi-Cal (Medicaid) program reimbursement payments for fiscal years ending December 31, 2014, -2015, and -2016." No claim was filed on behalf of the state for the amounts allegedly owed for the HQAF fees before the applicable deadline had passed.

Violation of Automatic Stay or Lawful Condition?

Section 362 creates an automatic stay, which stops all efforts by creditors to collect on prepetition debt. Section 363(d)(1) requires sales of not-for-profit healthcare businesses to submit to applicable nonbankruptcy law, and California law allows the attorney general to impose conditions on the sale of not-for-profit assets. But if the attorney general can impose a condition requiring payment of a prepetition debt owed to the state, is that a violation of the automatic stay as set forth in Section 362 or a lawful condition imposed pursuant to the rule set by Section 363(d)(1)?

Section 362(a) imposes a stay on any acts to collect on prepetition obligations, but Section 362(b)(4) contains an exception to the automatic stay, which exempts the commencement or continuation of action to enforce police or regulatory powers. This exception is not unlimited, however.[12]

Courts have developed tests for whether a government act falls within this exception.

The first test is the "pecuniary purpose test," which holds that governmental actions protecting or promoting public health and safety or other police or regulatory interests are exempt. However, if the government action is one to protect or promote pecuniary or financial interests, the exception does not apply.[13]

The other widely used test to determine if the governmental action is exempt from the automatic stay is the "public policy test." Proceedings that adjudicate and effectuate public policy, as distinguished from those that adjudicate or vindicate private rights, are exempt from the stay.[14]

Because there are no cases interpreting the scope of or limits on the state's powers under Section 363(d)(1), theoretically the state could impose conditions on a sale requiring repayment of prepetition debts as a condition to the sale in bankruptcy, as California did with regard to the sale of Garden's assets. However, the authors suggest that courts should apply the same tests as have been developed vis-à-vis Section 362(b)(4) so that the state could take acts or impose conditions as a prerequisite to the sale only in furtherance of a valid police or regulatory goal, not merely to advance its pecuniary interests as a creditor above the interests of other creditors.

Conflict with Section 525?

As part of its condition that the buyer cure the debtor's claims to the Medi-Cal program, the state threatened to bar the buyer from further participation in that program if it failed to do so. Such a ban would result in the buyer forfeiting millions of dollars that would otherwise be paid to the hospital under the HQAF program. If the state could impose such a condition outside of bankruptcy, Section 363(d)(1) suggests that it could impose such a condition even in a bankruptcy sale. However, the authors think that such a result would run afoul of the protections of Section 525 of the Bankruptcy Code.

Although there is no precedent on point, blocking the buyer from participating in the HQAF program because of its failure to pay the prepetition HQAF claims of the state could constitute a violation of Section 525.[15] That section provides that a government unit may not "deny, revoke, suspend, or refuse to renew a license, permit, charter, franchise or other similar grant to…a person that is or has been a debtor under this title…or another person with whom such bankrupt or debtor has been associated, solely because such bankrupt or debtor is or has been a debtor under this title or…has been insolvent before the commencement of the case…or has not paid a debt that is dischargeable in the case under this title…."[16]

Except as it specifically provides, Section 525 prohibits a "governmental unit" from, among other things, discriminating against a party under a government program solely because the debtor has failed to pay a dischargeable debt. Perhaps the leading case interpreting Section 525 is the U.S. Supreme Court's decision in *Federal Communications Commission v. NextWave Communications, Inc.*[17] In *Nextwave*, the Federal Communications Commission (FCC) cancelled certain licenses owned by the debtor but denied that the proximate cause for its cancellation of the licenses was the failure to make payments due to the FCC. Instead, the FCC contended that Section 525 did not apply because the commission had a valid regulatory motive for the cancellation.

The Supreme Court gave short shrift to this argument, stating that the FCC's motive was "irrelevant." The court did not believe that the statute's reference to a failure to pay a debt as the sole cause of cancellation of a license could be reasonably interpreted to include the governmental unit's motive in effecting the cancellation. "Section 525 means nothing more or less than that the failure to pay a dischargeable debt must alone be the proximate cause of the cancellation — the act or event that triggers the agency's decision to cancel, whatever the agency's ultimate motive in pulling the trigger may be."[18]

The FCC contended that NextWave's license obligations to the commission were not "debt[s] that [are] dischargeable" in bankruptcy. First, the FCC argued that regulatory requirements, such as a full and

With regard to Gardens, it seems that the conditions imposed by the California attorney general, albeit seemingly consistent with Section 363(d)(1), are in violation of Section 525, and the latter should control.

timely payment condition, are not properly classified as "debts" under the Bankruptcy Code. In the view of the FCC, the financial nature of a condition on a license did not convert that condition to a debt. The Supreme Court characterized this argument as nothing more than a retooling of the FCC's argument that "regulatory conditions" should be exempt from Section 525. The court again dismissed this argument, saying "a debt is a debt," even when the payment obligation is a regulatory requirement.[19]

The FCC also argued that NextWave's obligations were not "dischargeable" in bankruptcy because bankruptcy courts did not have the jurisdictional authority to alter regulatory obligations.[20] Noting that dischargeability is not tied to the existence of such authority, the court stated that a preconfirmation debt is dischargeable unless it falls within one of the exceptions to dischargeability contained in the Bankruptcy Code.

On several occasions, other courts have also held that Section 525(a) supersedes other provisions of the Bankruptcy Code with respect to government entities.[21] Turning specifically to the interplay between Section 525(a) and other provisions of the Bankruptcy Code, courts

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have found that Section 525(a) was the more specific statute, and it was a "basic principle of statutory construction that a specific statute... controls over a general provision."[22] For example, in the housing context, the court found that Section 525(a) was more specific because, while Section 365 authorized landlords to evict debtor-tenants for nonpayment of discharged prepetition rent, Section 525(a) "specifically prohibits landlords who are also governmental units from evicting debtor-tenants solely because of nonpayment of discharged prepetition rent."[23]

With regard to Gardens, it seems that the conditions imposed by the California attorney general, albeit seemingly consistent with Section 363(d)(1), are in violation of Section 525, and the latter should control.[24] If it does, the attorney general's decision to compel repayment or be barred from the HQAF program is a violation of Section 525.

Unresolved Issue

While the Gardens case is still pending, it raises serious issues in the interpretation of Section 363(d)(1), on which precedent provides little guidance at the moment. In the current circumstances the only seemingly certain thing is that this issue will be raised again.

[1] "Estimating the Impact of Repealing the Affordable Care Act on Hospitals," American Hospital Association, aha.org/content/16/impact-repeal-aca-report.pdf.

[2] All references to "section" are to sections of the Bankruptcy Code, 11 U.S.C. §§ 101-1530.

[3] Bankruptcy Abuse Prevention and Consumer Protection Act of 2005, Pub. L. 109-8, 119 Stat. 23.

[4] One of the most publicized cases dealing with this issue was the Chapter 11 bankruptcy of Allegheny Health Education and Research Foundation in 1998. For a detailed discussion of this case, see L.R. Burns, J. Cacciamani, J. Clement and W. Aquino, *The fall of the house of AHERF: the Allegheny bankruptcy,* Health Affairs 19, no. 1 (2000), content.healthaffairs.org/content/19/1/7.full.pdf+html?sid=2eafd938-3671-4d48-9051-547793d6a22e. In AHERF the Bankruptcy Court refused the requests of the attorney general to allow it to investigate AHERF's use of restricted endowments, to appoint an interim trustee, and to allow it to review any bids before the assets were sold. *In re Bankruptcy Appeal of Allegheny, Health, Education and Research Foundation,* Appeal of Order Staying/Enjoining Orphans Court Proceedings, 252 B.R. 309 (W.D. Pa. 1999).

[5] 11 U.S.C. Subsection 363(d)(1) (Trustee may use, sell or lease property of the estate "only in accordance with applicable nonbankruptcy law that governs the transfer of property by a corporation or trust that is not a moneyed, business or commercial corporation or trust."); 541(f) (Property held by a debtor that is a not-for-profit corporation under Internal Revenue Code § 501(c)(3) may be transferred to an entity that is not such a corporation "only under the same conditions that would apply if the debtor had not filed a case" under the Bankruptcy Code.); 1129(a)(16) (A Chapter 11 plan can only be confirmed if all transfers of property are "made in accordance with any applicable provisions of nonbankruptcy law that govern the transfer of property by a corporation or trust that is not a moneyed, business, or commercial corporation or trust.")

[6] An earlier article on these provisions is Samuel R. Maizel and Mary D. Lane, "The Sale of Nonprofit Hospitals through Bankruptcy: What BAPCPA Wrought," *ABI Journal,* Vol. XXX, No. 5, June 2011.

[7] *In re Gardens Regional Hospital and Medical Center, Inc.,* Case No. 2:16-bk-17463-ER (Bankr. C.D. Cal.).

[8] Medi-Cal is California's Medicaid program. It provides healthcare services for, among others, low-income individuals. www.dhcs.ca.gov/services/medi-cal/pages/default.aspx.

[9] Cal. Corp. Code Sections 5914-5925; 11 Cal. Code Reg. Section 999.5. Examples of the kinds of conditions imposed by the California Attorney General can be found at California Department of Justice, *Nonprofit Hospital Transaction Notices,* available at oag.ca.gov/charities/nonprofithosp.

[10] HQAF imposes a fee on certain general acute care hospitals to make supplemental and grant payments and increased capitation payments to hospitals. www.dhcs.ca.gov/provgovpart/Pages/HQAF.aspx ("The program provides funding for supplemental payments to California hospitals that serve Medi-Cal and uninsured patients. Revenue from the HQAF also provides funding for children's health care coverage, pays direct grants to public hospitals, and reimburses DHCS for the direct costs of administering the program. The program has been very successful, providing billions of dollars in supplemental payments to California hospitals.").

[11] The state "assesses a fee on certain general acute care hospitals to be used, for the most part, as the non-federal share of supplemental Medi-Cal payments to eligible hospitals for inpatient and outpatient services. The money collected is deposited into the hospital quality assurance revenue fund." *Id.*

[12] See *State of Missouri v. U.S. Bankruptcy Court,* 647 F.2d 768, 776 (8th Cir. 181) ("[W]e believe that the term 'police or regulatory power' refers to the enforcement of state laws affecting health, welfare, morals, and safety, but not regulatory laws that directly conflict with the control of the ***res*** or property by the bankruptcy court.").

[13] *In re Medicar Ambulance Co., Inc.,* 166 B.R. 918 (Bankr. N.D. Calif. 1994).

[14] *Medicar Ambulance Co., Inc.,* 166 B.R. at 926-27.

[15] *Hiser v. Blue Cross of Greater Philadelphia (In re St. Mary Hospital),* 89 B.R. 503, 513 (Bankr. E.D. Pa. 1988) (Court held that Section 525(a) barred the Medicare Program from requiring the debtor to repay prepetition obligations as a condition for remaining in the Medicare Program.).

[16] 11 U.S.C. Section 525(a). See *In re Sun Healthcare Group, Inc.,* 2002 U.S. Dist. LEXIS 17868 (D. Del. 2002); *In re Psychotherapy & Counseling Ctr., Inc.,* 195 B.R. 522, 531 (Bankr. D.C. 1996) ("were HHS's exclusion [from Medicare and state health care programs] based solely on the debtor's nonpayment of debt, it might run afoul of the Code's antidiscrimination provision under 11 U.S.C. § 525(a) . . . . This sort of government action, which would interfere with the debtor's breathing spell and fresh start, is just the sort of discriminatory activity 11 U.S.C. § 525(a) was intended to prevent.").

[17] 537 US 293, 123 S.Ct. 832 (2003).

[18] 123 S.Ct. at 838-39.

[19] *Id.* at 839. See also *Bradley v. Barnes (In re Bradley),* 989 F.2d 802 (5th Cir. 1993) ("Section 525 does not prohibit a state from denying or revoking a license based upon a determination that the public safety would be jeopardized by granting or allowing continued possession of a license, but it does prohibit a state from exacting a discharged debt as the price of receiving or retaining a license.").

[20] Courts have noted the broad jurisdiction of bankruptcy courts in general, and when ruling pursuant to Section 525 in particular. See, *e.g., Applegate v. March,* 64 B.R. 448, 450 (Bankr. E.D. Va. 1986) ("No court in the realm holds such a wide subject matter jurisdiction as does the Bankruptcy Court ... the entirety of §525, every word, is utterly sweeping.").

[21] See, *e.g.,* 315 F.3d 80 (2d Cir. 2002).

[22] *Id.* at 93 (quoting *HCSC-Laundry v. United States,* 450 U.S. 1, 6 (1981)).

[23] *Id.* See also *In re Aikens,* 503 B.R. 603, 607-08 (Bankr. S.D.N.Y. 2014) (finding that Section 362(b)(22) was the "more general" statute because it "applies to all landlord and tenant relationships, public and nonpublic alike," whereas Section 525(a) applies "to the subset of such relationships that are with government units alone").

[24] See, *e.g., In re St. Mary Hospital,* 89 B.R. at 512 (Court held that Section 525(a) "eliminates" the right of the Medicare Program to compel a debtor to accept Medicare's recoupment of prepetition obligations as a condition for utilization of its Medicare provider agreement, even though Section 365(b)(1) would otherwise require it.).

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KILLING THE PATIENT TO CURE THE DISEASE: MEDICARE'S JURISDICTIONAL BAR DOES NOT APPLY TO BANKRUPTCY COURTS

Samuel R. Maizel[*]
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ABSTRACT

Sections 405(g) and 405(h) of the Social Security Act require exhaustion of administrative remedies prior to judicial review for any claims brought under the Medicare Act. Generally, these claims arise when the Centers for Medicare and Medicaid Services decides that a hospital owes the government for prior overpayment. The appeal of such decisions can take years, potentially forcing hospitals to close due to a lack of continued Medicare payments. As such, filing for bankruptcy protection quickly becomes one of the hospital's primary avenues for survival. Historically, however, some bankruptcy courts have looked to the legislative context of § 405(h) and determined that bankruptcy courts lack jurisdiction over Medicare claims prior to the exhaustion of administrative remedies. This Article argues that such an interpretation is incorrect because the plain language of § 405(h) renders it inapplicable to a federal bankruptcy court's jurisdictional grant, and is also contrary to the Bankruptcy Code's purpose.

INTRODUCTION

Acute care hospitals and other providers of goods and services to Medicare beneficiaries face a very difficult situation. Many of the patients treated by hospitals, the supplies provided to patients in hospitals, and numerous other goods and services, are paid for by the Medicare program.[1] However, if the

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[1] The Medicare Program is a federal health insurance program for people age 65 or older, people under age 65 with certain disabilities, and people of all ages with permanent kidney failure requiring dialysis or a kidney transplant. The Medicare Program has three parts: Part A Hospital Insurance covers hospice care, some

Centers for Medicare and Medicaid Services ("CMS") (or a private contractor working under contract to CMS), which administers the Medicare Program, decide the hospital owes the government for a prior overpayment, the Medicare Program arguably has the right to recoup the amount it believes it is owed by offsetting it against monies otherwise payable to the hospital. The hospital has the right to appeal the decision, but in the meantime, its cash flow could be reduced to a point where it cannot stay in business and provide its services to Medicare beneficiaries. The right to appeal CMS's decision is, in many instances, a meaningless right, because it takes years to proceed through the Medicare Program's appeals process. In the meantime, many hospitals risk being forced to close their doors during this time because they cannot pay their bills if Medicare does not pay them.

This Article addresses a unique jurisdictional issue that can shorten the time required to obtain judicial review of a CMS decision by going directly to federal bankruptcy court. Two bankruptcy court decisions from 2015, *In re Bayou Shores, SNF, LLC*[2] and *In re Nurses' Registry and Home Health Corp.*,[3] held that Medicare's jurisdictional bar under 42 U.S.C. § 405(h), which would otherwise prevent judicial review of CMS decisions prior to exhausting Medicare's appeals process, does not apply to federal bankruptcy courts. If bankruptcy courts continue to make this finding consistently (as this Article argues they should), then filing for bankruptcy would become an important option available to health care providers and suppliers to resolve disputes with CMS and the Medicare Program when they would otherwise go out of business absent the speedy resolution of these disputes. However, bankruptcy courts (as well as federal district courts and circuit courts of appeal) have debated this issue for more than thirty years and are not in agreement on the outcome.

This Article concludes that debtors in bankruptcy court are exempt from 42 U.S.C. § 405(h)'s exhaustion requirement because its plain language does not bar bankruptcy court jurisdiction prior to exhaustion—thus, bankruptcy courts do not have to wait. However, some language in § 405(h)'s "legislative

home health care, inpatient care in hospitals, and some care in skilled nursing facilities; Part B Medical Insurance covers physician care and outpatient care among other things; and Part C covers prescription drugs. CMS (formerly known as the Health Care Financing Administration), is a component of the United States Department of Health and Human Services. *See* Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (codified as amended at 42 U.S.C. §§ 1395 to 1395kkk-1).

[2] 525 B.R. 160, 166 (Bankr. M.D. Fla. 2014).

[3] 533 B.R. 590, 593–94 (Bankr. E.D. Ky. 2015).

history"[4] has caused courts to ignore the statute's plain language in favor of trying to interpret what Congress meant when it passed § 405(h). This analysis is flawed; § 405(h)'s plain language should govern its interpretation and application. Part I of this Article discusses § 405(h)'s background and legislative history. Part II outlines the current state of the Medicare appeals process, noting the delays that plague the system. Part III discusses the requirement that the proceedings "arise under" the Medicare Act. Part IV analyzes the analytical framework in which § 405(h) has been interpreted and concludes that § 405(h)'s plain language, not its legislative history, should govern its application.

I. BACKGROUND ON 42 U.S.C. § 405(h) AND ITS ANALYTICAL FRAMEWORK: MEDICARE'S JURISDICTIONAL BAR ABSENT EXHAUSTION OF ADMINISTRATION REMEDIES

A. Section 405(h) and Its Legislative History

The Social Security Act requires exhaustion of administrative remedies prior to judicial review through 42 U.S.C. §§ 405(g) and (h), and this requirement specifically applies to the Medicare Act—which itself has been described by courts as one of the "most completely impenetrable texts within human experience"[5]—via 42 U.S.C. §§ 1395ii (incorporating § 405(h)) and 1395ff(c) (incorporating § 405(g)).[6] The relevant provisions state:

> **42 U.S.C. § 405(g) Judicial Review**
>
> Any individual, after any final decision of the Commissioner . . . may obtain a review of such decision by a civil action. . . . The court shall

[4] In 1984, § 405(h) was amended by the Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2663(a)(4)(D), 98 Stat. 1162. The language cited to by courts to read beyond § 405(h)'s plain language is contained in the Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2664(b), 98 Stat. 1162. Because § 2664(b) is itself legislation, it cannot be "legislative history." The analysis courts must employ when considering § 2663 in conjunction with § 2664 is that of statutory construction, and not legislative intent. Be that as it may, this Article uses the "legislative history" label to refer to arguments based on § 2664(b) to mirror the language, however imprecise, used by the courts.

[5] Cooper Univ. Hosp. v. Sebelius, 636 F.3d 44, 45 (3d Cir. 2010) (internal quotation marks and citations omitted).

[6] *See also* 42 U.S.C. § 1395oo(f) (West Supp. 1977) (added in 1974). Generally, the concept of requiring exhaustion of administrative remedies provides that a party is not entitled to judicial relief unless and until available administrative remedies have been exhausted. Myers v. Bethlehem Shipbuilding Corp., 303 U.S. 50–51 (1938). The doctrine of exhaustion of administrative remedies is applicable in bankruptcy cases. *See, e.g.*, *In re* Cottrell, 213 B.R. 33 (M.D. Ala. 1997) (discussing statutory and non-statutory exhaustion).

> have power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Commissioner . . . with or without remanding the cause for a rehearing. . . . The judgment of the court shall be final except that it shall be subject to review in the same manner as a judgment in other civil actions.
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> **42 U.S.C. § 405(h) Finality of Commissioner's Decision**
>
> The findings and decision of the Commissioner . . . after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision . . . shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, . . . or any officer or employee thereof shall be brought under § 1331 or 1346 of title 28 to recover on any claim arising under this subchapter.[7]

Absent a final decision by the applicable administrative body, federal courts cannot take jurisdiction over a disputed issue arising under the Social Security or Medicare Acts. The concept underlying this requirement is that a party is not entitled to federal judicial relief unless and until available administrative remedies have been exhausted.[8] The question then becomes whether such a jurisdictional limitation applies only to those suits brought pursuant to 28 U.S.C. §§ 1331 and 1336, or if § 405(h) applies to other federal jurisdictional grants, including the bankruptcy courts' jurisdictional grant in 42 U.S.C. § 1334.

Section 405 was enacted in 1939 as part of the Social Security Act.[9] At that time, it barred jurisdiction under 28 U.S.C. § 41.[10] Section 41 contained

[7] 42 U.S.C. §§ 405(g), (h) (2015). In this discussion, we address an instance where the exhaustion requirement is based on a statute. There are cases, however, where courts have required parties to exhaust their administrative remedies based on the court's discretion, rather than a statute. In such cases requiring the exhaustion of administrative remedies, it is generally thought to encourage more economical and less formal means of dispute resolution, as well as to promote efficiency. *See generally* Stephens v. Pension Benefit Guar. Corp., 755 F.3d 959, 964–66 (D.C. Cir. 2014) (discussing ERISA).

[8] *See generally Myers*, 303 U.S. at 50–51.

[9] 42 U.S.C. § 405(h) (Supp. V 1939); BP Care, Inc. v. Thompson, 398 F.3d 503, 515 n.11 (6th Cir. 2005). *See* Pub. L. No. 76-379, § 205(h), 53 Stat. 1360, 1371 (1939) (amendment to Social Security Act adding jurisdictional bar now found at 42 U.S.C. § 405(h)).

[10] In 1939, 42 U.S.C. § 405(h) stated:

> 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 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 41 of Title 28 to recover on any claim arising under sections 401–09 of this chapter.

twenty-eight sub-sections that granted the United States district courts "original jurisdiction" over various types of claims, including, in sub-section 19, "all matters and proceedings in bankruptcy."[11] In 1948, when Congress revised the U.S. Code, it extracted these jurisdictional grants from § 41 and re-codified some of them as 28 U.S.C. §§ 1331 to 1348, 1350 to 1357, 1359, 1397, 2361, 2401, and 2402.[12] The re-codification included numerous substantive changes, such as removing the designation of a married woman as "disabled" for the purpose of tolling of the statute of limitations for her to bring a claim against the United States government.[13] Although Congress re-wrote § 41, it did not correspondingly update § 405(h), which maintained its reference to § 41 for the next three decades. As such, § 405(h) was applied as though it referred to all of the jurisdictional grants that previously existed in § 41, largely due to the proposition in the 1975 Supreme Court decision *Weinberger v. Salfi* that the 1948 re-codification of 28 U.S.C. § 41 "caused no substantive change in the coverage of [§ 405(h)'s] jurisdictional bar."[14]

In 1976, one year after the *Weinberger* decision, the Office of Law Revision Counsel[15] revised § 405(h) by removing its reference to 28 U.S.C. § 41 and replacing it with references to 28 U.S.C. §§ 1331 (federal question jurisdiction) and 1346 (suits against the United States).[16] Seemingly (and to at least one court, "clearly"), these were the only jurisdictional grants the Office

See also BP Care, Inc., 398 F.3d at 515 n.11.

[11] 28 U.S.C. § 41 (1946), 36 Stat. 1091, 1093 (1911), 28 U.S.C. § 41(19) (1934).

[12] Pub. L. No. 80-773, 62 Stat. 869, 930–35 (1948); 28 U.S.C. §§ 1331–1348, 1350–1357, 1359, 1397, 2361, 2401, 2402 (1952); *see also In re* St. Mary Hosp., 123 B.R. 14, 17 (E.D. Pa. 1991). Absent from the re-codification was, for example, § 41(4)'s grant of original jurisdiction in the federal district courts for "all suits arising under any law relating to the slave trade." 28 U.S.C. § 41(4) (1946).

[13] *Compare* 28 U.S.C. § 41(20) (1946) ("The claims of married women, first accrued during marriage . . . entitled to the claim, shall not be barred if the suit be brought within three years after the disability has ceased . . . ."), *with* 28 U.S.C. § 2401 (1952) ("The action of any person under legal disability or beyond the seas at the time the claim accrues may be commenced within three years after the disability ceases.").

[14] *In re* Nurses' Registry & Home Health Corp., 533 B.R. 590, 594 (Bankr. E.D. Ky. 2015) (citing Weinberger v. Salfi, 422 U.S. 749, 756 n.3 (1975) ("The literal wording of this section bars actions under 28 U.S.C. § 41. At the time § 405(h) was enacted, and prior to the 1948 re-codification of Title 28, § 41 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 Social Security statutes.")).

[15] The Office of the Law Revision Counsel is part of the United States House of Representatives and publishes the United States Code. *See* 2 U.S.C. § 285(b) (2015). The United States Code contains the general and permanent laws of the United States.

[16] 28 U.S.C. §§ 1331, 1346; BP Care, Inc. v. Thompson, 398 F.3d 503, 515 n.11 (6th Cir. 2005).

of Law Revision Counsel believed were relevant to Medicare Act claims.[17] And so, after almost three decades, the Social Security Act caught up with and incorporated the changes in the Code pertaining to federal court jurisdiction.

Eight years later, in 1984, Congress expressly enacted the Law Revision Counsel's changes as part of the Deficit Reduction Act of 1984 ("DRA").[18] As part of the DRA, Congress enacted a provision entitled, "Effective Dates," which stated in sub-section (b) that:

> Except 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*.[19]

Some courts have found that this provision represents Congress's caution to the courts not to interpret § 2663's "technical corrections" as "substantive changes" to § 405(h).[20] In so doing, however, these courts have ignored § 405(h)'s facially limited applicability to §§ 1331 or 1346.[21]

B. Section 405(h)'s Purpose and Application

Section 405(h) serves two primary purposes. First, its rigorous enforcement is said to aid in and benefit from the development of the Secretary of Health and Human Services's expertise.[22] Second, it is intended to prevent "disgruntled" claimants from bringing actions in federal court instead of exhausting their remedies with the agency.[23]

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[17] *Nurses' Registry*, 533 B.R. at 594 ("Clearly the Office of Law Revision Counsel believed that these grants of jurisdiction were the only ones relevant to SSA or Medicare Act claims.").

[18] Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2663(a)(4)(D), 98 Stat. 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 . . . .'"). Changes to a statute by the Law Revision Counsel are not binding absent enactment by Congress.

[19] Deficit Reduction Act § 2664(b) (emphasis added).

[20] *E.g.*, *In re* St. Mary Hosp., 123 B.R. 14, 17 (E.D. Pa. 1991).

[21] *See* Midland Psychiatric Assocs., Inc. v. United States, 145 F.3d 1000, 1004 (8th Cir. 1998) (applying a jurisdictional bar in a case invoking 28 U.S.C. § 1332); Bodimetric Health Servs., Inc. v. Aetna Life & Cas., 903 F.2d 480, 488–89 (7th Cir. 1990) (applying a jurisdictional bar in a case invoking 28 U.S.C. § 1332); Total Renal Labs., Inc. v. Shalala, 60 F. Supp. 2d 1323, 1331 (N.D. Ga. 1999) (applying a jurisdictional bar in a case invoking 28 U.S.C. § 1361).

[22] *E.g.*, *St. Mary Hosp.*, 123 B.R. at 17.

[23] United States v. Tenet Healthcare Corp., 343 F. Supp. 2d 922, 926–27 (C.D. Cal. 2004).

With these purposes in mind, hundreds of courts, including dozens of bankruptcy courts, have analyzed the applicability of § 405(h) since the 1980s. During that time, courts have elaborated on the legal standard for determining whether § 405(h) applies to bar a court's jurisdiction. The first step in the analysis is to determine whether the claim "arises under" the Medicare Act.[24] If it does, the next step—and the question we address herein—is whether the claim falls within § 405(h)'s jurisdiction: "under § 1331 or 1346 of title 28."[25] As discussed in more detail below, one line of cases looks to § 405(h)'s legislative context and defines that jurisdictional grant broadly to include all forms of federal court jurisdiction, including bankruptcy jurisdiction under 28 U.S.C. § 1334;[26] the other line of cases reasons (correctly, in our view) that the plain language of § 405(h) only restricts judicial review prior to exhaustion for claims brought under 28 U.S.C. §§ 1331 and 1346.[27]

A claim "arises under" the Medicare Act when: (1) the "standing and substantive basis for the presentation" of the claim is the Medicare Act;[28] and (2) the claim is "inextricably intertwined" with a claim for Medicare benefits.[29] In evaluating whether a claim arises under the Medicare Act, courts have looked beyond whether the claim was allegedly brought under the Constitution, other federal statutes, or even state law, to find that the claim nevertheless arose under the Medicare Act because it was inextricably intertwined with the Medicare Act.[30] Courts have also "refused to treat the remedy sought as dispositive of the 'arising under' question."[31] In essence, the issue as to whether a claim "arises under" the Medicare Act is very broadly interpreted.[32]

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[24] 42 U.S.C. § 405(h) (2015); *see also* Quinones v. United Health Grp. Inc., No. 14-00497, 2015 WL 3965961, at *4 (D. Haw. June 30, 2015); Nat'l Ass'n for Home Care & Hospice, Inc. v. Burwell, 77 F. Supp. 3d 103, 109 (D.D.C. 2015); *In re* St. Johns Home Health Agency, Inc., 173 B.R. 238, 244–45 (Bankr. S.D. Fla. 1994).

[25] *E.g.*, *Bodimetric Health Servs.*, 903 F.2d at 488.

[26] *E.g.*, Nicole Med. Equip. & Supply, Inc. v. TriCenturion, Inc., No. 10-389, 2011 WL 1162052, at *14 n.24 (E.D. Pa. Mar. 28, 2011).

[27] *E.g.*, *In re* Town & Country Home Nursing Servs., Inc., 963 F.2d 1146, 1155 (9th Cir. 1991).

[28] Do Sung Uhm v. Humana, Inc., 620 F.3d 1134, 1141 (9th Cir. 2010) (quoting Heckler v. Ringer, 466 U.S. 602, 615 (1984)).

[29] *Id*.

[30] *See id.* at 1141–42.

[31] *Id.* at 1142.

[32] Shalala v. Ill. Council on Long Term Care, Inc., 529 U.S. 1, 14 (2000) ("Claims for money, claims for other benefits, claims of program eligibility, and claims that contest a 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

If a claim both arises under the Medicare Act and falls within § 405(h)'s jurisdictional bar, a court may not review the claim unless it has received a final decision from the Secretary.[33] This finality requirement has two elements. First, it has a non-waivable requirement that the claim has been "presented to" the Secretary.[34] Second, it has a waivable requirement that the Secretary's administrative remedies have been "exhausted," commonly known as the "exhaustion requirement."[35] Determining whether the exhaustion requirement can be waived in any case is not "mechanical" and should be "guided by" the exhaustion requirement's underlying policies.[36] Instead, and after the claim has been "presented to" the Secretary, courts analyze three factors from the Supreme Court's decision in *Mathews v. Eldridge* to determine if the exhaustion requirement should be waived: (1) whether the claim is "collateral" to the demand for benefits, (2) whether exhaustion would be "futile," and (3) whether the plaintiff would suffer "irreparable harm" if required to navigate the agency's review process.[37] A claim is "collateral" when it challenges an agency policy and the outcome of the merits of that challenge does not impact the plaintiff's benefits award—in other words, "if [the claim] doesn't automatically increase benefits if successful."[38] Whether a claim is "futile" turns on its futility within the context of the Medicare system—in other words, whether favorable agency review could actually grant the plaintiff the relief sought.[39] Finally, "irreparable harm" results when any damage caused to the plaintiff by the delay awaiting final agency review cannot be remedied with money.[40] In addition to the *Eldridge* factors, courts will weigh the harm to the government and the purpose of the Medicare Act when determining whether to waive a plaintiff's exhaustion requirement.[41] For our purposes, however, we focus on the period before the *Eldridge* exhaustion review and consider

provisions. There is no reason to distinguish among them in terms of the language or in terms of the purposes of § 405(h).").

[33] *E.g.*, Nat'l Ass'n for Home Care & Hospice, Inc. v. Burwell, 77 F. Supp. 3d 103, 109 (D.D.C. 2015) (citing Mathews v. Eldridge, 424 U.S. 319, 326 (1976)).

[34] *E.g.*, *id*.

[35] *Id*.

[36] *Id.* (citing Bowen v. City of New York, 476 U.S. 467, 484 (1986)).

[37] Miller v. Burwell, No. 14-CV-4245, 2015 WL 2257278, at *4 (N.D. Ill. May 11, 2015) (citing Mathews v. Eldridge, 424 U.S. 319, 330 (1976); Martin v. Shalala, 63 F.3d 497, 504 (7th Cir.1995)).

[38] *Miller*, 2015 WL 2257278, at *6.

[39] *Id.* at *7.

[40] *Id*. (quoting Shalala v. Ill. Council on Long Term Care, Inc., 529 U.S. 1, 13 (2000)).

[41] *E.g.*, V.N.A. of Greater Tift Cty. v. Heckler, 711 F.2d 1020, 1032 (11th Cir.1983), *cert. denied* 466 U.S. 936 (1984).

whether § 405(h) applies to bar a bankruptcy court's jurisdiction prior to exhaustion in the first place.

II. THE CURRENT STATE OF MEDICARE CLAIMS DISPUTES PROCESS AND APPEALS

A. Steps in the Medicare Appeals Process

There are several ways a hospital can become involved in a Medicare dispute. First, Medicare could deny a hospital's claim or a group of claims. Second, Medicare could review a hospital's annual cost report and decide the hospital was overpaid. And third, Medicare could suspend payments due to concerns about a hospital's billing practices, including allegations of fraud.

Regarding the first avenue, the Medicare appeals process for a denied hospital claim contains five distinct steps. Medicare contractors, under the supervision of CMS, conduct the first two levels of review.[42] First, the hospital could ask the Medicare Administrative Contractor ("MAC") (also referred to as a "fiscal intermediary" ("FI")) that actually denied its claims or declared the overpayment to "redetermine" its decision. Initial submitted claims are usually quite rudimentary, but to commence the redetermination the hospital has to compile documents that support its claim and file the appeal within 120 days of the denial.[43] If that redetermination is denied (the MAC has 60 days to act), the hospital has 180 days to file for reconsideration to the Qualified Independent Contractor ("QIC").[44] If this appeal is denied (the QIC has 60 days to decide), the hospital can appeal to an administrative law judge ("ALJ") who operates under the supervision of the Office of Medicare Hearings and Appeals ("OMHA").[45] If the ALJ decides against the hospital, the next level of appeal is the Medicare Appeals Council of the Departmental Appeals Board ("DAB").[46] The DAB decision is the "final decision" referenced in § 405(g),

[42] Courts have not allowed suits against these private contractors to proceed as a way to avoid the jurisdictional bar to suing the federal agency (CMS) itself. *See, e.g.*, Bodimetric Health Services, Inc. v. Aetna Life & Cas., 903 F.2d 480, 487–88 (7th Cir. 1990). This is because Medicare contractors are merely conduits for payment and have no vested interest in the Medicare funds they administer. 42 U.S.C. § 1395kk-1(a)(4)(A), (B) (2015).

[43] 42 C.F.R. § 405.942(a) (2015).

[44] 42 C.F.R. § 405.962(a).

[45] 42 C.F.R. § 405.1000.

[46] 42 C.F.R. § 405.1100.

so that only after the DAB decides can a federal court have jurisdiction over the matter in dispute.[47]

Another avenue a hospital may take through the Medicare appeals process is based on a review of a hospital's cost report. At the end of a hospital's fiscal year, it files a "cost report" that describes the actual claims submitted during that year. A MAC or FI reviews the cost report and makes an initial determination of whether the hospital was overpaid or underpaid during the cost year.[48] If the hospital was overpaid, the MAC or FI will issue a notice of overpayment, and if payment is not forthcoming, may recover the overpayment through recoupment of outgoing payments. The MAC or FI subsequently performs a full audit of the cost report and issues a Notice of Program Reimbursement ("NPR"), which is the MAC's final determination as to the alleged overpayment.[49] The MAC has seven years to issue the NPR, however, and thus the process can be lengthy. The hospital may appeal an adverse NPR to the Provider Reimbursement and Review Board ("PRRB"),[50] and it is only after receiving a PRRB decision that a hospital may obtain judicial review of an adverse NPR in federal district court.[51]

Finally, if there are questions about a hospital's claims against Medicare, the Medicare Program can institute administrative measures, such as a prepayment review of claims or a suspension of payments, which may result in delayed, smaller, or even the absence of payments to the hospital.[52] If a payment suspension is initiated, the hospital can submit a rebuttal that the CMS or the MAC reviews. A suspension is generally not appealable, but once a determination of an overpayment is made, the same appeals process for denied claims (described above) applies.

So, naturally, the question is "how long does all this take?" The answer: it can be a really long time.[53] Why? Because review at the ALJ level is broken.

[47] Review by the DAB is discretionary, and if it decides to review the ALJ decision, the ALJ decision becomes the "final" decision.

[48] 42 C.F.R. § 413.20.

[49] 42 C.F.R. § 405.1803.

[50] The PRRB reviews costs reports and handles "provider" payment disputes that are not claims related. MACs also review "claims" including "supplier" claim payment issues. (Suppliers are not providers, so MACs use a different process for claims payment issues). Providers also use the ALJ process for claims disputes.

[51] 42 U.S.C. § 1395oo(a) (2015); 42 C.F.R. § 405.1835.

[52] 42 C.F.R. §§ 405.370–75. As a general rule, suspensions are limited to 180 days, with a possible one-time 180-day extension. However, there are some exceptions that allow longer suspensions.

[53] The average processing time for appeals decided by the OMHA in fiscal year 2015 was 547.1 days, a number that may be underreporting the problem because an increasing number of appeals in 2015 also created

The OMHA is currently staffed to handle approximately 72,000 claims on appeal in a year. However, as of July 1, 2014, it had over 800,000 claims pending on appeal and was getting an additional 10,000 to 16,000 claim appeals per week (while it can only dispose of approximately 1,300 claims per week).[54] The situation is so bad that as of June 2015, Medicare offered to settle over 300,000 appeals based on inpatient claims for sixty-eight cents on the dollar.[55]

B. A Hospital's Dilemma

As discussed above, a hospital's appeals process can take a long time. And once the QIC's decision is made, CMS can institute recoupment[56] against the hospital's ongoing payments (and while the ALJ decision is pending). Although the hospital will be repaid if it later prevails in the appeals process, this creates a potentially fatal dilemma. On the one hand, the hospital must exhaust the administrative process before appealing the Medicare Program's decision in federal district court. Yet, the delay associated with exhausting the administrative process could put the hospital out of business by reducing the hospital's cash flow to a point where it could not continue to operate pending the administrative decision. Thus, the hospital's only viable option may be to eschew the administrative process by filing for bankruptcy. Bankruptcy courts, in turn, have been wrestling with the issue of whether they have jurisdiction over this type of matter for decades.

III. SECTION 405(h)'S APPLICATION IN BANKRUPTCY CASES

Although 28 U.S.C. § 1334 provides the statutory basis for bankruptcy courts' jurisdiction and expressly makes that jurisdiction "exclusive,"[57] courts

a 20–24 week delay in even docketing new requests into OMHA's case processing system. *Adjudication Timeframes*, OFFICE OF MEDICARE HEARINGS AND APPEALS, http://www.hhs.gov/omha/important_notice_regarding_adjudication_timeframes.html (last visited December 21, 2015).

[54] *Office of Medicare Hearings and Appeals Workloads: Hearing on Exploring Medicare Appeal Reform Before the H. Comm. on Oversight & Gov't Reform & the Subcomm. on Energy Policy, Healthcare & Entitlements*, 113th Cong. (2014) (statement of Nancy J. Griswold, Chief A.L.J., Office of Medicare Hearings and Appeals), www.hhs.gov/asl/testify/2014/07/t20140710a.html (last visited on Feb. 13, 2015).

[55] *Inpatient Hospital Reviews*, CENTERS FOR MEDICARE & MEDICAID SERVICES (Sept. 23, 2015, 9:26 PM), https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/medical-review/inpatienthospitalreviews.html.

[56] Recoupment occurs when Medicare recovers an overpayment by withholding from ongoing payments to a provider.

[57] 28 U.S.C. § 1334 (2015) (emphasis added).

analyzing § 405(h) in the bankruptcy context are nevertheless split on whether its jurisdictional limitation to claims "brought under § 1331 or 1346 of title 28" also bars judicial review absent exhaustion under the bankruptcy jurisdictional grant, § 1334. The line of cases finding that bankruptcy cases do not fall under § 405(h) primarily rely on § 405(h)'s plain language (which is limited to §§ 1331 and 1346), as well as § 1334's grant of exclusive jurisdiction to the bankruptcy courts over the debtor's estate.[58] The line of cases holding that bankruptcy claims do fall within § 405(h)'s jurisdiction bar and require presentment and exhaustion to the Secretary before seeking judicial review primarily rely upon § 405(h)'s legislative context, which the courts argue implicitly cites to every jurisdictional grant contained in the former 28 U.S.C. § 41, and therefore includes bankruptcy jurisdiction.[59]

Outside of the bankruptcy context, courts are understandably less likely to find that parties are able to avoid § 405(h)'s jurisdictional bar. For example, courts have held that claims brought under mandamus jurisdiction (28 U.S.C. § 1361) and diversity jurisdiction (28 U.S.C. § 1332) are not excused from Medicare's exhaustion requirement.[60] Although § 405(h)'s plain language

[58] *E.g.*, *In re* Nurses' Registry & Home Health Corp., 533 B.R. 590, 595 (Bankr. E.D. Ky. 2015); *In re* Bayou Shores SNF, LLC, 525 B.R. 160, 166 (Bankr. M.D. Fla. 2014); *In re* Consol. Med. Transp., Inc., 300 B.R. 435, 445 (Bankr. N.D. Ill. 2003); *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); First Am. Health Care of Ga., Inc. v. U.S. Dep't of Health & Human Servs., 208 B.R. 985, 989 (Bankr. S.D. Ga. 1996), *vacated and superseded*, No. 96-2007, 1996 WL 282149 (Bankr. S.D. Ga. Mar. 11, 1996); *In re* Rusnak, 184 B.R. 459, 462–63 (Bankr. E.D. Pa. 1995); *In re* Healthmaster Home Health Care, Inc., No. 95-01031A, 1995 WL 928920, at *1 (Bankr. S.D. Ga. Apr. 13, 1995); *In re* Univ. Med. Ctr., Inc., 973 F.2d 1065, 1072 (3d Cir. 1992); *In re* Town & Country Home Nursing Servs., Inc., 963 F.2d 1146, 1155 (9th Cir. 1991); *In re* Shelby Cty. Healthcare Servs. of Ala., Inc., 80 B.R. 555, 559–60 (Bankr. N.D. Ga. 1987); *In re* Clawson Med., Rehab. & Pain Care Ctr., P.C., 9 B.R. 644, 648 (Bankr. E.D. Mich.), *rev'd*, 12 B.R. 647 (E.D. Mich. 1981).

[59] *E.g.*, *In re* Hodges, 364 B.R. 304, 306 (Bankr. N.D. Ill. 2007) (analyzing in the Social Security context); *In re* House of Mercy, Inc., 353 B.R. 867, 872 (Bankr. W.D. La. 2006); Excel Home Care, Inc. v. U.S. Dep't of Health & Human Servs., 316 B.R. 565, 572 (D. Mass. 2004); U.S. Dep't of Health & Human Servs. v. James, 256 B.R. 479, 481 (W.D. Ky. 2000); *In re* Hosp. Staffing Servs., Inc., 258 B.R. 53, 56 (S.D. Fla. 2000); *In re* Mid-Delta Health Sys., Inc., 251 B.R. 811, 816 (Bankr. N.D. Miss. 1999); *In re* Tri County Home Health Servs., Inc., 230 B.R. 106 (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* AHN Homecare, LLC, 222 B.R. 804, 812 (Bankr. N.D. Tex. 1998); *In re* Home Comp Care, Inc., 221 B.R. 202, 206 (N.D. Ill. 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, 119 (Bankr. W.D. Mo. 1991); *In re* St. Mary Hosp., 123 B.R. 14, 17 (E.D. Pa. 1991); *In re* Visiting Nurse Ass'n of Tampa Bay, Inc., 121 B.R. 114 (Bankr. M.D. Fla. 1990); *In re* Berger, 16 B.R. 236, 237–38 (Bankr. S.D. Fla. 1981); *Clawson*, 12 B.R. at 653.

[60] *E.g.*, BP Care, Inc. v. Thompson, 398 F.3d 503, 515 (6th Cir. 2005) (mandamus jurisdiction); Bodimetric Health Servs., Inc. v. Aetna Life & Cas., 903 F.2d 480, 488–89 (7th Cir. 1990) (diversity jurisdiction); Nicole Med. Equip. & Supply, Inc. v. TriCenturion, Inc., No. 10-389, 2011 WL 1162052, at *4

makes this reading strained, the outcome at least makes more sense in the context of mandamus and diversity jurisdiction because those jurisdictional grants are more susceptible to concealing a Medicare claim under the guise of another claim to improperly avoid going through the Medicare appeals process. And, more importantly, the parties employing mandamus or diversity statutes in a federal district court may not face the same potential fate as a hospital that has initiated bankruptcy proceedings: slow resolution of the claim by the Medicare appeals process could be that hospital's death knell. In short, debtors in bankruptcy courts fighting for their survival should be treated differently under the law.

A. Overview of § 405(h) Litigation in Bankruptcy Courts

1. In re Clawson Medical, Rehabilitation and Pain Care Center

Three cases capture the bulk of the substantive arguments employed in the analysis between § 405(h) and bankruptcy jurisdiction. Among the first cases to discuss the issue, 1981's *In re Clawson Medical, Rehabilitation and Pain Care Center*,[61] also happens to be among the most comprehensive. *Clawson* involved a Medicare service provider that sought the bankruptcy court's order enjoining Medicare from taking actions that would have "reduced the debtor's revenues below levels at which the business can be operated."[62] The *Clawson* court noted that this factual context was "becoming increasingly familiar to the courts," albeit not in the bankruptcy context.[63] The debtor alleged that the changes in its Medicare payments rendered the continuation of its business untenable and, combined with delays in the Medicare appeals review process, would cause it to cease operations.[64] The bankruptcy court granted the debtor's motion.[65]

The *Clawson* court first reasoned that the Bankruptcy Reform Act of 1978[66] gave the bankruptcy courts "exclusive jurisdiction of the debtor's

(E.D. Pa. Mar. 28, 2011) (diversity jurisdiction); Younes v. Burwell, No. 15-11225, 2015 WL 3556689, at *2 (E.D. Mich. Apr. 2, 2015) (diversity jurisdiction).

61 9 B.R. 644.

62 *Id.* at 646.

63 *Id*.

64 *Id*.

65 *Id.* at 649–50, 652.

66 Bankruptcy Reform Act of 1978, Pub. L. No. 95-598, 92 Stat. 2549 (codified at 11 U.S.C. § 301). At the time, the bankruptcy jurisdiction statute was 28 U.S.C. § 1471(e) (1978).

property."[67] This, in turn, authorized bankruptcy court jurisdiction over a debtor's estate and claims "irrespective of congressional statements to the contrary in the context of specialized legislation."[68] This jurisdiction included jurisdiction over issues the resolution of which would "have a considerable impact on the [debtor's] estate and on its prospects for effecting a successful reorganization."[69] Because such determinations were "crucial" to the administration of the debtor's estate, the *Clawson* court found it had jurisdiction over the debtor's claims, irrespective of the language of § 405(h).[70]

The *Clawson* court then went on to explain that § 405(h) did not bar its jurisdiction over the debtor's claims because it only applies "in disputes to which it is applicable."[71] And because § 405(h) did not expressly bar jurisdiction under what was then numbered 28 U.S.C. § 1471, it did not bar review of the debtor's Medicare claims.[72] Indeed, the court reasoned, "[s]uch omission has been found to permit review under other sections of Title 28[] and is *indicative of Congressional intent not to preclude jurisdiction*."[73] The court noted that the Bankruptcy Reform Act "extensively" amended the Bankruptcy Code but did not include a reference to the revised statute in § 405(h) and concluded that, "in the absence of 'clear and convincing evidence' of legislative intent to preclude or condition this Court's jurisdiction, no further barriers will be erected."[74] This reasoning was consistent with Congress's intent for revamping the Bankruptcy Code: eliminating the "frequent, time-consuming and expensive litigation of the question whether the bankruptcy court has jurisdiction of a particular proceeding."[75] One way to

[67] *Clawson*, 9 B.R. at 647. This authorizes bankruptcy court jurisdiction over a debtor's estate and claims "irrespective of congressional statements to the contrary in the context of specialized legislation." *See also In re* Town & Country Home Nursing Servs., Inc., 963 F.2d 1146, 1155 (9th Cir. 1991).

[68] *Clawson*, 9 B.R. at 647.

[69] *Id*.

[70] *Id.* at 647–48.

[71] *Id.* at 648.

[72] *Id*.

[73] *Id*. (citing White v. Mathews, 559 F.2d 852, 855–56 (2d Cir. 1977); Whitecliff, Inc. v. United States, 536 F.2d 347, 351 (Ct. Cl. 1976); Fox v. Harris, 488 F. Supp. 488 (D.D.C. 1980) (emphasis added), *rev'd*, 12 B.R. 647 (E.D. Mich. 1981); Ark. Soc'y of Pathologists v. Harris, CCH Medicare and Medicaid Guide, ¶ 30, 706 (E.D. Ark. 1980).

[74] *Clawson*, 9 B.R. at 648 (citing Johnson v. Robison, 415 U.S. 361, 373–74 (1974); Chelsea Comm. Hosp., SNF v. Mich. Blue Cross Ass'n, 630 F.2d 1131, 1132–36 (6th Cir. 1980); Wayne State Univ. v. Cleland, 590 F.2d 627, 632 (6th Cir. 1980)).

[75] *Clawson*, 9 B.R. at 648–49 (citing H.R. Rep. No. 95-595, at 45 (1977), *reprinted in* 1978 U.S.C.C.A.N. 6007).

accomplish such a goal was through a comprehensive jurisdictional grant to the bankruptcy courts over the debtor's estate and its corresponding claims.[76]

Finally, in the context of its preliminary injunction analysis, the *Clawson* court discussed in depth both (1) the harm the debtor would face if it were forced to stop operating because its Medicare payments were stopped and (2) that the Medicare review process took so long the debtor became unable to cover its operating expenses.[77] It found that, once shut down, the likelihood the debtor would be able to revive the business would be low, in part due to the "loss of goodwill" the debtor would suffer as a result.[78] Because revival would be unlikely, the debtor would be forced to liquidate, and the estate's value at liquidation would likewise have decreased in value due to the shutdown.[79] The *Clawson* court recognized (as courts regularly do in the trademark and intellectual property context, for example) that the value of lost goodwill would be "difficult if not impossible" to calculate and recover in monetary damages.[80] Moreover, shutting down would harm the debtor's patients and employees, who would be forced to seek out other facilities and jobs—an unnecessary toll on innocent parties, particularly if the debtor's claims were successful.[81] For all these reasons, the *Clawson* court determined the "best" reading of the statute was that it had jurisdiction over the debtor's Medicare claims.[82]

2. In re St. Johns Home Health Agency

The second case, decided nearly fifteen years later, was *In re St. Johns Home Health Agency*,[83] and there, the bankruptcy court came to a different conclusion. Faced with facts similar to *Clawson*, the *St. Johns* court declined to take jurisdiction over the debtor's Medicare claims in the bankruptcy court for three primary reasons. First, it found that the absence of reference to bankruptcy jurisdiction in § 405(h) was due to a scrivener's error, basing its conclusion on § 405(h)'s "legislative history," and thus bankruptcy jurisdiction

[76] *Id.* at 649.

[77] *Id.* at 650–52.

[78] *Id*. at 650.

[79] *Id*.

[80] *Id.* at 650–51; *see also* Dunkin' Donuts Franchised Rests. v. Elkhatib, No. 09 C 1912, 2009 WL 2192753, at *4 (N.D. Ill. July 17, 2009) (stating that loss of goodwill is impossible to quantify or reverse).

[81] *Clawson*, 9 B.R. at 651.

[82] *Id*.

[83] 173 B.R. 238, 242, 247–48 (Bankr. S.D. Fla. 1994). Sam Maizel, one of this Article's authors, represented the United States in *In re St. Johns Home Health Agency, Inc.*

was incorporated implicitly by reference.[84] Second, the court voiced concern that, if it did have jurisdiction, a hospital might use a bankruptcy filing as a "shortcut to judicial review" of a party's administrative claims.[85] Finally, and perhaps most surprisingly, the *St. Johns* court indicated that it did not matter whether, as a result of its ruling, the debtor would be unable to reorganize.[86]

3. In re Healthback

The third case is 1999's *In re Healthback*.[87] Like the court in *Clawson*, the court in *Healthback* also concluded that independent bankruptcy jurisdiction existed to cover the claim, that § 405(h)'s plain language does not include § 1346's bankruptcy jurisdictional grant, and that jurisdiction was supported by the purpose of the Bankruptcy Code because the debtor might cease to exist without its protection.[88]

The *Healthback* court also addressed three new arguments. First, it held that § 405(h)'s legislative history cautioning courts against reading a *substantive* change into the technical modifications is inapposite because § 405(h)'s jurisdictional grant is *procedural* in nature.[89] This argument is discussed in more detail in Section V below. Second, it rejected the Secretary's argument that it could not "judicial[ly] review" the debtor's Medicare claim.[90] According to the court, "judicial review" means "review of an administrative decision [in] an adjudicatory process to directly determine [its] legality."[91] Thus, "judicial review" is not what a bankruptcy court does; instead, bankruptcy courts "exercise jurisdiction over the property of the estate to ensure that all creditors are treated equally within the scope of the Bankruptcy

[84] *Id.* at 244; *see also* Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2664(b), 98 Stat. 1162.

[85] *St. Johns Home Health Agency, Inc.*, 173 B.R. at 243 ("[T]he possibility that its administrative remedy may not provide relief as quickly as St. Johns desires, or indeed may require to survive, is one of the potentially unfortunate consequences of doing business in a heavily regulated field where compensation is highly dependent upon administrative processes. . . . [P]roviders which [*sic*] choose to operate within the Medicare system on a cash-poor basis take a knowing risk that an intermediary's determination might delay payment, and their risk of being forced out of business alone does not justify a fundamental deviation from the statutory scheme[.]" (citing V.N.A. of Greater Tift Cty. v. Heckler, 711 F.2d 1020, 1034 (11th Cir.1983), *cert. denied* 466 U.S. 936 (1984))).

[86] 173 B.R. at 242, 243–44.

[87] 226 B.R. 464, 479 (Bankr. W.D. Okla. 1998), *vacated*, No. 97-22616, 1999 WL 35012949 (Bankr. W.D. Okla. May 28, 1999).

[88] *Id.* at 469–71, 473–74.

[89] *Id.* at 472–73.

[90] *Id.* at 469–70.

[91] *Id*.

Code."[92] That a bankruptcy court's administration of the debtor's estate might frustrate the Secretary's jurisdiction does not "constitute illegal interference" with the same.[93] Finally, the court rejected the Secretary's "primary jurisdiction doctrine" argument, which would require a judicial body to defer the decision-making process to the administrative agency's "special competence."[94] The *Healthback* court determined that the doctrine cannot be relied upon at the "whim" of a pleader and instead may only be invoked "if the benefits of obtaining the agency's aid would outweigh the need to resolve the litigation expeditiously."[95]

4. Other § 405(h) Arguments Analyzed in the Bankruptcy Context

Other arguments courts have considered when determining whether the § 405(h) jurisdictional bar applies in bankruptcy cases include: whether Medicare payments are themselves an asset in the debtor's estate,[96] whether a

92 *Id.* at 470.

93 *Id*.

94 *Id.* at 470–71 ("The doctrine of primary jurisdiction, generally, requires that where a matter has been placed under the authority and special competence of an administrative body, the courts should suspend judicial process until that administrative body has had the opportunity to address the issue in question.").

95 *Id.* at 471.

96 The commencement of a bankruptcy case creates a bankruptcy estate. 11 U.S.C. § 541(a)(1) (2012). Property of the estate includes "all legal or equitable interests . . . in property" held by the debtor "as of commencement of the case." *Id.* The phrase "legal or equitable interests" in property includes "every conceivable interest of the debtor, future, nonpossesssory, contingent, speculative, and derivative." *In re* Yonikus, 996 F.2d 866, 869 (7th Cir. 1993) (citation omitted). Although § 541(a) defines what interests of the debtor become property of the estate, applicable non-bankruptcy law, usually state law, determines the existence and scope of the debtor's interest in a particular asset as of commencement of the case. Butner v. United States, 440 U.S. 48, 55 (1979) ("Property interests are created and defined by state law."); McCarthy, Johnson & Miller v. N. Bay Plumbing, Inc. (*In re* Pettit), 217 F.3d 1072, 1078 (9th Cir. 2000). Thus, courts have held that the scope of § 541(a) includes "contingent future payments that were subject to a condition precedent on the date of bankruptcy." *In re* Bagen, 186 B.R. 824, 829 (Bankr. S.D.N.Y. 1995) (citing H.R. Rep. No. 595, 95th Cong., 1st Sess. 175–76 (1977)), *aff'd*, 201 B.R. 642 (S.D.N.Y. 1996). However, courts are split on whether government medical payments, such as Medicare or Medicaid, constitute "property." *Compare* Sulphur Manor, Inc. v. Burwell, No. CIV-15-250, 2015 WL 4409062, at *2 (E.D. Okla. July 20, 2015) (emphasis added) (quoting Geriatrics, Inc. v. Harris, 640 F.2d 262 (10th Cir. 1981)) ("*Medicaid* providers do not have a property right to continued enrollment as a qualified provider."), *with* First Am. Health Care of Ga., Inc. v. U.S. Dep't of Health & Human Servs., 208 B.R. 985, 990 (Bankr. S.D. Ga. 1996), *vacated and superseded*, No. 96-2007, 1996 WL 282149 (Bankr. S.D. Ga. Mar. 11, 1996) ("First American is entitled to bi-weekly PIPs because it continues to provide reimbursable services to Medicare beneficiaries under the Provider Agreements."). Section 541(c)(1)(A) of the Bankruptcy Code expressly states that any "interest of the debtor in property becomes property of the [debtor's] estate . . . notwithstanding any provision in an agreement . . . or applicable nonbankruptcy law that restricts or conditions transfer of such interest by the debtor." 11 U.S.C. § 541(c)(1)(A). Additionally, § 542(b) requires that "an entity that owes a debt that is property of the estate and that is matured, payable on demand, or payable on order, shall pay such debt to, or

debtor going out of business because its Medicare payments stopped and it could not appeal quickly enough to remain in operation will result in "precluding" review of the debtor's claims or merely "postpone" it,[97] whether the government will be harmed if it is not able to be the first to review and decide the debtor's claims,[98] and whether permitting such jurisdiction will encourage bankruptcy filings simply to avoid the agency's review process.[99]

In 2015, two significant bankruptcy court opinions involving the termination of Medicare payments and the bankruptcy court's jurisdiction in light of § 405(h) were issued: *In re Bayou Shores*[100] and *Nurses' Registry & Home Health Corp. v. Burwell*.[101] As discussed in more detail below, both found that the bankruptcy court's jurisdiction is not barred by § 405(h).

B. The In re Bayou Shores *Decisions*

1. The Facts of Bayou Shores

Bayou Shores involved a skilled nursing facility ("SNF") that was facing termination from the Medicare program, and, by extension, being forced to

on the order of, the trustee, except to the extent that such debt may be offset under section 553 of [the Bankruptcy Code] against a claim against the debtor." 11 U.S.C. § 542(b).

97 *See, e.g.*, Shalala v. Ill. Council on Long Term Care, Inc., 529 U.S. 1, 19 (2000).

98 *In re* Healthback, L.L.C., 226 B.R. 464, 472 (Bankr. W.D. Okla. 1998), vacated, No. 97-22616, 1999 WL 35012949 (Bankr. W.D. Okla. May 28, 1999) ("[A]dministrative inconvenience is not grounds for denying debtors their statutory rights, as a matter of due process. Thus, even though the exercise of this court's jurisdiction might cause administrative difficulties for the Department of Health and Human Services, these difficulties are not sufficient grounds for denying jurisdiction." (citing Frontiero v. Richardson, 411 U.S. 677, 690 (1973); Schlesinger v. Ballard, 419 U.S. 498, 506–07 (1975))); First Am. Health Care of Ga., Inc. v. U.S. Dep't of Health & Human Servs., 208 B.R. 985, 991 (Bankr. S.D. Ga. 1996), *vacated and superseded*, No. 96-2007, 1996 WL 282149 (Bankr. S.D. Ga. Mar. 11, 1996) ("If the relief sought by Parent and its providers is not granted, the Debtors are out of business, its approximately 15,000 employees will be out of work, and approximately 32,000 patients will be without, at least temporarily, needed home health care services. Conversely, the potential harm to the Defendants, if any, is completely pecuniary, does not affect people's health and well-being, is less immediate in effect, and more easily corrected at a later date than the sudden termination of health care services to infirm, disabled, or poor people.").

99 *Healthback*, 226 B.R. at 470, 474 (Bankr. W.D. Okla. 1998) ("[T]here is no indication that the debtor filed this bankruptcy case merely to circumvent the administrative requirements of 42 U.S.C. § 405 to obtain 'judicial review' of the withholding. . . . It seems highly improbable to this court that every home health care provider will declare bankruptcy for the purpose of avoiding the Medicare administrative requirements in response to this court exercising jurisdiction in this case.").

100 525 B.R. 160, 161 (Bankr. M.D. Fla. 2014). Although *In re Bayou Shores* presents interesting issues related to the automatic stay and executory contracts, among others, this Article will only discuss whether bankruptcy courts can be used to avoid fatal delay in obtaining judicial review of CMS's decisions.

101 533 B.R. 590 (Bankr. E.D. Ky. 2015).

close its doors.[102] The debtor operated a 159-bed SNF for patients with serious psychiatric conditions in St. Petersburg, Florida.[103] The vast majority—over 90 percent—of the debtor's revenue was derived from Medicare and Medicaid.[104] Between February and July of 2014, the debtor was cited on three separate occasions for noncompliance with Medicare Program requirements.[105] The debtor immediately cured the first two citations and CMS found the debtor to be in substantial compliance. Thereafter, the debtor also cured the third deficiency and hired an outside consultant to conduct a comprehensive review of the debtor's corrective measures.[106] Nevertheless, CMS did not visit the facility and instead elected to terminate the SNF's Medicare Provider Agreement.[107] Although the debtor appealed the decision to terminate, that appeal did not prevent CMS from denying payments.[108] On August 1, 2014, two days before the provider agreements were going to be terminated, the debtor filed a lawsuit in the District Court for the Middle District of Florida seeking an injunction to prohibit the termination of the provider agreement.[109] On the same day, the district court entered a temporary restraining order ("TRO") prohibiting the termination of the agreements until August 15, 2014.[110] However, once the government briefed the district court on the administrative exhaustion requirements described above, the district court dissolved the TRO.[111]

2. *The Bankruptcy Court's Decision Pertaining to Bankruptcy Jurisdiction over Medicare Matters*

Unable to pay its bills, the debtor filed a chapter 11 petition and sought an order preventing CMS from terminating the Medicare Provider Agreement between the debtor and the Medicare Program. The bankruptcy court granted that motion, and the debtor quickly filed a plan of reorganization and sought its confirmation. In its objection to confirmation, CMS argued that the bankruptcy court could not take jurisdiction over the Medicare disputes unless and until

102 *Bayou Shores*, 525 B.R. 160.
103 *Id.* at 161.
104 *Id.* at 162.
105 *Id.* at 163.
106 *Id.* at 164.
107 *Id*.
108 *Id*.
109 *Id*.
110 *Id.* at 164–65.
111 *See* Bayou Shores SNF, LLC v. Burwell, No. 8:14-cv-1849-T-33MAP, 2014 WL 4101761, at *8–10 (M.D. Fla. Aug. 20, 2014).

the debtor exhausted its administrative remedies, relying on the Medicare statutes described above. The bankruptcy court rejected that argument and confirmed the plan over CMS's objection.[112] The bankruptcy court ruled that it had jurisdiction because the plain language of § 405(h) did not restrict jurisdiction under 28 U.S.C. § 1334. The bankruptcy court referenced a similar decision in *First American Health Care of Georgia, Inc. v. HHS*,[113] although noting that this decision had been vacated because of a subsequent settlement between the parties.

3. The District Court's Decision Pertaining to Bankruptcy Jurisdiction over Medicare Matters

HHS appealed the bankruptcy court's order confirming the debtor's plan to the district court. The appeal of the confirmation order raised the jurisdictional issue of whether § 405(h) precluded the bankruptcy court from taking any action related to the Medicare Provider Agreement. In ruling on the appeals, the district court made several conclusions. First, "the bankruptcy court erred because as a matter of law 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."[114] Second, the bankruptcy court's decision that it had jurisdiction under § 1334 was in error because it ignored the jurisdictional bar provided for in the Medicare Act, and that "[t]he Bankruptcy Court exceeded its subject matter jurisdiction when it interfered with CMS termination of the provider agreements."[115] Third, that "[t]here 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) only after administrative remedies have been exhausted and the Secretary has issued a final agency decision."[116] The district court, therefore, ruled that the bankruptcy court lacked the jurisdiction because of the requirement for exhaustion of administrative remedies included in § 405(h).

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[112] Michael Nordskog, *Nursing Homes Chapter 11 Plan Ruled Feasible Despite Medicare Problems*, WESTLAW Bankruptcy Daily Briefing, Jan. 8, 2015, at 2015 WL 94779.

[113] 208 B.R. 985 (Bankr. S.D. Ga. 1996), *vacated and superseded*, No. 96-2007, 1996 WL 282149 (Bankr. S.D. Ga. Mar. 11, 1996).

[114] Fla. Agency for Health Care Admin. v. Bayou Shores SNF, LLC (*In re* Bayou Shores SNF, LLC), 533 B.R. 337, 340 (M.D. Fla. 2015).

[115] *Id.* at 341.

[116] *Id*.

4. Bayou Shores's Appeal

The debtor appealed the district court's ruling to the Eleventh Circuit Court of Appeals and moved to stay the termination of its Medicare payments pending the appeal. Although the Eleventh Circuit denied the stay, the district court granted it after Bayou Shores filed an emergency motion. In so holding, the district court noted:

> Bayou Shores presented ample evidence that absent a stay it and its patients, employees, and staff will suffer irreparable damage. The Court finds that if the stay is not continued, Bayou Shores will no longer be able to operate and will be forced to discharge its patients and terminate its staff. Notably, this evidence also relates to the public interest, an interest that is highly relevant here because it involves the patients and their family.
>
> ***
>
> Medicare and Medicaid are required under both federal and state law to pay for the care of Bayou Shores' patients regardless of where they reside, whether it be at Bayou Shores or at any other nursing home.[117]
>
> ***
>
> As Bayou Shores noted, *there is a significant factor of human dignity at issue here that this Court cannot ignore*. Bayou Shores' patients are comfortable, they know the staff, they have the same routines, and they retain some dignity and independence from this comfort and familiarity. It would be *draconian* to disrupt their dignity based on a jurisdictional debate that has resulted in significant contrary opinions among the circuit courts and the lower courts.[118]

Curiously, the district court highlighted the very policy reasons for permitting the speedy resolution of a debtor's Medicare disputes in a bankruptcy court, rather than through the Medicare appeals process, which would similarly cause providers to shutter their doors and harm their patients.

The case is currently pending in the Eleventh Circuit.

[117] *In re* Bayou Shores SNF, LLC, No. 8:14-BK-9521-MGW, 2015 WL 6502704, at *2 (M.D. Fla. Oct. 27, 2015).

[118] *Id*. at *3 (emphasis added).

C. The Nurses' Registry & Home Health Corp. *Decision*

In *Nurses' Registry & Home Health Corp. v. Burwell*, the bankruptcy court granted the debtor's emergency motion for preliminary injunction and temporary restraining order enjoining the suspension of debtor's Medicare payments.[119] The government filed a motion to stay pending appeal.[120] In reviewing the defendants' motion, the bankruptcy court analyzed § 405(h)'s jurisdictional bar in the context of the "likelihood of success" factor of the preliminary injunction standard.[121]

The *Nurses' Registry* court ultimately held that the government had a very low likelihood of success on the merits of its jurisdictional arguments on appeal, and in so doing expressly rejected the "legislative history" line of cases.[122] To begin, the bankruptcy court held that the debtor fell within an exception to § 405(h)'s jurisdictional bar because waiting for the Medicare review process to finish would have caused the debtor to "become defunct" and resulted in "no judicial review of its claims."[123] The bankruptcy court then turned to the legislative history arguments. First, the bankruptcy court held that, even if the change in § 405(h) from § 41 to §§ 1331 and 1346 was a "scrivener's error," the court did not have the power to correct that error and enforce § 405(h) as barring all of § 41's jurisdictional grants, including bankruptcy.[124] Second, the bankruptcy court noted that:

> [A]t least several of the technical amendments Congress enacted in the DRA made undeniably substantive changes to Social Security and Medicare, belying Congress's blanket assertion that none of the technical amendments were intended to affect any preexisting rights or interpretations, and thus, the suggestion to the contrary in the legislative history could not be given credence.[125]

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119 533 B.R. 590, 591 (Bankr. E.D. Ky. 2015).

120 *Id*.

121 *Id.* at 592.

122 *Id.* at 592–93, 594–96.

123 *Id.* at 593 ("Had this Court waited for the Medicare process to play itself out while Medicare continued to suspend payments, the Debtor would have become defunct, and the Debtor would never have been heard on its request for turnover. Thus, channeling the Debtor's claims through the agency would mean no judicial review of its claims at all.").

124 *Id.* at 595 ("If Congress hoped to bar all federal jurisdiction over unexhausted Medicare claims but mistakenly believed it could do so by only barring § 1331 and § 1346 jurisdiction, this Court cannot correct their mistake.").

125 *Id.* at 595–96.

The *Nurses' Registry* court highlighted, as an example, the repealing of "an entire title of the SSA, Title XIII, which provided a program of unemployment benefits for federal seamen," and noted that, "[i]f the DRA's technical amendments truly did not 'chang[e] or affect[ ] any right,' the Reconversion Unemployment Benefits for Seamen program is still federal law."[126]

As discussed in more detail below, the interpretation and application of § 405(h) by the courts in *Bayou Shores* and *Nurses' Registry* should be more widely followed, while the so-called legislative history rationale should be abandoned. If Congress does not want to provide bankruptcy courts with jurisdiction over pre-exhaustion review of a debtor-hospital's Medicare claims, it should so legislate.

IV. SECTION 405(h)'S "ARISING UNDER" JURISDICTION

For § 405(h) to prevent a court from exercising jurisdiction over a hospital's Medicare appeal, three conjunctive elements must be satisfied: (1) the claims must arise under the Medicare Act, (2) the party must be seeking "judicial review," and (3) the action must be brought under 28 U.S.C. §§ 1331 or 1346.[127] However, the Bankruptcy Code has its own jurisdictional statute that confers *exclusive* jurisdiction to the district and bankruptcy courts over cases "arising under" the Bankruptcy Code and involving the debtor's property.[128] The Bankruptcy Code's exclusive jurisdictional grant, combined with its fundamental purpose of providing debtors with an opportunity to have a "fresh start," makes it clear that it—and not the Medicare Act—should govern who determines a debtor's disputes with Medicare.

Claims "arise under" the Medicare Act when their resolution is "inextricably intertwined" with benefits determinations[129] and when their "standing and substantive bas[e]s" are created by the Medicare Act.[130] In a

126 *Id.* at 596; *see also* discussion *infra* at note 225.

127 42 U.S.C. § 405(h) (2015); *In re* Healthback L.L.C., 226 B.R. 464, 470 (Bankr. W.D. Okla. 1998), *vacated*, No. 97-22616, 1999 WL 35012949 (Bankr. W.D. Okla. May 28, 1999).

128 28 U.S.C. §§ 1334(a), (b) & (e) (2015).

129 Heckler v. Ringer, 466 U.S. 602, 621–24 (1984).

130 Weinberger v. Salfi, 422 U.S. 749, 760–61 (1975); *see also In re* St. Johns Home Health Agency, Inc., 173 B.R. 238, 244 (Bankr. S.D. Fla. 1994) (quoting V.N.A. of Greater Tift Cty. v. Heckler, 711 F.2d 1020, 1025 (11th Cir.1983), *cert. denied* 466 U.S. 936 (1984)) ("The central target of § 405(h) preclusion is 'any action envisioning recovery on any claim emanating from' the Medicare Act."). Courts will not indulge "cleverly concealed claims for benefits" that, by means of a sort of artful pleading, attempt to mask a Medicare benefits claim behind some other cause of action. Quinones v. UnitedHealth Grp. Inc., No. CIV. 14-00497 LEK, 2015 WL 3965961, at *3 (D. Haw. June 30, 2015).

vacuum, it would appear obvious that a hospital seeking to continue its Medicare payments after a CMS termination would "arise under" the Medicare Act.[131] But when a hospital becomes a debtor, the analysis changes.

To begin, although § 405(h) is said to prohibit a court's "judicial review" of Medicare decisions, a bankruptcy court exercising jurisdiction over a debtor's estate is not "judicial review" of a Medicare Program decision, but is rather an effort to ensure the debtor's creditors are treated fairly under the Bankruptcy Code.[132] Thus, the proper view of a bankruptcy court's jurisdiction is that of administering the debtor's estate (which may include Medicare payments owed to the debtor) and not a debtor's improper evasion of the Medicare appeals process.[133] This conclusion is supported by the very fact that the question arises before a bankruptcy court by a debtor; if an otherwise *solvent* hospital wanted merely to challenge a Medicare decision prior to exhaustion, it would only be able to do so in a federal district court and would not have to file, among other things, a first day declaration[134] to explain that it is unable to service its debts.[135]

The Bankruptcy Code's "arising under" jurisdictional grant should also trump the Medicare Act's jurisdictional grant because ignoring the former when the cessation of Medicare payments is at issue would frustrate the Bankruptcy Code's purpose.[136] The same fundamental frustration does not exist, however, if the Medicare Act's jurisdiction is superseded by a bankruptcy court. The courts that have found Medicare's jurisdictional bar controlling have done so in the context of the legislative history argument,[137]

131 *E.g.*, Timberlawn Mental Health Sys. v. Burwell, No. 3:15-CV-2556-M, 2015 WL 4868842, at *3 (N.D. Tex. Aug. 13, 2015) (In the context of a motion for a temporary restraining order, the court held that "[the Hospital's] claims arise under the Medicare Act because the Hospital seeks to continue its participation in the Medicare program pending an administrative appeal of CMS's termination decision.").

132 *Healthback*, 226 B.R. at 469–70.

133 *Id*.

134 "It is typical (particularly in large bankruptcy cases) for a debtor to file declarations or affirmations in support of the first day motions. These declarations [generally are signed] by the debtor's senior management, [and] give the trade creditor important information about the facts and circumstances leading to the bankruptcy filing, as well as a preliminary road map for where the case is headed. It will also highlight significant issues that may impede the efforts to reorganize." Jeffrey Baddeley, *Managing Trade Credit to Struggling Companies*, CORP. FIN. REV., May/June 2013, at 16, 19.

135 *See Healthback*, 226 B.R. at 470.

136 Courts should be reluctant to interpret a statute in a way that frustrates its purpose. *See* King v. Burwell, 135 S. Ct. 2480, 2484 (2015) ("Here, the [Affordable Care Act's] statutory scheme compels us to reject petitioner's interpretation because it would destabilize the individual insurance market in any State with a Federal Exchange, and likely create the very 'death spirals' that Congress designed the Act to avoid.").

137 *E.g.*, *In re* Hosp. Staffing Servs., Inc., 258 B.R. 53, 56 (S.D. Fla. 2000).

but that argument presumes—without support—that in the same breath Congress also intended to exclude a class of debtors (those who rely on Medicare payments to remain solvent) from bankruptcy protection.[138] If a hospital relies on Medicare payments to survive and those Medicare payments stop, the hospital shuts down, and the effects ripple throughout its patients, service providers, and staff.[139] To prevent such a (potentially unnecessary) result, the Bankruptcy Code exists to provide distressed businesses "breathing space" in which they can reorganize with assistance from the bankruptcy courts.[140] This is why bankruptcy (and district) courts have broad and exclusive jurisdiction over debtors and their assets and liabilities—without which external entities, including governmental entities such as CMS, would be able to interfere with the restructuring process and impinge on a debtor's breathing space. Indeed, such interference is expressly prohibited by protections like the automatic stay, which pauses all litigations pending against a debtor, and is a protection that would be rendered meaningless if Medicare jurisdiction governed a debtor's dispute with Medicare because the debtor

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[138] *See* First Am. Health Care of Ga., Inc. v. U.S. Dep't of Health & Human Servs., 208 B.R. 985, 990 (Bankr. S.D. Ga. 1996), *vacated and superseded*, No. 96-2007, 1996 WL 282149 (Bankr. S.D. Ga. Mar. 11, 1996) ("First American is entitled to bi-weekly PIPs because it continues to provide reimbursable services to Medicare beneficiaries under the Provider Agreements.").

[139] The factual background in U.S. *ex rel.* Sarasola v. Aetna Life Ins. Co., 319 F.3d 1292, 1296–97 (11th Cir. 2003) aptly sums up the series of events:

> The court denied St. Johns's motion in a written order dated September 23, 1994. It agreed with the Secretary that it lacked jurisdiction to entertain the motion because St. Johns had not exhausted its administrative remedies. Assuming that it had jurisdiction, the court added, it could not "grant effective relief . . . under 11 U.S.C. § 365 without fundamentally and impermissibly altering the contractual relationship between St. Johns and the Secretary which incorporates the statutory and administrative scheme imposed by the Medicare Program." *The court's decision was St. Johns's death knell*. On November 10, 1994, the court entered an order approving the sale of St. Johns's assets (except the above-mentioned lawsuit pending against the Secretary and CMS) to Amitan Health Services, Inc. On August 21, 1995, St. Johns moved the court to convert its Chapter 11 case to a Chapter 7 liquidation. The court granted its motion.

(emphasis added). *Accord* Livingston Care Ctr., Inc. v. United States, No. 89-40200-FL, 1990 WL 125000, at *1 (E.D. Mich. May 31, 1990), *aff'd*, 934 F.2d 719 (6th Cir. 1991) ("Plaintiff's status as *Medicaid* provider was automatically terminated as well, which resulted in extensive lost revenues to plaintiff and its eventual bankruptcy." (emphasis added)); *see also* Sulphur Manor, Inc. v. Burwell, No. CIV-15-250-RAW, 2015 WL 4409062, at *3 (E.D. Okla. July 20, 2015) (analyzing irreparable injury in a preliminary injunction motion); *Healthback*, 226 B.R. at 471 n.8; *First Am. Health Care of Ga.*, 208 B.R. at 989–90; *In re* Tidewater Mem'l Hosp., 106 B.R. 876, 880 (Bankr. E.D.Va. 1989) (analyzing the automatic stay).

[140] *See In re* Town & Country Home Nursing Servs., Inc., 963 F.2d 1146, 1155 (9th Cir. 1991) ("The language of section 1334(b) grants jurisdiction to the district court, and therefore to the bankruptcy court, over civil proceedings related to bankruptcy and accords with the intent of Congress to bring all bankruptcy-related litigation within the umbrella of the district court, at least as an initial matter, irrespective of congressional statements to the contrary in the context of other specialized litigation.").

would then be litigating its rights before both the bankruptcy court and the Medicare ALJs.[141]

Moreover, finding that the Bankruptcy Code's *exclusive* jurisdictional grant applies to a debtor's Medicare Program payments and disputes does not frustrate the purpose of the Medicare Act. To begin, the argument that it would negatively impact the Medicare ALJs' ability to gain expertise rings hollow.[142] Medicare ALJs have their hands full with Medicare appeals as it is, and bankruptcy judges are competent to the task of adjudicating a wide variety of legal claims—Medicare questions are no different.[143] In addition, relieving Medicare of its jurisdiction over this small subsection of its providers will not harm the Medicare Act's purpose. Medicare will continue to function as it normally does, and in fact, given the backlog of Medicare appeals, losing this jurisdiction may actually be a *relief* to a system that is already burdened to the breaking point.[144] Indeed, resolution of the dispute could happen both earlier and more expeditiously if administered by a bankruptcy judge, preserving the Medicare Program's scarce administrative resources.

Even if a court were to find that Medicare's jurisdictional grant trumps the Bankruptcy Code's, bankruptcy courts would still be the proper venue to resolve a debtor's Medicare disputes because § 405(h) does not apply to bar a bankruptcy court's jurisdiction.

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[141] *See, e.g.*, *In re* Univ. Med. Ctr., Inc., 973 F.2d 1065, 1073 (3d Cir. 1992); *In re* Rusnak, 184 B.R. 459, 462–63 (Bankr. E.D. Pa. 1995); *Tidewater Mem'l Hosp.*, 106 B.R. at 880 ("Here, however, the Government's action in apparent violation of the automatic stay provisions of § 362 could well prevent the debtor from having an opportunity for rehabilitation and reorganization. There is an urgency here which goes beyond the domain of Medicare law, and the doctrine of exhaustion of administrative remedies should not be allowed to frustrate the clearly stated goals of the Bankruptcy Code.").

[142] *In re* St. Mary Hosp., 123 B.R. 14, 17 (E.D. Pa. 1991) ("Moreover, a broad reading of section 405(h) puts its interpretation in accord with Congress' intent to permit the Secretary in Medicare disputes to develop the record and base decisions upon his unique expertise in the health care field.").

[143] *See, e.g.*, *Healthback*, 226 B.R. at 472 n.10 ("Under 11 U.S.C. § 105(a) the court has the power to issue any order[,] process[,] or judgment necessary or appropriate to execute the provisions of Title 11. In almost all bankruptcy cases, the creditors and parties are inconvenienced to some degree. This court perceives no reason why the Department of Health and Human Services should receive special consideration in this context."); *First Am. Health Care of Ga.*, 208 B.R. at 991 (observing that the government is actually better off if the debtor continues receiving its payments because that increases its chances of exiting bankruptcy and repaying the government).

[144] *Office of Medicare Hearings and Appeals Workloads: Hearing on Exploring Medicare Appeal Reform Before the H. Comm. on Oversight & Gov't Reform & the Subcomm. on Energy Policy, Healthcare & Entitlements*, 113th Cong. (2014) (statement of Nancy J. Griswold, Chief A.L.J., Office of Medicare Hearings and Appeals), www.hhs.gov/asl/testify/2014/07/t20140710a.html (last visited Feb. 13, 2015).

V. INTERPRETING MEDICARE'S JURISDICTIONAL BAR

A. Discussion of Plain Language Argument

It is hornbook law that unambiguous language in a statute is given its plain meaning: "[T]he plain, obvious, and rational meaning of a statute is always to be preferred to any curious, narrow, hidden sense that nothing but the exigency of a hard case and the ingenuity and study of an acute and powerful intellect would discover."[145]

1. The Plain Language of 42 U.S.C. § 405(h)

The words Congress wrote into law in § 405(h) only bar federal court jurisdiction if the dispute arises under 28 U.S.C. §§ 1331 or 1346; bankruptcy jurisdiction under 28 U.S.C. § 1334 is not referenced. The Supreme Court observed as much in *Heckler v. Ringer*, "The 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[,]"[146] and again in *Shalala v. Illinois Council on Long Term Care, Inc.*, "The statute [§ 405(h)] *plainly bars § 1331 review* . . . ."[147] The plain meaning of § 405(h)'s jurisdictional limitations has been adopted by both the Third[148] and Ninth Circuits,[149] as well as by numerous district[150] and bankruptcy courts,[151] and has

[145] Lynch v. Alworth-Stephens Co., 267 U.S. 364, 370 (1925); *see also* E.P.A. v. EME Homer City Generation, L.P., 134 S. Ct. 1584, 1600–01 (2014) (quoting Pavelic & LeFlore v. Marvel Entm't Grp., Div. of Cadence Industries Corp., 493 U.S. 120, 126 (1989)) ("[A] reviewing court's task is to apply the text of the statute, not to improve upon it."); Barnhart v. Sigmon Coal Co., 534 U.S. 438, 460 (2002); United States v. Ron Pair Enters., Inc., 489 U.S. 235, 242 (1989); *In re* Kolich, 328 F.3d 406, 409 (8th Cir. 2003) ("The plain meaning of legislation should be conclusive . . . .").

[146] 466 U.S. 602, 614–15 (1984) (emphasis added).

[147] 529 U.S. 1, 10 (2000) (emphasis added).

[148] *In re* Univ. Med. Ctr., Inc., 973 F.2d 1065, 1072 (3d Cir. 1992).

[149] *In re* Town & Country Home Nursing Servs., Inc., 963 F.2d 1146, 1155 (9th Cir. 1991).

[150] *E.g.*, Cal. Clinical Lab. Ass'n v. Sec'y of Health & Human Servs., No. 14-CV-0673, 2015 WL 2393571, at *10 (D.D.C. May 20, 2015).

[151] *In re* Nurses' Registry & Home Health Corp., 533 B.R. 590, 595 (Bankr. E.D. Ky. 2015); *In re* Bayou Shores SNF, LLC, 525 B.R. 160, 166 (Bankr. M.D. Fla. 2014); *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); First Am. Health Care of Ga., Inc. v. U.S. Dep't of Health & Human Servs., 208 B.R. 985, 989 (Bankr. S.D. Ga. 1996), *vacated and superseded*, No. 96-2007, 1996 WL 282149 (Bankr. S.D. Ga. Mar. 11, 1996); *In re* Healthmaster Home Health Care, Inc., No. 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, 560 (Bankr. N.D. Ga. 1987).

gone unchanged by Congress for over twenty years.[152] Although § 405(h) and § 1334 are "incongruous," it is not "absurd" to have a bankruptcy exception to Medicare's exhaustion requirement,[153] particularly in light of the harm that can arise to the debtor due to stopped Medicare payments during the lengthy Medicare review process.[154] Thus, courts should not "allow[] ambiguous legislative history to muddy clear statutory language."[155]

The Supreme Court recently addressed statutory construction in the health care context in *King v. Burwell*,[156] and the Court's analytical framework in both the majority's opinion and Justice Scalia's dissent (both of which capture the thrust of the Court's plain language doctrine) strongly support applying § 405(h) based on its plain language. In *King*, the Court was charged with interpreting the short phrase, "established by the State," in the Affordable Care Act, and the outcome of which would either preserve or undermine the entire statutory scheme.[157] The Court chose preservation because it was "implausible" that Congress would have written the term such that it would cause a "death spiral" and undermine the entire Affordable Care Act.[158] In so holding, the Court determined that although the words appeared clear on the surface, they became ambiguous when viewed in light of the entire statute.[159] The Court reasoned that, "the words of a statute must be read in their context and with a view to their place in the overall statutory scheme," and only then can they be deemed non-ambiguous and subject to enforcement based on their plain meaning.[160]

Here, neither the context of the Social Security Act nor the Medicare Act render § 405(h)'s jurisdictional grant over 28 U.S.C. §§ 1331 and 1346 ambiguous. This is because the structures of the acts and their pertinent sections do not include contradictory cross-references or jurisdictional terms that, if defined one way would undermine the entirety of either the Medicare or Social Security Acts. If anything, relieving the Medicare Program of some of its appellate review jurisdiction and placing it with the bankruptcy courts for

152 *In re* Nurses' Registry & Home Health Corp., 533 B.R. 590, 595 (Bankr. E.D. Ky. 2015).

153 *Id*.

154 *See supra* at note 139; *see also, e.g.*, U.S. *ex rel.* Sarasola v. Aetna Life Ins. Co., 319 F.3d 1292, 1296–97 (11th Cir. 2003).

155 Milner v. Dep't of Navy, 562 U.S. 562, 572 (2011).

156 135 S. Ct. 2480 (2015).

157 *Id.* at 2489.

158 *Id.* at 2492–94.

159 *Id.* at 2490–91.

160 *Id.* at 2492.

debtors might actually aid the agency in the execution of its duties, alleviating some of the burden for its strained system resources to focus on the existing, crippling backlog of cases currently pending review therein.[161]

And, of course, Justice Scalia's dissent propounding the unassailable merits of the Court's well-established plain language doctrine supports a reading of § 405(h) that limits its jurisdictional bar to §§ 1331 and 1346. Justice Scalia notes that although "[l]aws often include unusual or mismatched provisions," courts may "not revise legislation just because the text as written creates an apparent anomaly."[162] Here, although § 405(h) may have formerly referred to a broad jurisdictional provision that included bankruptcy, it currently does not, and moreover, as it is presently written, § 405(h) contains no anomalies or references to other mismatched provisions—it clearly states that it applies only to §§ 1331 and 1346. Justice Scalia's reasoning continued that, "The purposes of a law must be 'collected chiefly from its words,' not 'from extrinsic circumstances.' Only by concentrating on the law's terms can a judge hope to uncover the scheme of the statute, rather than some other scheme that the judge thinks desirable."[163] In § 405(h), the words "under § 1331 or 1346 of title 28" plainly omit any reference to bankruptcy jurisdiction under 28 U.S.C. § 1334. And finally, he urged that, "[i]f Congress enacted into law something different from what it intended, then it should amend the statute to conform to its intent."[164] Here, Congress actually did draft something different into law to change its operation: previously, § 405(h) cited a broad jurisdictional statute that gave widespread reviewing authority to federal courts; now it cites to two out of nearly two dozen such jurisdictional grants, many of which were written or amended *after* § 405(h) was updated in 1984.

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161 *Office of Medicare Hearings and Appeals Workloads: Hearing on Exploring Medicare Appeal Reform Before the H. Comm. on Oversight & Gov't Reform & the Subcomm. on Energy Policy, Healthcare & Entitlements*, 113th Cong. (2014) (statement of Nancy J. Griswold, Chief A.L.J., Office of Medicare Hearings and Appeals), www.hhs.gov/asl/testify/2014/07/t20140710a.html (last visited Feb. 13, 2015).

162 *Burwell*, 135 S. Ct. at 2500 (Scalia, J., dissenting).

163 *Id.* at 2503 (Scalia, J., dissenting) (citing Sturges v. Crowninshield, 4 Wheat. 122, 202, 4 L.Ed. 529 (1819) (Marshall, C.J.)).

164 *Id.* at 2505 (Scalia, J., dissenting); *see also* Abbott Labs. v. Gardner, 387 U.S. 136, 141 (1967) (quoting Rusk v. Cort, 369 U.S. 367, 380 (1962)) ("[O]nly upon a showing of 'clear and convincing evidence' of a contrary legislative intent should the courts restrict access to judicial review."), *abrogated on other grounds by* Califano v. Sanders, 430 U.S. 99 (1977); *In re* W.J.P. Properties, 149 B.R. 604, 607 (Bankr. C.D. Cal. 1992) (citations omitted) ("The Supreme Court has on many occasions stressed that in interpreting statutes, the court should first look to the statute. If the statute is clear and unambiguous, the court should enforce the statute as written without reference to legislative history.").

2. The Plain Language of 28 U.S.C. § 1334

The plain language of 28 U.S.C. § 1334 is equally clear. Section 1334 provides the statutory basis for bankruptcy courts' jurisdiction. Specifically, it provides *exclusive jurisdiction* over all cases under title 11 and all property of the debtor and the estate, wherever located, to the district courts, which then may refer the case to the bankruptcy courts:

> (a) Except as provided in subsection (b) of this section, the district courts shall have *original and exclusive jurisdiction* of all cases under title 11.
>
> ***
>
> (e) The district court in which a case under title 11 is commenced or is pending shall have *exclusive jurisdiction* of [] all of the property, wherever located, of the debtor as of the commencement of such case, and of property of the estate . . . .[165]

This structure creates no ambiguity,[166] and nothing suggests that this exclusive jurisdictional grant cedes to the Medicare Act.[167] Courts have thusly employed § 1334's plain meaning as independent grounds for permitting bankruptcy jurisdiction over Medicare disputes.[168] The Ninth Circuit has reconciled this

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165 28 U.S.C. § 1334 (2012) (emphasis added).

166 *See Burwell*, 135 S. Ct. 2480.

167 *See In re* Town & Country Home Nursing Servs., Inc., 963 F.2d 1146, 1155 (9th Cir. 1991) (emphasis added) ("The language of Section 1334(b) grants jurisdiction to the district court, and therefore to the bankruptcy court, over civil proceedings related to bankruptcy and accords with the intent of Congress to bring all bankruptcy-related litigation within the umbrella of the district court, at least as an initial matter, *irrespective of congressional statements to the contrary in the context of other specialized litigation*."). Although the Supreme Court stated, "Section 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'" in *Bd. of Governors of Fed. Reserve Sys. v. MCorp Fin., Inc.*, 502 U.S. 32, 41–42 (1991), that decision does not apply to the present discussion because there the Board's decision had not yet been rendered, and the debtor's estate had therefore not yet been harmed. Here, CMS would have already stopped payments to the hospital-debtor, thereby harming the debtor's estate—a situation expressly carved out of the *MCorp.* Court's decision based on 28 U.S.C. § 1334(d): "Moreover, contrary to MCorp's contention, the prosecution of the Board proceedings, prior to the entry of a final order and prior to the commencement of any enforcement action, *seems unlikely to impair the Bankruptcy Court's exclusive jurisdiction over the property of the estate protected by 28 U.S.C. § 1334(d)*." Bd. of Governors of Fed. Reserve Sys. v. MCorp Fin., Inc., 502 U.S. 32, 42 (1991) (emphasis added); *see also* Sunflower Elec. Co-op., Inc. v. Kan. Power & Light Co., 603 F.2d 791, 796 (10th Cir. 1979) (implying doctrine of exhaustion of administrative remedies is applicable only when agency has exclusive jurisdiction).

168 *E.g.*, *In re* Slater Health Ctr., Inc., 398 F.3d 98 (1st Cir. 2004) (affirming decision that bankruptcy jurisdiction under 28 U.S.C. § 1334 provides an independent basis for jurisdiction); *In re Town & Country Home Nursing*, 963 F.2d at 1154; *see also In re* Univ. Med. Ctr., Inc., 973 F.2d 1065, 1072 (3d Cir. 1992) ("Because we agree . . . that the Bankruptcy Code supplies an independent basis for jurisdiction in this case,

conclusion with its holdings that have excluded other jurisdictional grants from § 405(h). In *Do Sung Uhm v. Humana, Inc.*,[169] the court noted that although *Kaiser v. Blue Cross of California*[170] held that the absence of any reference to 42 U.S.C. § 1332 (diversity jurisdiction) in § 405(h) was irrelevant and diversity jurisdiction was still barred, § 1334's "broad jurisdictional grant over all matters conceivably having an effect on the bankruptcy estate" ultimately carried the day.[171] In short, *Do Sung Uhm* correctly concluded that bankruptcy is special, which is consistent with the Bankruptcy Code's plain language and purpose, neither of which are present in a dispute based on diversity jurisdiction where neither party is insolvent. This outcome is consistent with the rule of statutory construction that "when two statutes are capable of coexistence, it is the duty of the courts, absent a clearly expressed Congressional intention to the contrary, to regard each as effective"[172] because the Medicare Act and Bankruptcy Code "coexist" due to Medicare's jurisdictional carve-out for bankruptcy courts in § 405(h).

we reject the Secretary's arguments and find that the district and bankruptcy courts properly had jurisdiction under 28 U.S.C. §§ 157, 158 and 1334 and that we may properly exercise jurisdiction over this appeal under 28 U.S.C. §§ 158(d) and 1291."). Nor does § 1334(b)'s "original but not exclusive" language for "all civil proceedings arising under title 11, or arising in or related to cases under title 11" change the analysis. *See* Excel Home Care, Inc. v. U.S. Dep't of Health & Human Servs., 316 B.R. 565, 572 (D. Mass. 2004) ("The statute itself provides that "unless indicated otherwise by another Act of Congress," the district courts are endowed with "original *but not exclusive* jurisdiction of all civil proceedings arising under title 11, or arising in or related to cases under title 11."). As the United States Bankruptcy Appellate Panel of the Ninth Circuit explains:

> Essentially all litigation within a bankruptcy case is a "civil proceeding" within § 1334(b) "arising under, arising in, or related to" jurisdiction, which jurisdiction is concurrent with state courts. 28 U.S.C. § 1334(b). Although such jurisdiction is concurrent with state courts, the automatic stay renders state jurisdiction more theoretical than real until after the case is closed. 11 U.S.C. § 362. As one would expect, the decisions construing § 1334(b) deal with how to draw the line at the outer fringe of "related to" matters. Most circuits agree that the test of "related to" jurisdiction is whether the outcome of the proceeding could conceivably have any effect on the estate being administered in bankruptcy. . . . In short, virtually every act a bankruptcy judge is called upon to perform in a judicial capacity is a "civil proceeding" within § 1334(b).

In re Menk, 241 B.R. 896, 908–09 (B.A.P. 9th Cir. 1999).

169 620 F.3d 1134, 1140 n.11 (9th Cir. 2010).

170 347 F.3d 1107, 1115 (9th Cir. 2003).

171 *Do Sung Uhm*, 620 F.3d at 1140 n.11.

172 J.E.M. Ag. Supply, Inc. v. Pioneer Hi-Bred Int'l, Inc., 534 U.S. 124, 143 (2001).

3. Enforcing § 405(h) Based on Its Plain Language Is Consistent with the Bankruptcy Code's Purpose

That § 405(h)'s plain language governs its interpretation is supported by the purpose of the Bankruptcy Code: "The purpose of Chapter 11 reorganization is to assist financially distressed business enterprises by providing them with breathing space in which to return to a viable state."[173] Absent such breathing space, a debtor may be forced to cease its operations, rendering virtually impossible a return to a viable state. The problem is particularly acute for hospital-debtors that rely on Medicare payments and cannot have their Medicare disputes appealed quickly enough to keep operating.[174]

A debtor's breathing space is created by the bankruptcy court's exclusive jurisdiction over its estate. If not for this exclusive jurisdiction, the debtor may be called to defend its assets and debts in multiple courts (here, the Medicare appeals labyrinth),[175] which would create a race to the courthouse for its creditors and, more importantly, distract the debtor from the important task of successful reorganization. Indeed, "[o]ne of the primary purposes of revising the statutory grant of jurisdiction to the bankruptcy courts [in 1978] was the elimination of frequent, time-consuming, and expensive litigation of the question whether the bankruptcy court has jurisdiction of a particular proceeding."[176] Thus, § 1334's exclusivity provision is susceptible to little legislative weakness: bankruptcy jurisdiction is exclusive "irrespective of congressional statements to the contrary in the context of specialized legislation," and "in the absence of clear and convincing evidence of

[173] *In re* Golden Ocala P'ship, 50 B.R. 552, 557 (Bankr. M.D. Fla. 1985).

[174] *In re* Tidewater Mem'l Hosp., 106 B.R. 876, 880 (Bankr. E.D. Va. 1989) ("Here, however, the Government's action in apparent violation of the automatic stay provisions of § 362 could well prevent the debtor from having an opportunity for rehabilitation and reorganization. There is an urgency here which goes beyond the domain of Medicare law, and the doctrine of exhaustion of administrative remedies should not be allowed to frustrate the clearly stated goals of the Bankruptcy Code.").

[175] To require a hospital to complete the "complex and time-consuming maze of the [Medicare] administrative review process" as a prerequisite to obtaining bankruptcy relief will "virtually ignore the purpose of the changes in the jurisdictional grant enacted in the [1978] Reform Act elimination of delay and expense as a barrier to a successful reorganization." *In re* Clawson Med., Rehab. & Pain Care Ctr., P.C., 9 B.R. 644, 49 (Bankr. E.D. Mich.), *rev'd*, 12 B.R. 647 (E.D. Mich. 1981).

[176] *Clawson*, 9 B.R. at 648–49.

legislative intent to preclude or condition [a bankruptcy c]ourt's jurisdiction, no further barriers will be erected."[177]

If a hospital is not provided with breathing space and Medicare is allowed to stop its payments while the hospital appeals an adverse CMS decision, the hospital may well run out of money and be forced to stop operating before the appeals process is complete.[178] True, § 405(h) is meant to act as a channeling requirement where virtually all challenges to Medicare decisions go through the agency.[179] This scheme becomes problematic, however, when adhering to it means "killing the patient to cure the disease."[180] And killing the patient can be precisely what happens when a court requires hospitals to appeal a decision that stops their essential Medicare payments through the Medicare appeals process: if the hospital dies before its Medicare appeal can be heard, it effectively will have lost its opportunity for meaningful judicial review,[181] and in turn, it will be difficult or impossible to reorganize.[182] Consequently,

[177] *Id.* at 648 (citing Johnson v. Robison, 415 U.S. 361, 373 (1974); Chelsea Comm. Hosp., SNF v. Mich. Blue Cross Ass'n, 630 F.2d 1131 (6th Cir. 1980); Wayne St. Univ. v. Cleland, 590 F.2d 627, 632 (6th Cir. 1980)).

[178] *See* First Am. Health Care of Ga., Inc. v. U.S. Dep't of Health & Human Servs., 208 B.R. 985, 989–90 (Bankr. S.D. Ga. 1996), *vacated and superseded*, No. 96-2007, 1996 WL 282149 (Bankr. S.D. Ga. Mar. 11, 1996).

[179] Nat'l Ass'n for Home Care & Hospice, Inc. v. Burwell, 77 F.Supp.3d 103, 109 (D.D.C. 2015).

[180] *See In re* Jewish Mem'l Hosp., 13 B.R. 417, 420 (Bankr. S.D.N.Y. 1981).

[181] *E.g.*, Shalala v. Ill. Council on Long Term Care, Inc., 529 U.S. 1, 22–23 (2000) (emphasis omitted) ("Rather, the question is whether, as applied generally to those covered by a particular statutory provision, hardship likely found in many cases turns what appears to be simply a channeling requirement into complete preclusion of judicial review."); Frontier Health Inc. v. Shalala, 113 F. Supp. 2d 1192, 1193 (E.D. Tenn. 2000) ("If Woodridge Hospital were forced to close down before its administrative remedies had been exhausted, it would not be in a position to seek judicial review at the close of the administrative process."). Outside of the bankruptcy context, courts are unlikely to find this reasoning persuasive. *See, e.g.*, Fox Ins. Co v. Sebelius, 381 F. App'x 93, 95–96 (2d Cir. 2010) ("Fox's claimed financial harm does not constitute the circumstances in which the CMS's actions and their effects on Fox are subject to 'no review at all.' *Illinois Council* does not hold that where a party may suffer economic hardship it may sidestep administrative review."); Sulphur Manor, Inc. v. Burwell, No. CIV-15-250-RAW, 2015 WL 4409062, at *3 (E.D. Okla. July 20, 2015); Cal. Clinical Lab. Ass'n v. Sec'y of Health & Human Servs., No. 14-CV-0673, 2015 WL 2393571, at *10 (D.D.C. May 20, 2015). However, bankruptcy courts, employing their expertise on the matters affecting debtors' estates, frequently find otherwise. *E.g.*, U.S. *ex rel.* Sarasola v. Aetna Life Ins. Co., 319 F.3d 1292, 1296–97 (11th Cir. 2003); *In re* Healthback, L.L.C., 226 B.R. 464, 471 n.8 (Bankr. W.D. Okla. 1998), *vacated*, No. 97-22616, 1999 WL 35012949 (Bankr. W.D. Okla. May 28, 1999); *First Am. Health Care of Ga.*, 208 B.R. at 989–90; *In re* Tidewater Mem'l Hosp., 106 B.R. 876, 880 (Bankr. E.D.Va. 1989).

[182] *See, e.g.*, *Sulphur Manor*, 2015 WL 4409062, at *3 ("The court does find a showing of irreparable injury in the assertion that plaintiff will go out of business upon termination of the provider agreements . . . ."); *Healthback*, 226 B.R. at 471 n.8 ("In this matter, where there is no timely administrative remedy available to the debtor, this court will not require the debtor to, literally, commit suicide to adhere to this rule."); *First Am. Health Care of Ga., Inc*, 208 B.R. at 989–90; *Tidewater Mem'l Hosp.*, 106 B.R. at 880.

patients will have lost their access to care, Medicare will have lost a provider that potentially could reorganize and improve, and the hospital's employees will have lost their jobs.[183] But "[i]f there is not a potentially viable business in place worthy of protection and rehabilitation, the Chapter 11 effort has lost its raison d'etre."[184] Because the Bankruptcy Code in general—and chapter 11 in particular—exist to prevent the unnecessary shuttering of businesses that are temporarily but not irreversibly experiencing hardship, reading the natural language of § 405(h) as omitting reference to the Bankruptcy Code's jurisdictional grant in 28 U.S.C. § 1334 fully supports the purpose of the Bankruptcy Code.[185]

B. Discussion of the "Legislative History" Argument

The argument that § 405(h), as it is currently written, prevents bankruptcy courts from hearing Medicare claims prior to exhaustion of administrative remedies is based on explanatory language enacted by Congress when § 405(h) was amended in 1984.[186] This argument fails for six reasons, summarized here and explained in greater detail below.

First, to the extent § 2664(b) of the Deficit Reduction Act can be read as applying only to preclude substantive changes (a conclusion not supported by the statute's language), jurisdictional statutes are procedural, not substantive, and are therefore not covered by § 2664(b)'s directive.

Second, the 1948 re-codification of 28 U.S.C. § 41 did include substantive changes, and applying § 405(h) in 2015 to a jurisdictional statute dating back nearly a century (that includes, for example, a jurisdictional grant for questions pertaining to slavery) leads to absurd results.

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183 *See, e.g.*, *First Am. Health Care of Ga., Inc*., 208 B.R. at 989–90.

184 *In re* Golden Ocala P'ship, 50 B.R. 552, 557 (Bankr. M.D. Fla. 1985).

185 This outcome is consistent with other unique provisions in the Bankruptcy Code dealing with governmental entities. For example, § 525(a) of the Bankruptcy Code prohibits governmental entities from denying, revoking, superseding, or refusing to "renew a license, permit, charter, franchise, or other similar grant to, condition such a grant to, discriminate with respect to such a grant against . . . a person that is or has been a debtor under" the Bankruptcy Code. 11 U.S.C. § 525(a). The similar provisions dealing with private employers is much more limited. 11 U.S.C. § 525(b). Section 525(a) has been applied to licenses and government contracts and applied to prohibit the Medicare program from refusing to allow entities that have been through bankruptcy from future participation as a Medicare provider. *See, e.g.*, *In re* St. Mary Hosp., 89 B.R. 503, 504 (Bankr. E.D. Pa. 1988). *But see* E.H. Sperow, *Section 525(a) of the Bankruptcy Code Plainly Does Not Apply to Medicare Provider Agreements*, 34 J. HEALTH L. 487, 487–500 (2001). *See generally* F.C.C. v. NextWave Pers. Commc'ns Inc., 537 U.S. 293, 302 (2003); *In re* Stoltz, 315 F.3d 80, 95 (2d Cir. 2002).

186 *See supra* text accompanying notes 7, 11–18; Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2664(b), 98 Stat. 1162.

Third, since its extraction from § 41, 28 U.S.C. § 1334 (bankruptcy jurisdiction) has been amended and *expanded* several times as part of significant revisions to the entire Bankruptcy Code. Ignoring this presumes Congress meant to preclude certain individuals and businesses from bankruptcy protection—despite a lack of express language so stating—while it was at the same time greatly increasing the jurisdictional authority of bankruptcy courts.

Fourth, in addition to the changes to § 405(h), many of the other amendments made by Congress in § 2663 of the DRA affected parties' substantive and procedural rights and liabilities. This (combined with the second and third reasons above) lends strong evidence to an argument that the *real* scrivener's error is the overbroad catchall in § 2664(b) that none of the 250 sub-sections of the U.S. Code that § 2663 amended did so in a way that altered a party's rights or liabilities.

Fifth, § 2664(b) is labeled "Effective Dates" and ends with the limitation, "before that date." Just eight days "before that date" of the DRA's enactment, the Bankruptcy Reform Act of 1984 was passed, reaffirming the bankruptcy court's exclusive jurisdiction over a debtor's case and estate. The plain language of § 2664(b) therefore prohibits courts from ignoring the rights created in the Bankruptcy Reform Act.

Sixth and finally, even if the Office of Revision Counsel's change, which was then codified by Congress, was a "scrivener's error," courts are not permitted to correct technical legislative errors.

1. Jurisdiction Under § 405(h) is Procedural, Not Substantive

Assuming that § 2664(b) only applies to preclude any substantive changes that may be read into § 2663 (a conclusion unsupported by § 2664(b)'s plain language), such a preclusion would not apply to prevent alteration to § 405(h) because jurisdictional grants are procedural, not substantive.

As discussed above, Congress expressly enacted the Law Revision Counsel's changes to § 405(h) as part of the DRA.[187] As part of that

[187] Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2663(a)(4)(D), 98 Stat. 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 . . . .'"). Changes to a statute by the Law Revision Counsel are not binding absent enactment by Congress.

legislation, Congress included a provision entitled, "Effective Dates," which stated in § 2664(b) that:

> Except 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*.[188]

Beginning in 1990 with *Bodimetric Health Servs., Inc. v. Aetna Life & Cas.*,[189] courts have tended to assume, without explanation, that § 2664(b) applies only to substantive and not procedural changes.[190] However, a close reading of the statute and an analysis of its precise terms suggests otherwise. Section 2664(b) states, "none of such amendments shall be construed as changing or affecting *any right, liability, status, or interpretation*."[191] By its plain language, the word "right" in § 2664 is not qualified. As such, it is equally plausible—and, indeed, likely—that "right" includes *both* substantive *and* procedural rights. Moreover, Black's Law Dictionary includes a definition for "right," "substantive right," and "procedural right."[192]

In either event, to the extent that § 2664(b) does refer exclusively to substantive changes, it does not apply to § 405(h)'s jurisdictional bar, which is procedural in nature.[193] Black's Law Dictionary defines "substantive law" as, "[t]he part of law that creates, defines, and regulates the rights, duties, and

[188] *Id.* § 2664(b) (emphasis added).

[189] 903 F.2d 480, 489 (7th Cir. 1990).

[190] *E.g.*, Nichole Med. Equip. & Supply, Inc. v. TriCenturion, Inc., 694 F.3d 340, 346 (3d Cir. 2012) (citing *Bodimetric Health Servs., Inc*., 903 F.2d at 489); BP Care, Inc. v. Thompson, 398 F.3d 503, 515 (6th Cir. 2005); Midland Psychiatric Associates, Inc. v. United States, 969 F. Supp. 543, 549 (W.D. Mo. 1997), *aff'd*, 145 F.3d 1000 (8th Cir. 1998); Nicole Med. Equip. & Supply, Inc. v. TriCenturion, Inc., No. CIV.A. 10-389, 2011 WL 1162052, at *4 (E.D. Pa. Mar. 28, 2011); Reg'l Med. Transp., Inc. v. Highmark, Inc., 541 F.Supp. 2d 718, 731 (E.D. Pa. 2, 2008); Excel Home Care, Inc. v. U.S. Dep't of Health & Human Servs., 316 B.R. 565, 573 (D. Mass. 2004); Allstar Care Inc. v. Blue Cross & Blue Shield of S.C., 184 F. Supp. 2d 1295, 1298 (S.D. Fla. 2002); Total Renal Labs., Inc. v. Shalala, 60 F. Supp. 2d 1323, 1331 (N.D. Ga. 1999); *In re* Healthback, L.L.C., 226 B.R. 464, 473 (Bankr. W.D. Okla. 1998), *vacated*, No. 97-22616, 1999 WL 35012949 (Bankr. W.D. Okla. 1999); *In re* House of Mercy, Inc., 353 B.R. 867, 871 (Bankr. W.D. La. 2006); *In re* AHN Homecare, LLC, 222 B.R. 804, 808 (Bankr. N.D. Tex. 1998); *In re* St. Mary Hosp., 123 B.R. 14, 17 (E.D. Pa. 1991).

[191] Deficit Reduction Act § 2664(b).

[192] BLACK'S LAW DICTIONARY 623–24 (3d pocket ed. 2006).

[193] *See* Deficit Reduction Act § 2664(b).

powers of the parties."[194] Black's further defines "right" as, *inter alia*, "[s]omething that is due to a person by just claim, legal guarantee, or moral principle," "[a] power, privilege, or immunity secured to a person by law," and "[a] legally enforceable claim that another will do or will not do a given act; a recognized and protected interest the violation of which is a wrong."[195] A "substantive right" is, therefore, a "right that can be protected or enforced by law; a right of substance *rather than form*,"[196] whereas a "procedural right" is a "right that derives from legal or administrative procedure; a right that helps in the enforcement of a substantive right."[197] Because jurisdiction, a "court's power to decide a case or issue a decree,"[198] merely informs the parties of the proper forum, thereby "help[ing] in the enforcement of a substantive right," and does not create, define, or regulate rights—such as those arising under 42 U.S.C. § 405(h) and 28 U.S.C. § 1334—it is a procedural right, not a substantive one.[199] And to the extent § 2664(b) can be read to apply only to substantive rights, it does not apply to alter the plain meaning of § 405(h).[200]

Even if the phrase "none of such amendments shall be construed as changing or affecting any right, liability, status, or interpretation" in § 2664(b) can be read to apply to both substantive and procedural rights, it still fails to bar bankruptcy court jurisdiction over Medicare disputes prior to exhaustion under § 405(h), for the reasons outlined below.

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194 BLACK'S LAW DICTIONARY, *supra* note 192, at 686; *see also Healthback*, 226 B.R. at 473 ("**Substantive law.** That part of law which creates, defines, and regulates rights and duties of parties, as opposed to 'adjective, procedural, or remedial law,' which prescribes method of enforcing the rights or obtaining redress for their invasion. The basic law of rights and duties (contract law, criminal law, tort law, law of wills, etc.) as opposed to *procedural* law (law of pleading, law of evidence, *law of jurisdiction*, etc.).").

195 BLACK'S LAW DICTIONARY, *supra* note 192, at 623–24.

196 *Id.* at 624 (emphasis added).

197 *Id.*

198 *Id.* at 393.

199 Note, however, that the label "procedural" is not unassailable. When a procedural rule "makes changes in remedies, procedures, and evidence[,] such changes can have as profound an impact on behavior outside the courtroom as avowedly substantive changes." Luddington v. Ind. Bell Tel. Co., 966 F.2d 225, 229 (7th Cir. 1992) (Posner, J.); *see also* Associated Dry Goods Corp. v. E.E.O.C., 543 F. Supp. 950, 956 (E.D. Va. 1982) (discussing facially procedural EEOC rules and their substantive impact and reasoning that when a purportedly "procedural" rule "trenche[es] upon the rights and obligations of the parties affected" it could be considered "substantive"), *rev'd*, 720 F.2d 804 (4th Cir. 1983).

200 *In re* Healthback, L.L.C., 226 B.R. 464, 474 (Bankr. W.D. Okla. 1998), *vacated*, No. 97-22616, 1999 WL 35012949 (Bankr. W.D. Okla. May 28, 1999).

2. Federal Jurisdiction: Claims Against the United States

If § 405(h) refers to 28 U.S.C. § 41's jurisdictional grant, and not 28 U.S.C. §§ 1331 (federal question) and 1346 (concurrent jurisdiction to the district and other federal courts as to certain claims against the United States) as indicated in its text, then the *entirety* of § 41 must be enforced as it was then written, and not merely selectively. Applying this reasoning highlights the absurdity of referring to a law that was abrogated decades ago.

For example, there can be no dispute that § 405(h) covers jurisdiction under § 1346.[201] Before 1948, § 1346 was part of 28 U.S.C. § 41(20), which at the time provided that:

> No suit against the Government of the United States shall be allowed under this paragraph unless the same shall have been brought within six years after the right accrued for which the claim is made. *The claims of married women, first accrued during marriage*, of persons under the age of twenty-one years, first accrued during minority, and of idiots, lunatics, insane persons, and persons beyond the seas at the time the claim accrued, entitled to the claim, *shall not be barred if the suit be brought within three years after the disability has ceased*; but no other disability than those enumerated shall prevent any claim from being barred, nor shall any of the said disabilities operate cumulatively.[202]

The 1948 amendment broke the statute of limitations out of § 41 and re-codified it at 28 U.S.C. § 2401:

> [E]very civil action commenced against the United States shall be barred unless the complaint is filed within six years after the right of action first accrues. The action of any person under legal disability or beyond the seas at the time the claim accrues may be commenced within three years after the disability ceases.[203]

[201] 28 U.S.C. § 41 (1946); 28 U.S.C. §§ 1331 to 1348, 1350 to 1357, 1359, 1397, 2361, 2401, and 2402 (1952); *see also* Bodimetric Health Servs. Inc. v. Aetna Life & Cas., 903 F.2d 480 (7th Cir. 1990) (discussing how § 405(h) bars action brought under diversity jurisdiction statute although § 1332 is no longer mentioned in § 405(h)); AHN Homecare v. Home Health Reimbursement & HCFA, 222 B.R. 804, 807–08 (Bankr. N.D. Tex. 1998); *In re* St. Mary Hosp., 123 B.R. 14, 17 (E.D. Pa. 1991); *In re* Visiting Nurse Ass'n of Tampa Bay, Inc., 121 B.R. 114 (Bankr. M.D. Fla. 1990). Absent from the re-codification was, for example, § 41(4)'s grant of original jurisdiction in the federal district courts for "all suits arising under any law relating to the slave trade." 28 U.S.C. § 41(4) (1946).

[202] 28 U.S.C. § 41(20) (emphasis added).

[203] 28 U.S.C. § 2401 (1952).

Notably absent from § 2401 is the provision that labels married women "disabled" and stops the clock from running on the statute of limitations for claims against the United States while they are married.

Although the "disabled" label is disparaging, if the term were still in effect, it would actually confer a benefit to married women. If § 405(h) refers to 28 U.S.C. § 41, which ceased to exist in 1948, then a married woman whose claims against the United States arise during marriage would be able to avoid tolling the statute of limitations on those claims for potentially well beyond the six-year limit that applies to everyone else (albeit litigation of her claims would be limited to the Medicare appeals process). For example, if a woman's Medicare dispute arises during her marriage and her husband dies nine years later, then she would still have an additional three years to bring her claim, for a total limitations period of twelve years, more than double that of a non-married woman. Indeed, this is precisely the way courts during that era viewed 28 U.S.C. § 41(20) as operating: "[I]f her marriage tolled the statute, she failed to start her action within three years after the death of her husband, and is clearly barred."[204]

Circuit and lower courts have held, outside of the bankruptcy context, that the omission of references to other grants of jurisdiction should be ignored, and the pre-1984 version of the statute should be applied. These courts reason that because Congress, in passing the 1984 law that adopted the 1976 revision, wrote that the 1984 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."[205] But if this legislative language means any changes affecting a person's rights must be ignored (as some courts have held), then all such changes—for example, with regard to the jurisdictional rights of women—would also have to be ignored. Thus, applying the "guidance" in § 2664(b)'s legislative note also requires ignoring 28 U.S.C. § 2401 as it is currently written. Congress could not have intended such an absurd[206] and likely unconstitutional result,[207] and in 2016 and beyond, courts should not employ logical reasoning that would tend to enforce it.

[204] Stubbs v. United States, 21 F. Supp. 1007, 1010 (M.D.N.C. 1938).

[205] Bodimetric Health Services, Inc. v. Aetna Life & Cas., 903 F.2d 480, 488–89 (7th Cir. 1990) (holding that, even in the absence of reference to diversity jurisdiction provision 28 U.S.C. § 1332 in § 405(h), such suits were still barred).

[206] *See* Luddington v. Ind. Bell Tel. Co., 966 F.2d 225, 228 (7th Cir. 1992) (Posner, J.) ("Section [42 U.S.C.] § 1981 dates back to 1866. It is as unlikely that Congress was attempting to restore section 1981 to the

3. Federal Jurisdiction: Bankruptcy Jurisdiction

The legislative history argument also fails because applying § 405(h) to § 41 as it was written in 1935[208] requires ignoring the numerous (and painstaking) changes Congress has since made to bankruptcy jurisdiction. In particular, it would require sidestepping the grant of exclusive jurisdiction to bankruptcy courts over a debtor's estate, which was itself written into law to solve the complex jurisdictional fights that persisted during the preceding century.[209] In short, enforcing 28 U.S.C. § 41 as it was written before 1948 reinvigorates the jurisdictional morass that subsequent amendments to the Bankruptcy Code were expressly written to address—indeed, such a jurisdictional debate is the very topic of this article.

In 1935, 28 U.S.C. § 41(19) stated, "The district courts shall have original jurisdiction . . . [o]f all matters and proceedings in bankruptcy."[210] When § 41 was broken out into subparts in 1948, § 41(19) became § 1334 and the "phraseology" was modified to read, "The district courts shall have original jurisdiction, exclusive of the courts of the States, of all matters and proceedings in bankruptcy."[211]

Section 1334 remained unchanged until 1978. The 1978 amendment arose in the context of growing dissatisfaction with the Bankruptcy Act of 1898, which was still in effect at the time, causing Congress to overhaul the entire legislative scheme.[212] Among the problems with the Bankruptcy Act at the time was the limited effectiveness of bankruptcy adjudication, which worked as follows:

> Before the [1978] Act, federal district courts served as bankruptcy courts and employed a 'referee' system. Bankruptcy proceedings were generally conducted before referees, except in those instances in which the district court elected to withdraw a case from a referee. The referee's final order was appealable to the district court. The

understanding of its framers . . . . The new civil rights act reflects contemporary policy and politics, rather than a dispute between Congress and the Supreme Court over the mechanics of interpretation.").

[207] Applying the statute in this way may violate the Fifth Amendment's Equal Protection Clause. *See* Silbowitz v. Sec'y of Health, Ed. & Welfare, 397 F. Supp. 862, 867 (S.D. Fla. 1975), *aff'd sub nom.* Califano v. Silbowitz, 430 U.S. 924 (1977).

[208] Social Security Act Amendments of 1939, Pub. L. No. 379, § 205(h), 53 Stat. 1360, 1371.

[209] *See* Eric A. Posner, *The Political Economy of the Bankruptcy Reform Act of 1978*, 96 MICH. L. REV. 47, 62 (1997); N. Pipeline Constr. Co. v. Marathon Pipe Line Co., 458 U.S. 50, 53 (1982).

[210] 28 U.S.C. § 41(19) (1934).

[211] 28 U.S.C. § 1334 (Supp. II 1948).

[212] *See* Posner, *supra* note 209, at 61.

> bankruptcy courts were vested with 'summary jurisdiction'—that is, with jurisdiction over controversies involving property in the actual or constructive possession of the court. And, with consent, the bankruptcy court also had jurisdiction over some 'plenary' matters—such as disputes involving property in the possession of a third person.[213]

Under this regime, however, "bankruptcy judges did not have sufficient jurisdictional and remedial powers to decide cases in an expeditious way—they would have to refer issues outside their power to the supervising district court—and that bankruptcy judges' subordinate status weakened their authority with litigants."[214]

To remedy this defect, Congress created "in each judicial district, as an adjunct to the district court for such district, a bankruptcy court which shall be a court of record known as the United States Bankruptcy Court for the district."[215] Accompanying the creation of the courts was a broad jurisdictional grant in 28 U.S.C. § 1471 (which went into effect on April 1, 1984) that gave the bankruptcy courts "exclusive jurisdiction" of a debtor's bankruptcy case and assets:

> (a) Except as provided in subsection (b) of this section, the district courts shall have *original and exclusive jurisdiction of all cases under title 11*.
>
> (b) 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 or arising in or related to cases under title 11.
>
> (c) The bankruptcy court for the district in which a case under title 11 is commenced shall exercise all of the jurisdiction conferred by this section on the district courts.
>
> (d) Subsection (b) or (c) of this section does not prevent a district court or a bankruptcy court, in the interest of justice, from abstaining from hearing a particular proceeding arising under title 11 or arising in or related to a case under title 11. Such abstention, or a decision not to abstain, is not reviewable by appeal or otherwise.

213 *N. Pipeline Const. Co*., 458 U.S. at 53; Posner, *supra* note 209, at 62.

214 Posner, *supra* note 209, at 62; *see also N. Pipeline Constr. Co.*, 458 U.S. at 53.

215 *N. Pipeline Constr. Co.*, 458 U.S. at 53 (citing 28 U.S.C. § 151(a) (Supp. IV 1976)).

> (e) The bankruptcy court in which a case under title 11 is commenced *shall have exclusive jurisdiction of all of the property, wherever located, of the debtor, as of the commencement of such case*.[216]

Correspondingly, § 1334 was changed to provide for the appeals process:

> (a) The district courts for districts for which panels have not been ordered appointed under section 160 of this title shall have jurisdiction of appeals from all final judgments, orders, and decrees of bankruptcy courts.
>
> (b) The district courts for such districts shall have jurisdiction of appeals from interlocutory orders and decrees of bankruptcy courts, but only by leave of the district court to which the appeal is taken.
>
> (c) A district court may not refer an appeal under that section to a magistrate or to a special master.[217]

Shortly after the enactment of the 1978 Act, in *Northern Pipeline Construction Co. v. Marathon Pipe Line Co.*,[218] the Supreme Court held that the authority of the bankruptcy courts violated Article III of the United States Constitution because it "gave Article III powers to judges who do not have lifetime tenure and independent salaries."[219]

Congress fixed the statute in 1984, and amended the unconstitutional elements of the bankruptcy courts' jurisdictional grant in § 1334 as follows:

> (a) Except as provided in subsection (b) of this section, the district courts shall have *original and exclusive Jurisdiction of all cases under title 11*.
>
> (b) 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, or arising in or related to cases under title 11.
>
> (c)(1) Nothing in this section prevents a district court in the interest of justice, or in the interest of comity with State courts or respect for

[216] 28 U.S.C. § 1471 (Supp. IV 1978) (emphasis added).

[217] 28 U.S.C. § 1334 (Supp. III 1978) (changing § 1334's heading from "Bankruptcy matters and proceedings" to "Bankruptcy appeals").

[218] 458 U.S. at 73.

[219] Posner, *supra* note 209, at 93; *see N. Pipeline Constr. Co.*, 458 U.S. at 73 (holding that the authority granted to bankruptcy courts violated Article III of the Constitution).

> State law, from abstaining from hearing a particular proceeding arising under title 11 or arising in or related to a case under title 11.
>
> (2) Upon timely motion of a party in a proceeding based upon a State law claim or State law cause of action, related to a case under title 11 but not arising under title 11 or arising in a case under title 11, with respect to which an action could not have been commenced in a court of the United States absent jurisdiction under this section, the district court shall abstain from hearing such proceeding if an action is commenced, and can be timely adjudicated, in a State forum of appropriate jurisdiction. Any decision to abstain made under this subsection is not reviewable by appeal or otherwise. This subsection shall not be construed to limit the applicability of the stay provided for by section 362 of title 11, United States Code, as such section applies to an action affecting the property of the estate in bankruptcy.
>
> (d) The district court in which a case under title 11 is commenced or is pending shall have *exclusive jurisdiction of all of the property, wherever located, of the debtor as of the commencement of such case, and of the estate*.[220]

Notably, Congress removed the provision providing bankruptcy courts with "all of the jurisdiction conferred by this section on the district courts."[221]

Given the substantial amount of effort and energy that went into overhauling the Bankruptcy Code in 1978 and 1984—again, an overhaul geared towards solving this very jurisdictional debate—it is implausible that Congress intended to deprive the bankruptcy courts of "exclusive jurisdiction" over the debtor and its estate when the debtor was a hospital that sought to challenge a Medicare payment decision. This would lead to the absurd result that the Bankruptcy Code's protections do not apply to a small but not insignificant part of the population of debtors (insolvent hospitals relying on Medicare payments) due to an inferred deference to Medicare's administrative expertise. If Congress preferred the development of administrative expertise to judicial efficiency in bankruptcy proceedings, it would have expressly excluded bankruptcy jurisdiction from *every* type of administrative proceeding in the Bankruptcy Code. But it did not. Instead, by providing "an independent basis for bankruptcy court jurisdiction," Congress made clear that in the

[220] 28 U.S.C. § 1334 (Supp. III 1984) (emphasis added).

[221] *Compare* 28 U.S.C. § 1471(c) (Supp. IV 1978), *with* 28 U.S.C. § 1334 (Supp. III 1984).

Medicare Act and elsewhere, "exhaustion of administrative remedies pursuant to other jurisdictional statutes is not required."[222]

4. Section 2663 Contains Numerous Sections that Change Parties' Rights

If § 2663 of the DRA is interpreted to have made no changes to a party's rights, many of its provisions lead to absurd results. And this, combined with the clarity of the Bankruptcy Code, makes it more likely that the actual scrivener's error is the broad statement in § 2664(b) that none of the hundreds of changes in § 2663(a) alter a party's rights.

The court in *Nurses' Registry* highlights four such absurdities:

- A change in § 2663 to 42 U.S.C. § 1307 added to the law making it a crime to impersonate a "former wife divorced" to obtain information about a Social Security beneficiary's benefits provisions for husbands, mothers, and fathers; no change in rights under § 2664(b) would mean that § 1307 still only made it a crime to impersonate a "former wife divorced."[223]
- "Congress amended 42 U.S.C. § 422(b)(4), since repealed, which mandated deductions from Social Security benefits on account of refusal to accept rehabilitation services, to not apply to 'full-time elementary or secondary school students' between the ages of eighteen to twenty-two, whereas § 422(b)(4) previously carved out all 'full-time students' of the same ages. If Defendants were right about the ineffectiveness of the DRA's technical amendments, college students between the ages of eighteen to twenty-two would have continued to be exempt from § 422(b)(4) until its repeal in 1999."[224]
- "[M]ost remarkably, a 'technical amendment' in the DRA repealed an entire title of the SSA, Title XIII, which provided a program of unemployment benefits for federal seamen. If the DRA's technical amendments truly did not 'change or

[222] *In re* Town & Country Home Nursing Servs., Inc., 963 F.2d 1146, 1154 (9th Cir. 1992) (quotation marks omitted).

[223] *In re* Nurses' Registry & Home Health Corp., 533 B.R. 590, 596 (Bankr. E.D. Ky. 2015).

[224] *Id*.

> affect any right,' the Reconversion Unemployment Benefits for Seamen program is still federal law."[225]
>
> - Regarding the Medicare Act, "At least one of the DRA's sixty-five 'technical amendments' to the Medicare Act, while minor, is likewise unmistakably substantive. This amendment amended 42 U.S.C. § 1395y's exclusion of certain benefits during the period from when an individual becomes eligible under Medicare to 'the month in which such individual attains the age of 70,' to an exclusion of benefits during the period from eligibility to 'the month *before the month* in which such individual attains the age of 70.' In other words, this 'technical amendment,' which Congress claimed did not 'affect any right,' abbreviated a benefits exclusion by a month."[226]

Therefore, if § 2663 made no changes to parties' rights, then many of its textual changes make no sense. However, § 2664(b) has been plainly misapplied and misinterpreted because courts have wholly ignored its key qualifier: language limiting the time period of its efficacy.

5. "Before That Date" Language

Section 2664(b) of the "technical" amendments in the DRA states that, "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*."[227] However, the Bankruptcy Reform Act of 1984, which granted bankruptcy courts broad jurisdictional authority over a debtor's estate, was passed eight days before the DRA. As such, § 2664(b) actually preserves the jurisdictional rights granted to bankruptcy courts as they existed *before* the passage of the DRA, which would be based on the

[225] *Id*. It bears noting that Title XIII's effective period expired on June 30, 1950. Olga S. Halsey, *Reconversion Unemployment Benefits for Seamen*, SOCIAL SECURITY BULLETIN (Aug. 1949), https://www.ssa.gov/policy/docs/ssb/v12n8/v12n8p15.pdf. But even reading this example out of the *Nurses' Registry* court's reasoning does not alter the overall conclusion that § 2663 does, in fact, alter rights. Nor does § 2663's title, "OTHER TECHNICAL CORRECTIONS IN THE SOCIAL SECURITY ACT AND RELATED PROVISIONS" and its location in "Subtitle D—Technical Corrections" change this outcome because where, as is the case with § 405(h), there is no ambiguity in the statutory language the "title of a statute . . . cannot limit the plain meaning of [its] text." Pa. Dep't of Corrs. v. Yeskey, 524 U.S. 206, 212 (1998).

[226] *Nurses' Registry*, 533 B.R. at 596 n.11 (citing 42 U.S.C. § 1395y(b)(3)(A)(iii) (1982) and 42 U.S.C. § 1395y(b)(3)(A)(iii) (Supp. 1985)).

[227] Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2664(b), 98 Stat. 1162 (1984) (emphasis added).

Bankruptcy Reform Act. Section 2664(b)'s plain language[228] therefore requires § 1334 to be read out of § 405(h) because § 1334 was passed eight days earlier and grants significant procedural and substantive rights to bankruptcy courts over the debtor's estate.[229] Indeed, it is implausible that Congress enacted the Bankruptcy Code and its jurisdictional grant and then, just over a week later, abrogated parts of it in the Medicare Act without any explicit intent to do so.

6. Courts Lack Power to Correct Technical Errors

Finally, § 405(h) must be enforced as written even if its omission of § 1334 is a technical error because courts cannot correct technical errors.[230] If Congress enacts something it did not intend to, the solution is for Congress to pass another law amending it.[231] Indeed, "courts only correct drafting errors where they are certain, usually for reasons of absurdity, that an error occurred, and where the error is a 'technical mistake in transcribing' a law rather than a 'substantive mistake in designing' a law."[232] If the omission of § 1334 from § 405(h) was a technical error, as the "legislative history" argument requires, it must nevertheless be enforced as written until Congress amends or rewrites it.

CONCLUSION

Despite the compelling nature of the plain language argument, whether a bankruptcy court jurisdictional grant supersedes Medicare's is an issue that has resulted in many contrary decisions over more than two decades. Still, the recent decisions in *Nurses' Registry* and *Bayou Shores* remind bankruptcy attorneys and financial advisors that the bankruptcy court may offer relief to a distressed hospital by avoiding spending years wandering the desert that is the

228 Assuming § 405(h)'s jurisdictional grant is substantive and not procedural. *See supra* at note 193; *In re* Healthback, L.L.C., 226 B.R. 464, 472–73 (Bankr. W.D. Okla. 1998), *vacated*, No. 97-22616, 1999 WL 35012949 (Bankr. W.D. Okla. May 28, 1999).

229 The "under the provisions of law involved" parenthetical includes § 405(h) and § 1334.

230 Even if § 2664(b) and its apparently broad application is a scrivener's error that a court cannot correct, enforcing it as written does not change the present analysis due to its qualifying time limitation language discussed above.

231 Lamie v. U.S. Trustee, 540 U.S. 526, 542 (2004) ("If Congress enacted into law something different from what it intended, then it should amend the statute to conform it to its intent. 'It is beyond our province to rescue Congress from its drafting errors, and to provide for what we might think . . . is the preferred result.' This allows both of our branches to adhere to our respected, and respective, constitutional roles. In the meantime, we must determine intent from the statute before us." (quoting United States v. Granderson, 511 U.S. 39, 68 (1994) (Kennedy, J., concurring))).

232 *In re* Nurses' Registry & Home Health Corp., 533 B.R. 590, 595 (Bankr. E.D. Ky. 2015) (quoting King v. Burwell, 135 S.Ct. 2480, 2505 (2015) (Scalia, J., dissenting)).

Medicare appeals process and instead having its life-threatening disputes handled quickly and efficiently by a federal bankruptcy court.

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).

in *Hollander v. Brezenoff*,[94] where the court affirmed summary judgment against a Medicaid provider on its breach-of-contract claim because the claim did not arise from contract but rather was statutorily determined.

Does Filing Bankruptcy Transform a Medicare Provider Agreement Into a Contract?

Does the filing of a bankruptcy petition alter the essential nature of the agreement between the parties, turning it from a statutory entitlement agreement to a contract? If the Medicare Provider Agreement is not a contract outside of bankruptcy, the United States offers no explanation as to why the filing of a bankruptcy petition would change the agreement into a contract. The Bankruptcy Code does not define the word "contract," although it is employed, among other places, in section 365. Thus, the definition of "contract" comes from applicable non-bankruptcy law,[95] and applicable non-bankruptcy law, as expressed by federal courts nationwide, universally holds that the Medicare Provider Agreement is not a contract. The Government cannot point to a provision in the Bankruptcy Code that would change an agreement that is not a contract outside of bankruptcy into a contract when a bankruptcy case is commenced, because there is none.

If a Medicare Provider Agreement is not a "contract" outside of bankruptcy—if, using the Government's words, it "imposes no duties upon the United States,"[96] "imposes no duties upon a provider that are not also embodied" in applicable law,[97] and does "not establish a contractual relationship"[98]—then there is nothing in the Bankruptcy Code that would convert its essential nature. So nothing about the filing of a bankruptcy petition should turn this statutory entitlement or license into a contract.

Moreover, a Medicare Provider Agreement does not display any of the characteristics of an enforceable contract under the standards of the *Restatement (Second) of Contracts*, which informs federal law on this issue. For one, it simply does not impose any additional obligations on the provider that do not already exist in the Medicare statutes and regulations. According to the Government, which is the drafter and proponent of the Medicare Provider Agreement, the Medicare Provider Agreement also fails to set forth a single obligation of the Government. Hence, there are no rights or duties under the Medicare Provider Agreement aside from those already imposed under existing law. The seemingly inescapable conclusion is that the Medicare Provider Agreement is an enrollment form, the functional equivalent of a statement of participation or an application for a license or permit to participate in a government program. Consequently,

94. 787 F.2d 834 (2d Cir. 1986).
95. *See generally supra* note 5.
96. *See supra* note 29.
97. *See supra* note 29.
98. *See supra* note 30.

they are not "executory contracts" as that term is used under section 365 of the Bankruptcy Code.

In sum, while the courts cited for the "majority" position within bankruptcy reason (if they analyze the issue at all) in terms of the benefits and burdens of the Medicare Provider Agreement that create mutual obligations, the courts in *BDK Health Management* and *Kings Terrace*, along with virtually every court to consider the issue outside of bankruptcy, correctly conclude that these benefits and burdens are statutorily created. It is readily apparent from a review of the Medicare Provider Agreements that they are merely form documents used to memorialize a provider's participation in the Medicare or Medicaid program. Consequently, the Medicare Provider Agreements are not contracts but rather are statutory entitlement licenses.[99]

Why Does It Matter?

The treatment of the Medicare Provider Agreement can be an important factor in the resolution of a bankruptcy involving a healthcare industry entity. To bring the highest price for the assets of a hospital, for example, many buyers will need to obtain the Medicare Provider Agreement from the seller-debtor as part of the assets being transferred. Getting a new Medicare Provider Agreement can take months, and during that period of time, the hospital will be treating Medicare beneficiaries without any assurance of being paid for those services.[100] If the Medicare Provider Agreement were a contract, the buyer would have to assume successor liability for monies owed to the Government, including any overpayments from CMS to the seller discovered subsequent to the sale closing and, possibly, even for any fraud allegations against the seller. And because the Govern-

99. As noted earlier, at least one bankruptcy court suggested that even if the Medicare Provider Agreement is not an express contract, perhaps it is an implied-in-fact contract. Implied-in-fact contracts are recognized as enforceable against the United States. *See, e.g.*, Goldings v. United States, 98 Fed. Cl. 470, 479 (2011) ("The elements of a binding contract with the United States are identical for express and implied-in-fact contracts."); Cibinic & Nash, *supra* note 53, at 179 (citing Balt. & Ohio R.R. v. United States, 261 U.S. 592 (1923)). The *Restatement (Second) of Contracts* defines an implied contract as being created when the conduct of the parties indicates that they have actually manifested their mutual assent but an express offer or acceptance is absent. Restatement (Second) of Contracts §§ 4, 19 (Am. Law Inst. 1981). There are several ways an implied contract can be created against the Government, including course of conduct and acceptance of benefits. Cibinic & Nash, *supra* note 53, at 180–82. Whereas the former seems inappropriate to our situation here (it generally relates to a formal contract that has been informally amended by subsequent conduct), the latter seems at least to offer superficial support to the idea that the Medicare Provider Agreement creates an implied contract. It generally requires the Government to accept benefits with the knowledge that the contractor expects to be compensated. Cibinic & Nash, *supra* note 53, at 181 (citing, *inter alia*, Pac. Mar. Assoc. v. United States, 108 F. Supp. 603 (Ct. Cl. 1952)). However, that the provider conferred a benefit on the Government is not at all clear, because the medical care is not provided to the Government; rather, it is provided to Medicare beneficiaries and the Government's obligation to pay is created by statute, not by contract. In fact, as described earlier, the Government expressly denies that it receives any benefit from the services and products provided to Medicare beneficiaries. *See supra* note 35. Finally, to the extent an implied contract requires the parties to manifest mutual assent, as described earlier, the Government expressly rejects the notion it has agreed to any obligations through the Medicare Provider Agreement. *See supra* note 29.

100. Delta Health Grp., Inc. v. HHS, 459 F. Supp. 2d 1207, 1210 (N.D. Fla. 2006).

ment and its agents have years to review and audit cost reports filed by the seller, the buyer would have enormous unliquidated contingent liabilities. So, outside of bankruptcy, buyers will adjust for this risk by either reducing the purchase price or escrowing significant amounts of the purchase price for significant periods of time.

However, if a seller can transfer a Medicare Provider Agreement in bankruptcy, the seller may be able to increase the amounts paid or eliminate the escrow requirement. If that transfer is as a contract, however, the Government has leverage over the provider. The Government can demand that any outstanding liabilities be paid as cure of the defaults related to the Medicare Provider Agreement, and it can demand adequate assurance from the buyer. If, however, the seller can transfer the Medicare Provider Agreement as a statutory license, the seller can sell the Medicare Provider Agreement without successor liability and obtain maximum value for the assets being sold.

Estoppel

Based on the Government's position in numerous cases that Medicare Provider Agreements are not contracts, it should be judicially and equitably estopped from taking a contrary position in bankruptcy cases. Judicial estoppel is an equitable doctrine that "prevents a party who has successfully taken a position in one proceeding from taking the opposite position in a subsequent proceeding."[101] In *Reynolds v. Commissioner of Internal Revenue*, the court stated:

> The judicial estoppel doctrine protects the integrity of the judicial process by preventing a party from taking a position inconsistent with one successfully and unequivocally asserted by the same party in a prior proceeding. The purpose of the doctrine is to protect the courts "from the perversion of judicial machinery." Courts have used a variety of metaphors to describe the doctrine, characterizing it as a rule against "playing 'fast and loose with the courts,'" "blowing hot and cold as the occasion demands," or "hav[ing] [one's] cake and eat[ing] it too." Emerson's dictum that "a foolish consistency is the hobgoblin of little minds" cuts no ice in this context.[102]

Judicial estoppel requires three elements: (1) the party to be estopped must be asserting a position that is factually incompatible with a position taken in a prior proceeding; (2) the prior inconsistent position must have been accepted by the tribunal; and (3) the party to be estopped must have taken inconsistent positions intentionally for the purpose of gaining unfair advantage.[103]

The Government has repeatedly taken the position that Medicare Provider Agreements are not contracts, and the cases cited above are just several examples

101. King. v. Herbert J. Thomas Mem'l Hosp., 159 F.3d 192, 196 (4th Cir. 1998) (citations omitted); *see also* Patriot Cinemas, Inc. v. Gen. Cinema Corp., 834 F.2d 208, 212 (1st Cir. 1987); Edwards v. Aetna Life Ins. Co., 690 F.2d 595, 598 (6th Cir. 1982).

102. 861 F.2d 469, 472–73 (6th Cir. 1988) (internal citations omitted).

103. *Id.*; *see also* New Hampshire v. Maine, 532 U.S. 742, 749–51 (2001).

of that position being accepted by courts, thereby defeating providers' claims or defenses based on contract principles. As one specific example, consider the Government's position in *Southeast Arkansas Hospice, Inc. v. Sebelius*.[104] Southeast Arkansas Hospice asserted a cause of action against the Government that its Medicare Provider Agreement was an unconscionable contract, and it sought a preliminary injunction to stay collection of certain repayments. The Government contested the plaintiff's request for a preliminary injunction and moved to dismiss the complaint on the ground that the Medicare Provider Agreement is not a contract.[105] The court agreed with the Government's argument and found the Medicare Provider Agreement was not a contract. As a result, the court denied the provider's request for a preliminary injunction and dismissed the complaint.[106]

The Government's conduct should satisfy the elements of judicial estoppel. First, the position that a Medicare Provider Agreement is an executory contract is factually inconsistent with the position that it is not a contract at all. As discussed above, if the Government owes no duties under the Medicare Provider Agreement, if the provider has no non-statutory duties under the Medicare Provider Agreement, and the parties do not have a contractual relationship, the Medicare Provider Agreement cannot be an executory contract. Second, the Government's prior inconsistent position has been widely accepted by tribunals, as evidenced by the *Southeast Arkansas Hospice* case and other cases discussed earlier in this article. Third, it could be argued that the Government has taken inconsistent positions intentionally for gaining unfair advantage. Certainly, the Government is aware of the positions it takes nationwide in breach-of-contract cases outside of bankruptcy and the positions it takes in bankruptcy cases. Indeed, the Government purposefully alters its position based on the forum: if it is in bankruptcy where a contract counterparty has certain benefits under section 365 of the Bankruptcy Code, the Medicare Provider Agreement is a contract; if the Government is in any other forum in which a provider may have a remedy or a defense based on contract, then the Medicare Provider Agreement is not a contract. The Government's position in *Tenet Healthcare* shows that it is aware of the contrary position taken in bankruptcy. In response to the provider's citation to a bankruptcy case in *Tenet Healthcare*, the Government attempted to limit the

104. No. 3:13-CV-00134-KGB (E.D. Ark.). It is immaterial for judicial estoppel purposes that the provider seeking to invoke the doctrine was not a party to many of the cases cited above. *See* Edwards v. Aetna Life Ins. Co., 690 F.2d 595, 598 (6th Cir. 1982) (noting that judicial estoppel, unlike equitable estoppel, does not require privity, as it is "intended to protect the integrity of the judicial process" rather than protecting litigants from less scrupulous opponents); USinternetworking, Inc. v. Gen. Growth Mgmt., Inc. (*In re* USinternetworking, Inc.), 310 B.R. 274, 282 (Bankr. D. Md. 2004) (same).

105. See Defendant's Response to Plaintiff's Application for a Temporary Restraining Order/Preliminary Injunction at 9, Se. Ark. Hospice, Inc. v. Sebelius, No. 3:13-CV-00134-KG (E.D. Ark. Feb. 3, 2014); The Secretary of Health and Human Services' Brief in Support of Motion to Dismiss at 8–9, Se. Ark. Hospice, Inc. v. Sebelius, No. 3:13-CV-00134-KG (E.D. Ark. May 19, 2014).

106. *See* Se. Ark. Hospice, Inc. v. Sebelius, 1 F. Supp. 3d 915 (E.D. Ark. 2014) (denying injunction); Se. Ark. Hospice, Inc. v. Sebelius, No. 3:13-CV-00134-KG, slip op. at 18–19 (E.D. Ark. Mar. 26, 2015) (granting motion to dismiss).

application of the bankruptcy case law, but ultimately asserted "in neither context, bankruptcy nor federal court, are Medicare Provider Agreements enforceable as contracts."[107] Thus, it is clear that it is not by "inadvertence" or "mistake"[108] that the Government's position changes depending on which is more favorable in the particular context.

This situation illustrates the public policy interests served by the doctrine of judicial estoppel. The doctrine is "invoked to prevent a party from playing 'playing fast and loose with the courts,' 'from blowing hot and cold as the occasion demands'; or from attempting 'to mislead the courts to gain unfair advantage.'"[109] In breach-of-contract cases outside of bankruptcy, the Government repeatedly takes the position that Medicare Provider Agreements are not contracts and it owes no contractual obligations to providers to defeat breach-of-contract claims by providers or contract defenses asserted by providers. In bankruptcy, it takes the opposite position, asserting Medicare Provider Agreements are executory contracts, with obligations due both sides, to obtain the benefits afforded to counterparties under section 365 of the Bankruptcy Code. The Government is attempting to "have [its] cake and eat it too,"[110] which is exactly what judicial estoppel is intended to prevent. Consequently, the Government should be estopped from asserting in subsequent bankruptcy cases that Medicare Provider Agreements are contracts.[111]

In addition, if the Government successfully argues in prior litigation with a provider that the Medicare Provider Agreement is not a contract, then the Government should also be equitably estopped from arguing that the Medicare Provider Agreement is a contract in a subsequent bankruptcy proceeding between the same parties. The doctrine of equitable estoppel is "'designed to protect any adversary who may be prejudiced by [an] attempted change of position.'"[112]

107. United States' Sur-Reply to Tenant's Reply to Its Motion for Summary Adjudication (Statute of Limitations) at 3, United States v. Tenant Healthcare Corp., No. CV-03-206, 2005 WL 3784642 (C.D. Cal. Dec. 22, 2005).

108. *See* King v. Herbert J. Thomas Mem'l Hosp., 159 F.3d 192, 196 (4th Cir. 1998) (discussing elements and stating judicial estoppel does not apply "where the party's inconsistent positions resulted from inadvertence or mistake").

109. *King*, 159 F.3d at 196 (quoting Lowery v. Stovall, 92 F.3d 219, 223, 225 (4th Cir. 1996)); *see also* Browning Mfg. v. Mims (*In re* Coastal Plains, Inc.), 179 F.3d 197, 205 (5th Cir. 1999) ("[T]he doctrine is intended to protect the judicial system, rather than litigants . . . ."); Shadow Factory Films Ltd. v. Swilley (*In re* Swilley), 295 B.R. 839, 850 (Bankr. D.S.C. 2003) (same).

110. *Lowery*, 92 F.3d at 225 (quoting Duplan Corp. v. Deering Milliken, Inc., 397 F. Supp. 1146, 1177 (D.S.C. 1974)).

111. Although it is not without controversy, courts have held that judicial estoppel "applies to a party's stated position, regardless of whether it is an expression of intention, a statement of fact or a legal assertion." Helfand v. Gerson, 105 F.3d 530, 535 (9th Cir. 1997); *In re* Cassidy, 892 F.2d 637, 642 (7th Cir. 1990) ("We think that the change of position on the legal questions is every bit as harmful to the administration of justice as a change on an issue of fact."), *cert. denied*, 498 U.S. 812 (1990); Kira A. Davis, *Judicial Estoppel and Inconsistent Positions of Law Applied to Fact and Pure Law*, 89 CORNELL L. REV. 191, 215 (2003). Thus, that the Government's argument is a legal assertion should not bar application of judicial estoppel.

112. First Union Commercial Corp. v. Nelson, Mullins, Riley & Scarborough (*In re* Varat Enters., Inc.), 81 F.3d 1310, 1317 (4th Cir. 1996) (quoting Guinness PLC v. Ward, 955 F.2d 875, 899 (4th Cir. 1992)).

Equitable estoppel applies when four elements are met: (1) the party estopped knew the relevant facts; (2) the party estopped intended for its conduct to be relied or acted upon or the party acting has the right to believe the conduct was so intended; (3) the party acting was ignorant of the true facts; and (4) the party acting relied on the conduct to its injury.[113] In many cases the first two elements are met as the Government certainly knows the nature of the Medicare Provider Agreements and, apparently, intends for providers and courts to rely on its position that the Medicare Provider Agreement is not a contract. Providers should not be expected to foresee that the Government would later completely change its position after it succeeded on its non-contractual claims. In fact, in non-bankruptcy litigation, providers may rely on the Government's position that Medicare Provider Agreements are not contracts by not asserting contract defenses, counterclaims, or contractual damages evidence. Having relied on the Government's position in the non-bankruptcy forum, the provider should be able to go into the bankruptcy court and utilize the remedies under the Bankruptcy Code for statutory licenses and other assets, rather than being faced with the contrary position that Medicare Provider Agreements are now executory contracts that instead must be dealt with under section 365 of the Bankruptcy Code.

In sum, if a Medicare Provider Agreement is not a contract outside of bankruptcy, the doctrines of judicial estoppel and equitable estoppel should prevent the Government from taking the inconsistent position that it is a contract in bankruptcy.[114]

Historically, courts have been reluctant to allow estoppel arguments against the United States,[115] but they have allowed estoppel arguments against the

113. *Id.*

114. In addition, if the Government asserts purely non-contractual claims against the provider in pre-bankruptcy litigation, like in *Drakeford*, the related doctrine of claim preclusion may also provide a basis for preventing the Government from asserting new grounds for recovery in the subsequent bankruptcy. Claim preclusion, which in this context is also referred to as the rule against claim splitting, "'prohibits a plaintiff from prosecuting its case piecemeal and requires that all claims arising out of a single wrong be presented in one action.'" Wellin v. Wellin, No. 2:13-CV-1831-DCN, 2014 U.S. Dist. LEXIS 72432, at *10 (D.S.C. May 28, 2014) (quoting Sensormatic Sec. Corp. v. Sensormatic Elecs. Corp., 273 F. App'x 256, 264 (4th Cir. 2008)). Under the doctrine of claim preclusion, a first lawsuit will bar the second claim where there is (i) an identity of causes of action and (ii) an identity of the parties or their privies in the two suits. *Id.* (citing Pueschel v. United States, 369 F.3d 345, 354–55 (4th Cir. 2004)). Claim splitting combined with the federal definition of a cause of action "requires that a plaintiff allege in one proceeding all claims for relief arising out of a single core of operating facts, or be precluded from pursuing those claims in the future." Shaver v. F.W. Woolworth Co., 840 F.2d 1361, 1365 (7th Cir. 1988).

115. Heckler v. Cmty. Health Servs., 467 U.S. 51, 60 (1984) ("It is well settled that the Government may not be estopped on the same terms as any other litigant."). Although courts have been reluctant to apply equitable estoppel in certain contexts against the Government on the same terms as other litigants, more modern cases have moved away from a blanket prohibition. *See generally* 4 KENNETH C. DAVIS, ADMINISTRATIVE LAW TREATISE §§ 20:1–20:6 (2d ed. 1983 & Supp. 1984) (general discussion of estoppel against Government). Courts have allowed equitable estoppel against the Government where "justice and fair play require it," usually based on the presence of affirmative misconduct (as opposed to simple negligence). Bd. of Cty. Comm'rs v. Isaac, 18 F.3d 1492, 1498 (10th Cir. 1994); Watkins v. U.S. Army, 875 F.2d 699, 706–07 (9th Cir. 1989), *cert. denied*, 111 S. Ct. 384 (1990); *see generally* Michael C. Pitore, *Equitable Estoppel: Its Genesis, Development and Application in Government Contracting*, 19 PUB. CONT. L.J. 606 (1990); Renata Petrylaite, *Can the Doctrine of Equitable Estoppel Be Applied Against a Government*, 2

United States when it acts in its proprietary capacity.[116] Although the burden is higher when invoking estoppel against the Government, that burden is not insurmountable.[117] And courts have been more willing to allow judicial estoppel against the Government than equitable estoppel.[118]

It is not always easy to determine whether the Government is acting in its proprietary role as opposed to its sovereign capacity. The United States Court of Appeals for the Ninth Circuit described the difference: "In its proprietary role, the Government is acting as a private concern would; in its sovereign role, the Government is carrying out its unique governmental functions for the benefit of the whole public."[119] In the Medicare context, the distinction can be hard to fathom. By providing the Medicare program the Government is arguably acting in its unique role for the benefit of the public. But it is hard to distinguish between the Government paying a hospital for providing a certain medical procedure and a private insurance company such as Aetna or Blue Cross paying the same hospital for providing the exact same medical procedure. In fact, the Government providing health insurance is indistinguishable from many private concerns that provide health insurance.

Transfer of Medicare Provider Agreement Under Section 363 or Section 365

If the Medicare Provider Agreement is an executory contract, it must be transferred under section 365 of the Bankruptcy Code, which requires that the debtor assume the Medicare Provider Agreement[120] and then assign it to the party buying the agreement.[121] The Government prefers this approach because section 365 of the Bankruptcy Code requires the debtor to cure existing defaults and then effectively reinstates the contract, as if bankruptcy had not intervened.[122] Additionally,

Int'l J. Baltic L. 97, 101 (2004). Given the clear inconsistencies in the Government's approach, it is hard to see how this is not affirmative misconduct. Affirmative misconduct is defined as affirmative acts of misrepresentation or concealment. *Bd. of Cty. Comm'rs*, 18 F.3d at 1499. Neither can the Government argue that this is simply a mistake, because a single federal agency represents it in most of these cases. The Government's position is almost always presented by the Civil Division of the U.S. Department of Justice, which represents most federal agencies, in most circumstances, in federal litigation, or the local U.S. Attorney's office. HHS has no independent litigation authority.

116. *See, e.g.*, Emeco Indus. Inc. v. United States, 485 F.2d 652 (Ct. Cl. 1973) (per curiam) (applying estoppel in the context of an award of a Government contract).

117. Reynolds v. Comm'r of Internal Revenue, 861 F.2d 469, 474 (6th Cir. 1988).

118. *Id.*

119. United States v. Ga.-Pac. Co., 421 F.2d 92, 101 (9th Cir. 1970).

120. 11 U.S.C. § 365(a) (2012).

121. *Id.* § 365(f)(1); *see, e.g.*, A.R.S.C. Co. v. Rickel Home Ctrs. (*In re* Rickel Home Ctrs., Inc.), 209 F.3d 291, 298–99 (3d Cir. 2000).

122. 11 U.S.C. § 365(b) (2012); *see, e.g.*, Elliott v. Four Seasons Props. (*In re* Frontier Props)., 979 F.2d 1358, 1367 (9th Cir. 1992) (the debtor that assumes a contract under section 365 must perform "in full, just as if bankruptcy had not intervened."); *In re* Allen, 135 B.R. 856, 864 (Bankr. N.D. Iowa 1992) (assuming a contract under section 365 only allows the debtor to carry on with the contract according to its terms).

transfer of an executory contract under section 365 requires the party taking the contract to provide adequate assurance of future performance.[123]

In the context of a bankruptcy of a Medicare provider, it is not at all uncommon that the reason for the bankruptcy is that the Government or an agent of the Government has determined that the Medicare provider was overpaid during some prior period. In such circumstances, the Government notifies the provider of the alleged overpayment and gives the provider the option of appealing the determination. During the appeal process, however, the provider is expected to reimburse the Government or face offset of ongoing payments. These overpayments are frequently the cause of the bankruptcy filing, and repayment is beyond the ability of the provider. In other words, if it could "cure" the defaults as necessary to assume and assign the provider agreement, it would not be in bankruptcy in the first place.

However, if the Medicare Provider Agreement is a license to treat Medicare beneficiaries and subsequently bill Medicare, it can be sold under section 363 of the Bankruptcy Code. Section 363 of the Bankruptcy Code provides that a debtor can sell assets and the claims of creditors attach to the proceeds of the sale and provides in pertinent part:

> (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.[124]

Although not without controversy, most bankruptcy courts have held that a license issued by a Government agency is property of the bankruptcy estate,[125] is protected by the automatic stay imposed under section 362 of the Bankruptcy Code,[126] and can be sold under section 363 of the Bankruptcy Code.[127] This is

123. 11 U.S.C. § 365(b)(1)(C); *see, e.g.*, Cinicola v. Scharffenberger, 248 F.3d 110, 120 (3d Cir. 2001); Richmond Leasing Co. v. Capital Bank, N.A., 762 F.2d 1301, 1309–10 (5th Cir. 1985).

124. 11 U.S.C. § 363 (2012).

125. *See In re* Nat'l Cattle Cong., Inc., 179 B.R. 588 (Bankr. N.D. Iowa 1995), *remanded*, 91 F.3d 1113 (8th Cir. 1996) (a license is property of the bankruptcy estate and the state's efforts to revoke the license in order to compel the post-petition payment of a pre-petition claim was void); *see also* Bd. of Trade of Chi. v. Johnson, 264 U.S. 1 (1924) (refusing to limit the concept of property to the definition of property under non-bankruptcy law, the court held that a seat on the Chicago Board of Trade, which was not considered property of the seat holder under Illinois law, constituted property of the debtor seat holder's bankruptcy estate); *compare* California v. Farmers Mkts., Inc. (*In re* Farmers Mkts., Inc.), 792 F.2d 1400, 1403 (9th Cir. 1986) (holding debtors take licenses subject to statutory restrictions), *with In re* Hoffman, 65 B.R. 985, 993 (D.R.I. 1986) (holding restrictions on transfer of a license unenforceable where the restrictions are a "legislative device designed to foster the collection of delinquent debts").

126. *In re* Elsinore Shores Assocs., 66 B.R. 723 (Bankr. D.N.J. 1986) (attempt to revoke gaming license to enforce pecuniary interest was a violation of the automatic stay).

127. *In re* Re Tak Commc'ns, 985 F.2d 916 (7th Cir. 1993); *In re* Fugazy Express, Inc., 124 B.R. 426 (S.D.N.Y. 1991); *In re* Smith, 94 B.R. 220 (Bankr. M.D. Ga. 1988).

because the bankruptcy estate is created automatically upon the commencement of the bankruptcy case.[128] The term "estate" is broadly defined and includes all of a debtor's legal or equitable interests in property, whether tangible or intangible, at the commencement of the case.[129] Unlike with regard to what property rights a debtor has, which are determined by applicable non-bankruptcy law (usually state law), it is federal, not state, law that determines what property falls within the bankruptcy estate.[130]

This issue has also been raised in the context of a Medicaid Provider Agreement, in *In re Skyline Manor, Inc.*[131] In *Skyline Manor*, the trustee elected to reject the Medicaid Provider Agreement, which rendered, among other things, a Medicaid depreciation recapture claim an unsecured claim.[132] However, the trustee also proposed to sell the debtor's assets to a third party under section 363 of the Bankruptcy Code, free and clear of the depreciation recapture claim, and in violation of applicable state law, which required any buyer to assume that liability or face not being given a new Medicaid Provider Agreement.[133] The bankruptcy court agreed with the trustee and allowed the sale of the Medicaid Provider Agreement under section 363(f)(5) of the Bankruptcy Code, over the objection of the State of Nebraska.[134]

If bankruptcy courts were to hold that the Medicare Provider Agreement was a license and not an executory contract, the debtor would have some advantages. For example, the Government would not have the right to demand adequate assurance of future performance and would not have the right to demand the cure of any existing defaults. However, to the extent that the Government has the right to approve the CHOW under applicable non-bankruptcy law (here, the Medicare Act), section 363 does not eliminate the need for such approval, except with regard to those issues relating to the debtor's financial condition.[135] Thus, a

128. 11 U.S.C. § 541 (2012) (A bankruptcy "estate is comprised of all the following property, where ever located: . . . all legal or equitable interests of the debtor in property as of the commencement of the case."); Taylor v. Freeland & Kronz, 503 U.S. 638, 642 (1992) ("When a debtor files a bankruptcy petition, all of his property becomes property of a bankruptcy estate.").

129. United States v. Whiting Pools, Inc., 462 U.S. 198, 203–05 (1983) ("The reorganization effort would have small chance of success, however, if property essential to running the business were excluded from the estate. Thus, to facilitate the rehabilitation of the debtor's business, all of the debtor's property must be included in the reorganization estate." (internal citations omitted)).

130. *See* Nobelman v. Am. Sav. Bank, 508 U.S. 324, 329 (1993) ("In the absence of a controlling federal rule, we generally assume that Congress has 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); *In re* Booth, 266 B.R. 105, 111 (Bankr. N.D. Ohio 2000).

131. No. BK14-80934, 2014 WL 7239703 (Bankr. D. Neb. Dec. 17, 2014).

132. *Id.* at *2.

133. *Id.* at *1–2.

134. *Id.* at *4.

135. 28 U.S.C. § 959(b) (2012) ("[A] trustee, receiver or manager appointed in any cause pending in any court of the United States, including a debtor in possession, shall manage and operate the property in his possession as such trustee, receiver or manager according to the requirements of the valid laws of the State in which such property is situated, in the same manner that the owner or possessor thereof would be bound to do if in possession thereof."); 11 U.S.C. § 362(b)(4) (2012) ("The filing of a petition [in bankruptcy], . . . does not operate as a stay—under paragraph (1), (2), (3), or (6) of subsection (a) of this section, of the commencement or continuation of an ac-

debtor seeking to sell a Medicare Provider Agreement or a buyer seeking to purchase a Medicare Provider Agreement would still have to apply for and obtain a change of ownership certification from the Government and satisfy any conditions for such a transfer, other than those related to the debtor's failure to repay Medicare obligations, and other than the buyer's failure to assume successor liability for such unpaid obligations.

Impact on Government's Setoff and Recoupment Rights

Setoff is an equitable right of a creditor to deduct a debt it owes to the debtor from a claim it has against the debtor arising out of a separate transaction. Recoupment differs in that the opposing claims must arise from the same transaction.[136] Outside of bankruptcy, the distinction is usually not significant; in bankruptcy, however, the distinction can be important. For example, the Bankruptcy Code codifies and governs setoff but is silent as to recoupment.[137] Most significantly, setoff is available in bankruptcy only when the opposing claims are both pre-petition claims or both post-petition claims, and setoff is subject to the automatic stay imposed against creditors by section 362 of the Bankruptcy Code.[138] Recoupment is not so limited.[139]

Here it is important to understand how bankruptcy courts have dealt with the Government's right to adjust ongoing post-petition payments to recover pre-petition debts to the Government. Most courts have held that a sale under section 363 of the Bankruptcy Code eliminates setoff rights vis-à-vis the buyer by permitting a sale free and clear of such interests[140] but that recoupment, being a defense, is not extinguished by a section 363 sale.[141]

The existence of a contractual relationship between a creditor and a debtor is an important factor in decisions that a creditor has a right of recoupment against a debtor (as opposed to a right of setoff). And the Government frequently seeks the right to recoup from monies owed to a provider any amounts owed by the provider to the Government. Where the relationship between the creditor and the debtor is contractual, and the mutual debts arise from the same contract, withholding from ongoing payments to offset earlier overpayments has frequently been allowed as re-

tion or proceeding by a governmental unit . . . [to] enforce such governmental unit's or organization's police and regulatory power, including the enforcement of a judgment other than a money judgment, obtained in an action or proceeding by the governmental unit to enforce such governmental unit's or organization's police or regulatory power.").

136. *In re* 105 E. Second St. Assocs., 207 B.R. 64, 68 (Bankr. S.D.N.Y. 1997).

137. 11 U.S.C. § 553(a) (2012) ("Except as otherwise provided in this section and in sections 362 and 363 of this title, this title does not affect any right of a creditor to offset a mutual debt owing by such creditor to the debtor that arose before the commencement of the case under this title against a claim of such creditor against the debtor that arose before the commencement of the case."); *see generally* Citizens Bank of Md. v. Strumpf (*In re* Strumpf), 516 U.S. 16 (1995) (discussing setoff rights in bankruptcy proceedings); Reiter v. Cooper, 507 U.S. 258, 265 n.2 (1993) (discussing recoupment rights in bankruptcy proceedings).

138. 11 U.S.C. § 362(a) (2012).

139. *In re* McMahon, 129 F.3d 93 (2d Cir. 1997).

140. *In re* Trans World Airlines, Inc., 275 B.R. 712, 718 (Bankr. D. Del. 2002).

141. *Id.* at 719.

coupment.[142] Because recoupment is an equitable defense, most courts recognize that application of the defense of recoupment in a contractual context is appropriate.[143] Where the parties' mutual debts arise out of the contract, recoupment is allowed because "there is but one recovery due on a contract, and that recovery must be determined by taking into account the mutual benefits and obligations of the contract."[144] Still, it is not settled that a ruling that the Medicare Provider Agreement is a contract would compel a conclusion that the Government's right is one of recoupment. Many courts have rejected the argument that because obligations arise from the same contract, they necessarily arise from the same transaction.[145] Although a comprehensive discussion of whether Medicare's right to offset future payments is a right of recoupment or setoff is outside of the scope of this article, if the court determines that the Medicare Provider Agreement is a contractual relationship, it is much more likely to find that the Government's offset rights are those of recoupment rather than setoff. Moreover, as discussed above, courts have held that section 363 sales can cut off a right of setoff, but not a right of recoupment.

Generally, if a Medicare provider can convince the court that the Medicare Provider Agreement creates a statutory entitlement relationship, rather than a contractual relationship, it is much more likely to be able to convince the court that even recoupment rights can be cut off by a sale under section 363 of the Bankruptcy Code. This follows from decisions in cases where the relationship between the Government and the debtor is statutory rather than contractual, such as Social Security beneficiaries or former service members, where courts have held the application of the doctrine of recoupment is questionable.[146]

142. *In re* U.S. Abatement Corp., 79 F.3d 393 (5th Cir. 1996) (holding that a right of recoupment existed where both obligations arose from the terms of the contract between the parties); *In re* Flagstaff Realty Assocs., 60 F.3d 1031 (3d Cir. 1995) (where the creditor's claim and the debtor's claim arise from the same lease, there are rights of recoupment); *In re* Coxson, 43 F.3d 189, 193–94 (5th Cir. 1995) (where creditor's and debtor's obligations arise out of the same contract recoupment is appropriate); Distrib. Servs. Ltd. v. Eddie Parker Interests Inc., 897 F.2d 811, 812 (5th Cir. 1990) ("Recoupment is a defense that goes to the foundation of plaintiffs' claim by deducting from plaintiffs' recovery all just allowances or demands accruing to the defendant with respect to the same contract or transaction.").

143. *See supra* note 140.

144. *In re* Alpco, 62 B.R. 184, 188 (Bankr. S.D. Ohio 1986) (quoting *In re* Maine, 32 B.R. 452, 455 (Bankr. W.D.N.Y. 1983)).

145. *See, e.g.*, *In re* Malinowski, 156 F.3d 131, 135 (2d Cir. 1998) ("Where the contract itself contemplates the business to be transacted as discrete and independent units, even claims predicated on a single contract will be ineligible for recoupment."); *In re* Peterson Distrib., Inc., 82 F.3d 956, 960 (10th Cir. 1996) (rejecting "same contract equals same transaction" as "overly simplistic" and holding that recoupment is only available where the obligations "are so closely intertwined that allowing the debtor to escape its obligations would be inequitable"); Univ. Med. Ctr. v. Sullivan (*In re* Univ. Med. Ctr.), 973 F.2d 1065, 1081–82 (3d Cir. 1992) ("same transaction" requirement for recoupment must be narrowly construed); *In re* Furr's Supermarkets, Inc., 320 B.R. 1, 6–7 (Bankr. D.N.M. 2004) ("It is not enough merely that the claims at issue arise out of the same contract; something more must be shown."); *In re* St. Francis Physicians Network, Inc., 213 B.R. 710, 719–20 (Bankr. N.D. Ill. 1997) (the requirements for recoupment "cannot be satisfied merely by showing that the two claims arose under the same contract"); *In re* Thompson, 182 B.R. 140, 147–49 (Bankr. E.D. Va. 1995) ("One contract alone, however, is not sufficient to establish a single transaction, since separate transactions may occur within the confines of the contract.").

146. *Compare* Lee v. Schweiker, 739 F.2d 870 (3d Cir. 1984), *In re* Rowan, 15 B.R. 834 (Bankr. N.D. Ohio 1981), *aff'd*, 747 F.2d 1052 (6th Cir. 1984) (government has no recoupment right to with-

Impact on Successor Liability

The Bankruptcy Code allows debtors to sell assets free and clear of claims, lien, and interests.[147] As mentioned earlier, if a buyer takes an assignment of the Medicare Provider Agreement, the United States will normally impose successor liability upon the buyer. In litigation around the nation, the Government takes the position that transfer of a Medicare Provider Agreement automatically results in successor liability on the entity taking the Medicare Provider Agreement, including being subject to the Government's recoupment rights.[148] However, if a debtor sells its Medicare Provider Agreement pursuant to section 363 of the Bankruptcy Code, it will argue that section 363(f) of the Bankruptcy Code allows it to sell the agreement "free and clear of any interest in such property," including any successor liability.[149]

Although section 363(f) of the Bankruptcy Code provides for the sale of assets "free and clear of any interests," the term "any interest" is not defined in the Bankruptcy Code. However, courts have frequently held that the scope of section 363(f) is not limited to *in rem* interests.[150] The Second, Third, Fourth, and Sev-

hold Social Security benefits "earned" post-petition to collect pre-petition debt), *In re* Vance, 298 B.R. 262, 267 (Bankr. E.D. Va. 2003) ("In order for the doctrine [of recoupment] to apply, . . . the source of the defendant's claims must be a contract, as opposed to a government entitlement program."), *and In re* Howell, 4 B.R. 102 (M.D. Tenn. 1980) (no recoupment of past overpayments under statutory entitlement program from future benefits), *with* Meyer v. Kan. Dep't of Labor (*In re* Meyer), 521 B.R. 918 (Bankr. D. Mo. 2014), *In re* Adamic, 291 B.R. 175, 184–85 (Bankr. D. Colo. 2003) (allowing state recoupment of prior overpaid unemployment benefits from post-petition benefits), *In re* Snodgrass, 244 B.R. 353 (Bankr. W.D. Va. 2000) (state entitled to exercise statutory right to recoup special separation benefit previously paid by deducting it from disability benefits), *In re* Gaither, 200 B.R. 847 (Bankr. S.D. Ohio 1996) (state does not violate the stay by recouping pre-petition overpayment from ongoing post-petition unemployment compensation because it is in the nature of a societal contract), *In re* Ross, 104 B.R. 171 (E.D. Mo. 1989) (allowing recoupment of unemployment compensation benefits), *In re* Keisler, 176 B.R. 605, 607 (Bankr. M.D. Fla. 1994) (government entitled to recoup prior overpayments from ongoing disability payments), *and In re* Newman, 35 B.R. 97, 99 (Bankr. W.D.N.Y. 1983) (government entitled to withhold disability benefits "earned" post-petition to offset lump sum severance payment made pre-petition where both "resulted" from same disability incident).

147. *See* 11 U.S.C. § 1123(a)(5)(D) (2012) (providing a sale of property of the estate "either subject to or free of any lien" as an example of a means for implementing a plan); *id.* § 1129(b)(2)(A)(ii) (allowing sale free and clear of liens to satisfy fair and equitable requirement for cram down); *id.* § 1141(c) ((stating property dealt with in the plan "is free and clear of all claims and interests of creditors").

148. Deerbrook Pavilion, LLC v. Shalala, 235 F.3d 1100, 1103–04 (8th Cir. 2000) (noting that when a new owner of a skilled nursing facility assumes an existing Medicare Provider Agreement, it becomes liable for obligations owed by the prior owner); United States v. Vernon Home Health, Inc., 21 F.3d 693, 696 (5th Cir. 1994) (holding that purchaser of home health agency that takes assignment of Medicare Provider Agreement is liable for seller's overpayment liabilities), *cert. denied*, 513 U.S. 1015 (1994); Delta Health Grp., Inc. v. HHS, 459 F. Supp. 2d 1207, 1221 (N.D. Fla. 2006) ("[C]ourts have *uniformly* interpreted the [Medicare] regulations to apply to and justify successor liability for [Civil Monetary Penalties] meaning that the new owner who assumes an existing [Medicare] [P]rovider [A]greement and number instead of applying for a new one will be responsible for the prior owner's liabilities.").

149. 11 U.S.C. § 363(f) (2012).

150. *See, e.g.*, Folger Adam Sec., Inc. v. DeMatteis/MacGregor, JV, 209 F.3d 252, 258 (3d Cir. 2000) (holding that debtors "could sell their assets under § 363(f) free and clear of successor liability that otherwise would have arisen under federal statute").

enth Circuits, and many lower courts, have applied an expansive interpretation of "any interest" to include not only *in rem* interests in property but also other obligations that may "arise from the property being sold."[151]

For example, in *In re Trans World Airlines, Inc.*, the United States Court of Appeals for the Third Circuit specifically addressed the scope of the term "any interest."[152] The Third Circuit observed that although some courts have "narrowly interpreted that phrase to mean only *in rem* interests in property," the trend in modern cases is toward "a more expansive reading of 'interests in property,' which 'encompasses other obligations that may flow from ownership of the property.'"[153]

The United States Court of Appeals for the Fourth Circuit considered what constitutes "interests" with regard to a bankruptcy sale under section 363 of the Bankruptcy Code in *United Mine Workers of America 1992 Benefit Plan v. Leckie Smokeless Coal Co. (In re Leckie Smokeless Coal Co.)*.[154] In *Leckie Smokeless*, the debtors were signatories to coal wage agreements and thus responsible for certain retiree health benefit obligations under the agreements and related federal statutes. In determining whether the obligations were "interests," the court first declined to limit the term to *in rem* interests.[155] Rather, the court held that the obligations were "interests" because of the relationship between the creditors' rights to payment and the use to which the debtors put their assets.[156] The Fourth Circuit reasoned that the rights to collect payments were interests because they are "are grounded, at least in part, in the fact that [the assets being sold] have been employed for coal mining purposes."[157] In reaching its conclusion, the *Leckie Smokeless* court cited *P.K.R. Convalescent Centers, Inc. v. Virginia (In re P.K.R. Convalescent Centers, Inc.)*[158] with approval. *P.K.R. Convalescent Centers* involved the Virginia Medicaid program's claim for depreciation recapture, which, under state law, it could collect from a purchaser and set off against future Medicaid reimbursements.[159] The bankruptcy court in that case held that the state's recapture rights were "interests," and thus the state law was preempted by section 363(f) of the Bankruptcy Code and cut off by the bankruptcy sale.[160]

In the bankruptcy of a Medicare provider, the Government's recoupment claims are arguably analogous to the benefit obligations in *Leckie Smokeless* and the depreciation recapture rights in *P.K.R. Convalescent Centers* and

151. *In re* Grumman Olson Indus. Inc., 467 B.R. 694, 702–03 (S.D.N.Y. 2012); *see also* Precision Indus., Inc. v. Qualitech Steel SBQ, LLC, 327 F.3d 537, 545 (7th Cir. 2003) (the term "any interest" in section 363(f) includes a lessee's possessory interest in a Chapter 11 debtor's real property).
152. 322 F.3d 283 (3d Cir. 2003).
153. *Id.* at 289–90.
154. 99 F.3d 573 (4th Cir. 1996).
155. *Id.* at 582.
156. *Id.*
157. *Id.*
158. 189 B.R. 90 (Bankr. E.D. Va. 1995).
159. *Id.* at 91–92.
160. *Id.* at 94.

WBQ Partnership v. Virginia Department of Medicine Assistance Services (In re WBQ Partnership).[161] As such, using the test articulated by the Fourth Circuit in *Leckie Smokeless*, there is a relationship between the right to assert recoupment and the debtor's use of the asset (providing services to Medicare beneficiaries). In short, the Government's alleged right is grounded in the asset (the Medicare Provider Agreement) that the debtor will seek to use or sell.

Further, the Fourth Circuit specifically endorsed that sales under section 363 could be accomplished free and clear of statutory rights such as the Government's right of recoupment, stating, "Congress has given no indication that bankruptcy courts cannot order property sold free and clear of interests that Congress has itself created by statute."[162] Consequently, applying the guidelines as set forth in *Leckie Smokeless*, the Government's alleged recoupment rights are "interests" that can be avoided pursuant to a free-and-clear sale under the Bankruptcy Code.[163]

In *In re Chrysler, LLC*,[164] the United States Court of Appeals for the Second Circuit, employing a broad reading of "any interest" in section 363(f), held that the bankruptcy court was permitted to authorize the sale of substantially all of the debtor's automobile manufacturing assets pursuant to section 363(f) free and clear of claims arising from the property being sold, including liability for tort claims.[165] More recently, in *Massachusetts Department of Unemployment Assistance v. OPK Biotech, LLC (In re PBBPC, Inc.)*,[166] the Bankruptcy Appellate Panel for the First Circuit held that the right of the Commonwealth of Massachusetts to treat a purchaser of substantially all of the assets of a Chapter 11 debtor as a "successor employer," to which the Commonwealth could apply the debtor's experience rating for purposes of calculating the purchaser's unemployment insurance contribution requirements, fell within the term "any interest," of which the debtor's assets could be sold free and clear. Its holding was based in part on the finding that:

> [T]he transfer of an employer's contribution rate to a successor asset purchaser is really an attempt to recover the money that the predecessor employer would have paid if it had continued in business. The liability for the increased rate thus follows any purchase of substantially all of the assets of an employer. The transfer of those assets alone, not the continuation of the Debtor's business, is sufficient to trigger the imposition of successor liability on a purchaser.[167]

Similarly, in *In re Tougher Industries*,[168] the bankruptcy court held that the right of the New York State Department of Labor to use the debtor's experience

161. 189 B.R. 97, 105 (Bankr. E.D. Va. 1995) (holding that Commonwealth of Virginia's right to recapture depreciation is an "interest" as that term is used in section 363 of the Bankruptcy Code).

162. *Leckie Smokeless*, 99 F.3d at 586.

163. *See also In re* BDK Health Mgmt., Inc., No. 98-609-B1, 1998 Bankr. LEXIS 2031, at *6 (authorizing the sale of the provider agreement free and clear of the Government's right to recoup future payments from the buyer).

164. 576 F.3d 108, 126 (2d Cir.), *vacated as moot sub nom.* Ind. State Police Pension Tr. v. Chrysler, LLC, 130 S. Ct. 1015 (2009).

165. *Id.* at 126; *see also In re* Gen. Motors Corp., 407 B.R. 463 (Bankr. S.D.N.Y. 2009).

166. 484 B.R. 860 (1st Cir. B.A.P. 2013).

167. *Id.* at 869.

168. Nos. 06-12960, 07-10022, 2013 WL 1276501 (Bankr. N.D.N.Y. Mar. 27, 2013).

rating to determine the buyer's tax liability as successor to the debtor was an "interest" in property, of which the debtor's assets could be sold free and clear.

Thus, courts in bankruptcy proceedings have consistently held that a buyer of a debtor's assets pursuant to a section 363 sale takes such assets free from successor liability resulting from pre-existing claims.[169] The purpose of an order purporting to authorize the transfer of assets free and clear of all "interests" would be frustrated if claimants could thereafter use the transfer as a basis to assert claims against the purchaser arising from the debtor's pre-sale conduct. Under section 363(f) of the Bankruptcy Code, the buyer is entitled to know that the debtor's assets are not infected with latent claims that will be asserted against the purchaser after the proposed transaction is completed. Accordingly, consistent with the above-cited case law, debtors have powerful arguments that an order approving the sale of a Medicare Provider Agreement under section 363 of the Bankruptcy Code should state that the successful bidder is not liable as a successor, under any theory of successor liability, for claims that encumber or relate to the assets being sold.

Section 525 Impact

Section 525(a) of the Bankruptcy Code is a governmental anti-discrimination provision that provides, in pertinent part:

> [A] governmental unit may not deny, revoke, suspend, or refuse to renew a license, permit, charter, franchise, or other similar grant to, condition such a grant to, discriminate with respect to such a grant against, deny employment to, terminate the employment of, or discriminate with respect to employment against, a person that is or has been a debtor under this title or a bankrupt or a debtor under the Bankruptcy Act, or another person with whom such bankrupt or debtor has been associated, solely because such bankrupt or debtor is or has been a debtor under this title or a bankrupt or debtor under the Bankruptcy Act, has been insolvent before the commencement of the case under this title, or during the case but before the

169. *See* MacArthur Co. v. Johns-Manville Corp. (*In re* Johns-Manville Corp.), 837 F.2d 89, 93–94 (2d Cir. 1988) (channeling of claims to proceeds consistent with intent of sale free and clear under section 363(f) of the Bankruptcy Code); Ninth Ave. Remedial Grp. v. Allis-Chalmers Corp., 195 B.R. 716, 732 (Bankr. N.D. Ind. 1996) (stating that a bankruptcy court has the power to sell assets free and clear of any interest that could be brought against the bankruptcy estate during the bankruptcy); Am. Living Sys. v. Bonapfel (*In re* All Am. of Ashburn, Inc.), 56 B.R. 186, 190 (Bankr. N.D. Ga. 1986) (product liability claims based on successor doctrine precluded after sale of assets free and clear); *In re* Hoffman, 53 B.R. 874, 876 (Bankr. D.R.I. 1985) (transfer of liquor license free and clear of any interest permissible even though the estate had unpaid taxes); *In re* New England Fish Co., 19 B.R. 323, 329 (Bankr. W.D. Wash. 1982) (transfer of property in free-and-clear sale included free and clear of Title VII employment discrimination and civil rights claims of debtor's employees). Some courts, concluding that section 363(f) of the Bankruptcy Code does not empower them to convey assets free and clear of claims, have nevertheless found that section 105(a) of the Bankruptcy Code provides such authority. *See, e.g.*, Volvo White Truck Corp. v. Chambersburg Beverage, Inc. (*In re* White Motor Credit Corp.), 75 B.R. 944, 948 (Bankr. N.D. Ohio 1987) (stating that the absence of specific authority to sell assets free and clear of claims poses no impediment to such a sale, as such authority is implicit in the court's equitable powers when necessary to carry out the provisions of the Bankruptcy Code).

> debtor is granted or denied a discharge, or has not paid a debt that is dischargeable in the case under this title or that was discharged under the Bankruptcy Act.[170]

This provision prohibits the Government from punishing a debtor for, among other things, failing to pay a dischargeable debt. As one can see from the plain language of section 525 of the Bankruptcy Code, contracts are not expressly mentioned in the list of relationships covered by section 525. For this reason, commentators agreeing with the argument that the Medicare Provider Agreement is a contract have argued that the Medicare Provider Agreement is not covered by section 525 of the Bankruptcy Code because it is not a "license, permit, charter, franchise or other similar grant" as enumerated by section 525.[171] However, a determination that the Medicare Provider Agreement is a contract is not necessarily fatal to a debtor's invocation of section 525. Some courts have held that although the word "contracts" is not included in section 525's text, the enumerated examples were not intended to be exclusive, and the section was intended to reach the grant or renewal of Government contracts.[172]

If a Medicare Provider Agreement is treated as a statutory license rather than an executory contract, it is squarely within the parameters of section 525(a).[173] Thus, debtors in bankruptcy may have a ground for thwarting the Government's efforts to recoup overpayments or suspend or terminate their Medicare Provider Agreement in bankruptcy. For example, in *Health Care Financing Administration v. Sun Healthcare Group, Inc. (In re Sun Healthcare Group, Inc.)*,[174] the Government informed the provider, which was a debtor in bankruptcy, that its participation in the Medicare and Medicaid programs would not be reinstated because of two outstanding overpayments and civil penalties owed to the Medicare program. The debtor then moved pursuant to sections 105(a)[175] and 525(a) of the Bankruptcy Code to compel the Government to recertify the debtor or, in the alternative, to allow the debtor to pay the pre-petition debts.[176] The bankruptcy

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170. 11 U.S.C. § 525(a) (2012).

171. E.H. Sperow, *Section 525(a) of the Bankruptcy Code Plainly Does Not Apply to Medicare Provider Agreements*, 34 J. HEALTH L. 487 (2001).

172. *See, e.g.*, *In re* Exquisito Servs., Inc., 823 F.2d 151 (5th Cir. 1987) (holding that the Government's refusal to renew a contract solely on the basis of the debtor's bankruptcy was a violation of section 525(a)).

173. *See, e.g.*, FCC v. Nextwave Personal Commc'ns Inc., 537 U.S. 293 (2003) (finding cancellation of FCC license a violation of section 525).

174. Nos. 99-3657, 99-3841, 2002 U.S. Dist. LEXIS 17868 (D. Del. 2002).

175. Section 105(a) of the Bankruptcy Code provides, in pertinent part:

> The court may issue any order, process, or judgment that is necessary or appropriate to carry out the provisions of this title. No provision of this title providing for the raising of an issue by a party in interest shall be construed to preclude the court from, sua sponte, taking any action or making any determination necessary or appropriate to enforce or implement court orders or rules, or to prevent an abuse of process.

11 U.S.C. § 105(a) (2012). Though seemingly broad, section 105 has limits. *See, e.g.*, *In re* Southmark Corp., 49 F.3d 1111, 1116 (5th Cir. 1995) (section 105 does not authorize bankruptcy courts "to act as a roving commissions to do equity").

176. Health Care Fin. Admin. v. Sun Healthcare Grp., Inc. (*In re* Sun Healthcare Grp., Inc.), Nos. 99-3657, 99-3841, 2002 U.S. Dist. LEXIS 17868, at *2 (D. Del. 2002).

court granted the debtor's motion, and the Government appealed.[177] On appeal, the district court considered whether the Medicare Provider Agreement is a license or "other similar grant" for purposes of section 525(a).[178] The Government argued that, because the Medicare Provider Agreements are executory contracts, they could not be covered under section 525 of the Bankruptcy Code. The district court disagreed, finding that the Third Circuit precedent[179] stating that the Medicare Provider Agreement was an executory contract did not address the applicability of section 525.[180] Rather, the district court noted that the Government "has never refuted the argument that without the provider agreement, the providers will lose the governmental benefit of compensation for their services."[181] As a result, the district court held that "although the Medicare Provider Agreement may not be a license in the strictest sense of the word, it is clearly similar to a license for section 525 purposes."[182] The court then found that the Government had discriminated against the debtor in violation of section 525 and affirmed the ruling of the bankruptcy court.

The Government will likely argue that it has the right to deny the transfer of the Medicare Provider Agreement because it has the regulatory authority to do so under the Medicare Act. It will also likely argue that because failure to pay obligations by a debtor (or assume the responsibility for paying those obligations by a buyer) is a violation of applicable statute and regulations, the Medicare Provider Agreement cannot be transferred without successor liability. However, the United States Supreme Court, in *FCC v. Nextwave Personal Communications Inc.*,[183] rejected a similar argument by the Federal Communications Commission:

> The FCC has not denied that the proximate cause for its cancellation of the licenses was NextWave's failure to make the payments that were due. It contends, however, that § 525 does not apply because the FCC had a "valid regulatory motive" for the cancellation. In our view, that factor is irrelevant. When the statute refers to failure to pay a debt as the sole cause of cancellation ("solely because"), it cannot reasonably be understood to include, among the other causes whose presence can preclude application of the prohibition, the governmental unit's motive in effecting the cancellation. Such a reading would deprive § 525 of all force. It is hard to imagine a situation in which a governmental unit would not have some further motive behind the cancellation—assuring the financial solvency of the licensed entity, or punishing lawlessness, or even (quite simply) making itself financially whole. Section 525 means nothing more or less than that the failure to pay a dischargeable debt must alone be the proximate cause of the cancellation—the act or event that triggers the agency's decision to cancel, whatever the agency's ultimate motive in pulling the trigger may be.[184]

177. *Id.* at *3.
178. *Id.* at *5.
179. Univ. Med. Ctr. v. Sullivan (*In re* Univ. Med. Ctr.), 973 F.2d 1065 (3d Cir. 1992).
180. *Sun Healthcare Grp.*, 2002 U.S. Dist. LEXIS 17868, at *5.
181. *Id.* at *6.
182. *Id.*
183. 537 U.S. 293 (2003).
184. *Id.* at 300 (internal citations omitted).

Thus, as long as the proximate cause of the Government's refusal to allow the transfer of the Medicare Provider Agreement relates to the unsatisfied financial obligations of the debtor to the Government, for the Government to impose successor liability or refuse to recognize the buyer as taking an assignment of the Medicare Provider Agreement without successor liability would be a violation of section 525 of the Bankruptcy Code.

Conclusion

For three decades bankruptcy courts have allowed the Government to argue that the Medicare Provider Agreement is an executory contract, despite the Government's strong arguments outside of bankruptcy that the Medicare Provider Agreement is not a contract, but merely the equivalent of a license creating a statutory entitlement to participate in the Medicare Program under existing statute and regulations. The Government's attempt to "have its cake and eat it too" should be rejected by courts. Instead, courts should require the United States to pick a position and adhere to it. Moreover, there are powerful arguments that a Medicare Provider Agreement has none of the characteristics of a contractual relationship and, in fact, that the Government itself rejects that the Medicare Provider Agreement is a contract outside of bankruptcy should be dispositive, as a matter of contract law, estoppel, and common sense. Instead, bankruptcy courts should recognize that the Medicare Provider Agreement is a license that can be sold under section 363 of the Bankruptcy Code, free and clear of interests, including successor liability.

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UNITED STATES BANKRUPTCY COURT

CENTRAL DISTRICT OF CALIFORNIA - LOS ANGELES DIVISION

In re VERITY HEALTH SYSTEM OF CALIFORNIA, INC., *et al.*, Debtor and Debtor In Possession.	Lead Case No. 2:18-bk-20151-ER Jointly Administered With: Case No. 2:18-bk-20162-ER Case No. 2:18-bk-20163-ER Case No. 2:18-bk-20164-ER Case No. 2:18-bk-20165-ER Case No. 2:18-bk-20167-ER Case No. 2:18-bk-20168-ER Case No. 2:18-bk-20169-ER Case No. 2:18-bk-20171-ER Case No. 2:18-bk-20172-ER Case No. 2:18-bk-20173-ER Case No. 2:18-bk-20175-ER Case No. 2:18-bk-20176-ER Case No. 2:18-bk-20178-ER Case No. 2:18-bk-20179-ER Case No. 2:18-bk-20180-ER Case No. 2:18-bk-20181-ER
☒ Affects All Debtors ☐ Affects Verity Health System of California, Inc. ☐ Affects O'Connor Hospital ☐ Affects Saint Louise Regional Hospital ☐ Affects St. Francis Medical Center ☐ Affects St. Vincent Medical Center ☐ Affects Seton Medical Center ☐ Affects O'Connor Hospital Foundation ☐ Affects Saint Louise Regional Hospital Foundation ☐ Affects St. Francis Medical Center of Lynwood Foundation ☐ Affects St. Vincent Foundation ☐ Affects St. Vincent Dialysis Center, Inc. ☐ Affects Seton Medical Center Foundation ☐ Affects Verity Business Services ☐ Affects Verity Medical Foundation ☐ Affects Verity Holdings, LLC ☐ Affects De Paul Ventures, LLC ☐ Affects De Paul Ventures - San Jose Dialysis, LLC Debtors and Debtors In Possession.	Chapter 11 Cases Hon. Judge Ernest M. Robles **DEBTORS' REPLY TO RESPONSE OF CALIFORNIA ATTORNEY GENERAL TO DEBTORS' BID PROCEDURES MOTION** Hearing: Date: October 24, 2018 Time: 10:00 a.m. Ctrm: Courtroom 1568 255 East Temple Street Los Angeles, CA 90012

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I. INTRODUCTION

The Debtors filed a motion (the "Motion") for approval of bid procedures and a potential sale of two of its hospitals, O'Connor Hospital and Saint Louise Regional Hospital (collectively, the "Hospitals"), to Santa Clara County (the "Buyer") [Docket No. 365]. On October 10, 2018, the California Attorney General (the "AG"), filed a "response" (the "Response") to the Motion [Docket No. 463], asserting that the transaction was subject to each and every one of the numerous conditions imposed in 2015 on the recapitalization of the Debtors by BlueMountain Capital Management LLC (the "Conditions").

In his Response, the AG argues that the Motion should not be granted unless the Debtors agree that the Conditions remain binding on any buyer, regardless of the impact of the Bankruptcy Code.[1] First, this issue is premature, because it is not clear, and will not be clear until after the auction, that the winning buyer will not voluntarily agree to abide by the Conditions. Therefore, it is premature to address this issue now. Second, the AG takes positions contrary to bankruptcy law, effectively arguing that it is simply not bound by federal law or subject to this Court's jurisdiction. Finally, the AG argues that the Conditions must remain binding on any buyers, and that it can compel specific performance of the Conditions, without explaining how the Debtors are to keep these hospitals open if no buyer is willing to take on the facilities subject to these Conditions. For all these reasons the AG's Response should be overruled.

II. Background

In 2015 the AG conditionally consented to the terms of the System Restructuring and Supporting Agreement between the Daughters of Charity Health System and its sole member, Daughters of Charity Ministry Services Corporation, certain funds managed by BlueMountain Capital Management, LLC, and Integrity Healthcare, LLC. The Conditions were imposed for periods ranging from 5 to 15 years. Generally, the terms of the Conditions include (1) transfers of control, (2) maintenance of health services, (3) required participation in Medicare and Medi-Cal programs, (4) community benefit programs, (5) charity care levels, (6) county contracts, (7) local

[1] All references to "sections" or "§" are to sections of the Bankruptcy Code, 11 U.S.C. §§ 101, et. seq., as amended.

governing boards, (8) medical staff compliance, (9) ethical and religious directives, and (10) annual attestation of compliance with the AG conditions. *See* Letter from Wendi A. Horwitz, Deputy Attorney General, to John O. Chesley, Ropes & Gray LLP, Re: Proposed Change in Governance and Control of Daughters of Charity Health System, dated Dec. 3, 2015 (the "AG Conditions Letter"), available at https://oag.ca.gov/sites/all/files/agweb/pdfs/charities/pdf/chs.pdf (last visited on Sept. 17, 2018) [Docket No. 60].

Each hospital has specific requirements as to services that had to be maintained or even expanded. For example, O'Connor Medical Center is required to maintain an emergency room with 23 licensed stations, 22 intensive care/coronary care beds, 39 obstetrics beds, 24 sub-acute beds, and 14 pediatric beds, among other things. It is also required to provide $15,295,925 of charity care annually and provide community benefit programs of at least $2,718,710 annually. It is also required to maintain Medi-Cal contracts with, among other parties, Anthem Blue Cross of California, a commercial health plan, regardless of the financial terms offered. Saint Louise Medical Center is required to maintain 8 licensed treatment stations for 10 years, provide no less than $1,822.623 in charitable care annually for five years, and provide no less than $873,145 in community benefits annually. Each of the conditions are based on the historical care provided by Verity's predecessor through these hospitals.

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III. The Sale of the Hospitals Is Not Subject to Attorney General Review

The Response implies that the proposed transaction is subject to AG review. However, the proposed sale to Santa Clara County is not subject to AG review. Section 5914 of the California Corporations Code ("Section 5914") provides that the sale of a not-for-profit ("NFP") healthcare facility is subject to AG review if the buyer is a (a) for-profit corporation or entity, (b) not-for-profit corporation or entity, or (c) mutual benefit corporation or entity. Cal. Corp. Code § 5914(a)(1) says, for example, "Any [healthcare] nonprofit corporation … shall be required to provide written notice to, and to obtain the written consent of, the Attorney General prior to entering into any agreement or transaction to do either of the following: (A) Sell, transfer, lease, … its assets to a for-profit corporation or entity or to a mutual benefit corporation or entity when a material amount of the assets of the nonprofit corporation are involved in the agreement or

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transaction." A similar provision provides the same obligation vis-à-vis sales to not-for-profit corporations or entities.

A county government is a public entity, not (i) a for-profit corporation or entity, (ii) a mutual benefit corporation or entity, or (iii) a not-for-profit corporation or entity. "A public entity is defined including "any State or local government." *Vartinelli v. Stapleton*, 2009 U.S. Dist. LEXIS 88553 (E.D. Mich. Aug. 3, 2009). The term "public entity" is used repeatedly in California law. *See, e.g.,* Cal. Pub. Contract Code § 7200(a)(2) ("For purposes of this section, 'public entity' means … [a] county, …."); Cal. Pub. Contract Code § 7201(a)(2) ("For purposes of this section, 'public entity' means … [a] county, …."). Based on the plain language of the statute, *Lamie v. United States Tr*., 540 U.S. 526, 534 (2004) ("[W]hen the statute's language is plain, the sole function of the courts . . . is to enforce it according to its terms."), the proposed sale to Santa Clara County is not subject to AG review because a county is not one of the types of organizations listed in Section 5914. This is a substantive distinction, not a technical one. The California legislature, through their conscience omission of public entities in Section 5914, specifically allowed public entities (directly responsible to the hospitals' stakeholders) to purchase hospitals and protect their own local public interest without interference from the more remote AG. *See generally*, *C & A Carbone, Inc. v. Town of Clarkstown, N.Y.*, 511 U.S. 383, 421, 114 S. Ct. 1677, 1697, 128 L. Ed. 2d 399 (1994) (Souter, D., dissenting) ("The local government itself occupies a [unique] market position, however, being the one entity that enters the market to serve the public interest of local citizens. . .").

IV. The Conditions Imposed in 2015 Can Be Cut Off by a Sale Pursuant to § 363

The AG argues that the Conditions will remain binding on any buyer of assets. However, a sale under § 363(f) allows the debtor to sell assets "free and clear of any interest in such property." This Court addressed a similar argument in *In re Gardens Regional Hospital and Medical Center, Inc*., 567 B.R. 820 (Bankr. C.D. Cal. 2017), where the AG asserted that conditions imposed in a proposed sale would be binding on any subsequent buyer. This Court stated that the Attorney General's authority to impose charitable care conditions on a buyer as part of the Attorney General's review of the sale of a not-for-profit hospital is an "interest in

property" that can be stripped off the assets through a sale under § 363. *Id.* at 825-830. This ruling is consistent with rulings by many courts which have interpreted "any interest" expansively to include not only in rem interests in property, but also other obligations that are "connected to or arise from the property being sold" or that could "potentially travel with the property being sold." *In re La Paloma Generating, Co*., 2017 WL 5197116, *4 (Bankr. D. Del. Nov. 9, 2017) (holding that emission surrender obligations created by California regulations and statutes and enforced by the California Air Resources Board are an interest in property which can be cut off by a § 363 sale) (quoting *In re Trans World Airlines, Inc*., 322 F.3d 283, 285, 288 (3d Cir. 2001) (holding that plaintiff's interests in travel vouchers that were issued to settle employment discrimination are an interest under § 363 because they arise from the property being sold)); *see also United Mine Workers of Am. 1992 Benefit Plan v. Leckie Smokeless Coal Co. (In re Leckie Smokeless Coal Co.)*, 99 F.3d 573, 581-82 (4th Cir. 1996) (holding that coal mine operators could sell their assets free and clear of their obligations to a benefits plan and fund under the Coal Act); *PBBPC, Inc. v. OPK Biotech, LLC (In re PBBPC, Inc.)*, 484 B.R. 860, 867-870 (1st Cir. B.A.P. 2013) (holding that debtor's assets could be sold free and clear of Commonwealth of Massachusetts's right to treat a purchaser of substantially all of the assets of chapter 11 debtor as a "successor employer" to which debtor's experience rating could be imputed to determine purchaser's unemployment insurance contribution); *In re ARSN Liquidating Corp. Inc*., 2017 WL 279472, *5 (Bankr. D.N.H. Jan. 20, 2017) (Nat'l Council on Compensation Ins. violated sale order by imputing debtor's workers' compensation experience rating to buyer in setting buyer's workers' compensation experience rating); *In re Vista Marketing Group Ltd*., 557 B.R. 630, 635-39 (Bankr. N.D. Ill. 2016) (free and clear language in sale order prevented a state sanitary district from asserting claim against asset purchaser for connection fee surcharge that was calculated based entirely on debtor's use of the district's sewer facilities); *United Mine Workers of Am. Combined Benefit Fund v. Walter Energy, Inc*., 551 B.R. 631, 641 (N.D. Ala. 2016) (sale under § 363 cuts off Coal Act obligations despite language in Act imposing successor liability on buyer); *In re Christ Hospital*, 502 B.R. 158, 76-79 (Bankr. D.N.J. 2013) (section 363 sales cut off tort claims against purchaser of nonprofit hospital); *In re Tougher Indus.*, 2013 WL 1276501 at

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**6-9 (Bankr. N.D.N.Y. Mar. 27, 2013) (holding that debtor's assets could be sold free and clear of New York State Department of Labor's right to use the debtor's experience rating to access the buyer's tax liability as successor to the debtor); *In re Grumman Olson Indus. Inc*., 467 B.R. 694, 702–03 (S.D.N.Y 2012) ("Section 363(f) can be used to sell property free and clear of claims that could otherwise be assertable against the buyer of the assets under the common law doctrine of successor liability"); *WBO P'ship v. Va. Dep't of Med. Assistance Servs. (In re WBO P'ship)*, 189 B.R. 97, 104–05 (Bankr. E.D. Va. 1995) (holding that Commonwealth of Virginia's right to recapture depreciation is an "interest" as that term is used in § 363(f)).

That the interests here are imposed by the AG under California law does not alter the impact of § 363. As shown above, "[c]ourts have held that interests in property include monetary obligations arising from the ownership of property, even when those obligations are imposed by statute" and are subject to the legal requirements of a sale under § 363. *In re Gardens Reg'l Hosp. & Med. Ctr., Inc.*, 567 B.R. at 825; *see also In re Tougher Indus.*, 2013 WL 1276501 at **6-9; *Walter Energy, Inc*., 551 B.R. at 641; *In re Leckie Smokeless Coal Co.*, 99 F.3d 573. Courts have long recognized "[t]he exclusive authority of Congress and the federal courts to pass and enforce the bankruptcy laws." *In re Old Carco LLC,* 442 B.R. 196, 207 (S.D.N.Y. 2010) (citing *Int'l Shoe v. Pinkus,* 278 U.S. 261, 263-64 (1929) ("A state is without power to make or enforce any law governing bankruptcies that impairs the obligation of contracts or . . . conflicts with the national bankruptcy laws.")). There is little question that, broadly speaking, federal bankruptcy law preempts state law. *See Myers v. United States*, 297 B.R. 774, 783 (S.D. Cal. 2003). The Bankruptcy Code itself provides for an automatic stay of all state proceedings against the debtor, § 362, and federal preemption in the field of bankruptcy extends to orders of the bankruptcy courts, which are vested "with authority to implement the federal statutory scheme" by the Bankruptcy Code. *Old Carco,* 442 B.R. at 209 (holding that principles of preemption preclude application of state car dealership franchise laws that conflict with orders issued by court in bankruptcy proceedings).

The Conditions are an interest in property subject to § 363(f) because they are based on the historical experience of the prior operator and applied to provide a base line for future

operations of the hospital. An "interest" can refer to any claim or obligation that is connected to or arises from the property being sold in a § 363 sale. *In re Trans World Airlines, Inc*., 322 F.3d at 289-90 (3d Cir. 2003) (followed by *In re PW, LLC*, 391 B.R. 25, 41 (B.A.P. 9th Cir. 2008) ("We believe that Congress intended 'interest' to have an expansive scope, as shown by [*Trans World*]"). Courts have held such conditions can be cut off by a sale under § 363. For example, Tougher Industries Enterprises, LLC and Tougher Mechanical Enterprises, LLC, bought substantially all of the assets of debtors in a sale under § 363. After the sale closed, the New York Department of Labor imposed on the buyers an elevated experience rating for the purposes of calculating their unemployment insurance premiums based on the high experience rate of the predecessor companies. The purchasers went back to court and argued that the assets they purchased were free and clear of any interests, including the debtors' not-so-favorable experience rating. The bankruptcy court agreed with the purchaser. *Tougher Indus.*, 2013 WL at **6-9 . Similarly, the First Circuit Bankruptcy Appellate Panel has concluded that "the transfer of an employer's unemployment insurance contribution rate to a successor asset purchaser is really an attempt to recover the money that the predecessor employer would have paid if it had continued in business" and therefore is an "interest" from which the property can be sold free and clear under § 363. *PBBPC, Inc.,* 484 B.R. at 869. The imposition of the Conditions is much like the experience rating or the unemployment insurance ratings, and should be subject to § 363.

The Response argues in effect that there is something unique about the Conditions, asserting that the AG's review and the Conditions are all about the effect of a transaction on the "availability and accessibility of healthcare services to the affected community." Response, at 6, lines 1-3 ("The **most significant question** is whether the proposed transaction will adversely affect the availability and accessibility of healthcare services to the community."); at 6, lines 9-11 ("**the primary purpose** of the conditions is to ensure the availability and accessibility of healthcare services to the affected community.") (emphasis added). However, there is no evidence to support the "significance" or "primacy" of this factor in the statutes or regulations cited as support for these assertions. To the contrary, the California Corporations Code merely lists this as one of 10 factors and of equal importance with, for example, the effect of the

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proposed transaction on the availability and accessibility of cultural interests in the facility. Cal. Corp. Code § 5917(a)-(j). It fairs no better in the California Code of Regulations where it is one of more than a dozen factors and subfactors to be considered, with no indication of relevance or relative importance. Cal. Code. Regs. tit. 11, § 999.5(f)(1)-(13).

This argument also fails because it tramples on the supremacy of federal bankruptcy law. The imposition of successor liability in this context would effectively defeat the possibility of selling the Debtors' assets "free and clear" of the liabilities of the Debtors, which would inevitably result in purchasers' being unwilling to pay as much for those assets. This would run counter to one of the core policies of the Bankruptcy Code in general, and § 363 in particular, of "maximizing the value of the bankruptcy estate." *See, e.g., Toibb v. Radloff*, 501 U.S. 157, 163 (1991); *United Mine Workers of Am. Combined Benefit Fund v. Walter Energy, Inc.*, 551 B.R. 631, 641 (N.D. Ala. 2016); *Myers*, 297 B.R. at 784 ("In Chapter 11 proceedings, the court is trying to obtain and preserve as many assets as it can to protect secured and unsecured creditors. To do so, it needs to approve sales of assets to third parties."). Additionally, the Conditions do not, at least on their face, uniformly relate to the health or safety of the community, or serve to further availability or accessibility of healthcare. For example, there is currently pending before the Court a motion to allow the Debtors to reject an financially onerous management contract of the Debtors. Nonetheless, continuation of that contract was a condition imposed by the AG.

The Response argues that the imposition of the Conditions is an exercise of the police or regulatory powers of the AG. However, it is not clear that there is a "police powers" exception to the powers granted a debtor by § 363. For example, § 362 has an express exception to the automatic stay for a governmental act which is an exercise of its police or regulatory powers. The absence of such an exception to the powers granted under § 363 should indicate that there is no such exception to the rule. *Gorbach v. Reno*, 219 F.3d 1087, 1093 (9th Cir. 2000) ("A particular statutory provision must be read in context with a view to its place in the statutory scheme, not in isolation.").

Moreover, even if there were such an exception, presumably the tests applicable to interpretation of the police or regulatory powers exception would provide useful guidance. One

of them, § 362(b)(4), often called the "government regulatory exemption," provides that the automatic stay does not apply to "the commencement or continuation of an action or proceeding by a governmental unit . . . to enforce such governmental unit's . . . police and regulatory power." *In re Universal Life Church, Inc.,* 128 F.3d 1294, 1297 (9th Cir. 1997) (internal citations omitted). Courts in the Ninth Circuit have applied two alternative tests when determining whether government action falls under the government regulatory exemption: the pecuniary purpose test and the public policy test. *Id.* Under the pecuniary purpose test, the court must determine "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." *Id.* By contrast, under the public policy test, the court must determine whether the government's action is intended to either "effectuate public policy" or to "adjudicate private rights." *Id*. If the court determines that the government's action is intended either to protect the government's pecuniary interest in the debtor's property or to adjudicate private rights, the government regulatory exemption will not apply and the automatic stay will be imposed. *Id*.

First, the phrase 'police or regulatory power" is not as broad as the AG would suggest; and the Ninth Circuit holds that it "refers to the enforcement of laws affecting health, welfare, morals and safety, but not regulatory laws that directly conflict with the control of the res or property by the bankruptcy court." *In re Universal Life Church, Inc.*, 128 F.3d 1294, 1297 (9th Cir. 1997), as amended on denial of reh'g (Dec. 30, 1997). The bankruptcy court has wide discretion to ascertain whether public health and safety is truly at the heart of the relief sought - or is being conveniently and remotely clung to as a toehold to gain an advantage in the bankruptcy case, particularly to financially benefit third parties. For instance, in *In re FirstEnergy Sols. Corp.*, 2018 WL 2315916 (Bankr. N.D. Ohio May 18, 2018), the Bankruptcy Court for the Northern District of Ohio found that the Federal Energy and Regulatory Commission (FERC) could not continue a proceeding under the public safety exception that - though it was "incidentally related to the core public policy" of FERC because it involved energy commerce - was principally concerned with obtaining "a pecuniary advantage to those counterparties relative to other similarly situated creditors of the estate" by essentially seeking "to elevate. . .obligations

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to counterparties [as] administrative expenses." *Id.* at **10-11. The Court held: "when the action incidentally serves public interests but more substantially adjudicates private rights, courts should regard the suit as outside the police power exception, particularly when a successful suit would result in a pecuniary advantage to certain private parties vis-a-vis other creditors of the estate, contrary to the Bankruptcy Code's priorities." *Id.* at *9.

Second, courts have recognized that states that impose conditions on buyers that require the buyers to make good on obligations of the debtor violate the Bankruptcy Code. *See, e.g., In re Aurora Gas, LLC,* 2017 WL 4325560 (Bankr. D. Alaska Sep. 26, 2017) (holding that state's condition to its approval of sale in bankruptcy was buyer paying unpaid obligations of debtor under state law violates the Bankruptcy Code and is unenforceable.).

Third, the Conditions do not relate to protecting the health of the community, but rather deal with the business operations of the Debtors. It is telling that the AG has no general powers over hospitals in California and cannot generally impose such onerous conditions on hospitals to protect the "availability or accessibility" of California residents to hospital services. Rather, it is only in the context of the AG's authority over NFP assets that he gains any authority over hospitals in California.

Finally, the AG fails to explain how the Debtors, buyers or the Court are expected to deal with their assertions in the Response concerning their powers vis-à-vis the Conditions. For example, the Response states that any buyer must agree to perform in accordance with the existing conditions and that the AG has the ability to obtain an order of specific performance to compel the Debtors and or a buyer to perform in accordance with the Conditions. The extent of this argument is unclear: is the AG arguing that it can compel a buyer to accept the Conditions, even if it is unwilling to do so? That the AG could get an order of specific performance to force a prospective buyer to accept these Conditions? Or, is the AG arguing that he can get an order of specific performance to compel the Debtors to only sell the hospitals to buyers who accept the Conditions? And if there are no buyers willing to accept the Conditions, is the AG arguing that it can get an order of specific performance compelling the Debtors to keep the hospitals open? If so, where does the AG propose the money is coming from to sustain those operations (given that

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the Debtors lose $175 million annually as an enterprise). No, the most likely outcome of the AG insisting on the continuing requirement of the existing Conditions is that no buyer will come forward to acquire the assets and the hospitals will be closed. *See Myers*, 297 B.R. at 784 ("Third parties cannot assess 'worth' if the Bankruptcy Court orders that they take the assets free and clear of any and all claims whatsoever, but nonetheless, unsecured creditors can 'lie in the weeds' and wait until the bankruptcy court approves a sale before it sues the purchasers."). If the AG is ***primarily*** concerned with the continued availability and accessibility of healthcare to the communities served by the hospitals, it is impossible to see how the AG's rigid insistence on the continued application of these Conditions furthers that goal.

V. CONCLUSION

For the reasons stated above, the AG's "Response", to the extent it is an objection, should be overruled.

Dated: October 17, 2018

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UNITED STATES BANKRUPTCY COURT

CENTRAL DISTRICT OF CALIFORNIA - LOS ANGELES DIVISION

In re VERITY HEALTH SYSTEM OF CALIFORNIA, INC., *et al.*, Debtor and Debtor In Possession.	Lead Case No. 2:18-bk-20151-ER Jointly Administered With: Case No. 2:18-bk-20162-ER Case No. 2:18-bk-20163-ER Case No. 2:18-bk-20164-ER Case No. 2:18-bk-20165-ER Case No. 2:18-bk-20167-ER Case No. 2:18-bk-20168-ER Case No. 2:18-bk-20169-ER Case No. 2:18-bk-20171-ER Case No. 2:18-bk-20172-ER Case No. 2:18-bk-20173-ER Case No. 2:18-bk-20175-ER Case No. 2:18-bk-20176-ER Case No. 2:18-bk-20178-ER Case No. 2:18-bk-20179-ER Case No. 2:18-bk-20180-ER Case No. 2:18-bk-20181-ER Chapter 11 Cases Hon. Judge Ernest M. Robles
☒ Affects All Debtors ☐ Affects Verity Health System of California, Inc. ☐ Affects O'Connor Hospital ☐ Affects Saint Louise Regional Hospital ☐ Affects St. Francis Medical Center ☐ Affects St. Vincent Medical Center ☐ Affects Seton Medical Center ☐ Affects O'Connor Hospital Foundation ☐ Affects Saint Louise Regional Hospital Foundation ☐ Affects St. Francis Medical Center of Lynwood Foundation ☐ Affects St. Vincent Foundation ☐ Affects St. Vincent Dialysis Center, Inc. ☐ Affects Seton Medical Center Foundation ☐ Affects Verity Business Services ☐ Affects Verity Medical Foundation ☐ Affects Verity Holdings, LLC ☐ Affects De Paul Ventures, LLC ☐ Affects De Paul Ventures - San Jose Dialysis, LLC Debtors and Debtors In Possession.	**DEBTORS' REPLY TO OBJECTION OF U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES AND CENTERS FOR MEDICARE AND MEDICAID SERVICES TO DEBTORS BID PROCEDURES MOTION** Hearing: Date: October 24, 2018 Time: 10:00 a.m. Ctrm: Courtroom 1568 255 East Temple Street Los Angeles, CA 90012

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I. INTRODUCTION

The Debtors filed a motion (the "Motion") for approval of bid procedures and a potential sale of two of its hospitals, O'Connor Hospital and Saint Louise Regional Hospital (collectively, the "Hospitals"), to Santa Clara County (the "Buyer") [Docket No. 365]. On October 10, 2018, the United States Department of Health and Human Services, acting through its designated agency, the Centers for Medicare and Medicaid Services (collectively the "United States" or "CMS"), filed an objection (the "Objection") [Docket No. 447] to the Motion arguing that the Health Insurance Benefit Agreements ("Provider Agreements"), which enable the Hospitals to receive Medicare payments for services provided to Medicare beneficiaries, were executory contracts which had to be transferred pursuant to § 365 of the Bankruptcy Code.[1]

In the Objection CMS incorrectly argues that the Motion should not be granted unless the Debtors agree that the Medicare Provider Agreement between the CMS and the Debtors must be treated as an executory contract. First, this issue is premature, because it is not clear -- and will not be clear until after the auction -- that the winning buyer will want to acquire the Purchase Agreements. If the winning bidder does not want the Provider Agreements this issue may be moot. Second, CMS takes positions contrary to binding Ninth Circuit precedent and its own prior arguments in the Central District of California (and to multiple federal courts) as to whether the Provider Agreement is a contract or not. Because CMS routinely and unequivocally argues, and prevails, on its argument that a Provider Agreement is not a contract, it should be estopped from arguing that the Provider Agreement is a contract here. Further, if the Court considers the merits of whether the Provider Agreement is an executory contract the Court should find that it is not a contract, or, alternatively, that is not executory. Finally, the Anti-Assignment Act does not apply in these circumstances. For all these reasons CMS's objection should be overruled.

II. CMS Should Be Estopped From Arguing That The Provider Agreement Is A Contract

CMS regularly argues and prevails on the argument that that the Medicare Provider

[1] All references to "§" or "sections" herein are to sections of the Bankruptcy Code, 11 U.S.C. § 101, et. seq, as amended, unless otherwise noted.

Agreement is not a contract in federal court. For example, CMS argued the following to the Central District of California Court in 2005:

> 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 government'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.

United States' Sur-Reply to Tenet's Reply to its Motion for Summary Adjudication (Statute of Limitations) (emphasis added), at 2, *United States v. Tenet Healthcare Corp*., No. CV-03-206, 2005 WL 3784642 (C.D. Cal. Dec. 22, 2005) (internal citations omitted).

This is not an outlier, and CMS has continued to argue (successfully) to federal courts that Provider Agreements are "not contracts" and do "not establish contractual relationships." *See Southeast Arkansas Hospice, Inc. v. Sebelius*, 1 Fed. Supp. 3d 915 (E.D. Ark. 2014) ("[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 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. …. The weight of authority supports a finding that the provider agreement is not a contract."); Government Parties' Reply in Further Support of their Motion for Partial Summary Judgment at 2, 4, *United States v. Malik*, No. 12-1234, 2103 WL 3948074 (D.D.C. June 13, 2013) ("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. … In the context of the Medicare program, the Medicare statute requires providers to enter into an agreement, commonly referred

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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.").

Because the United States regularly argues and prevails on its argument that the Medicare Provider Agreement is not a contract, the doctrine of judicial estoppel should be applied against the United States on this issue. Judicial estoppel is an equitable doctrine intended to protect the integrity of the judicial process by preventing a litigant from playing "fast and loose" with the courts. Federal law governs the application of judicial estoppel in federal court. *Helfand v. Gerson*, 105 F.3d 530, 533-34 (9th Cir. 1997). Under Ninth Circuit precedent, that the issue here is a legal rather than factual issue is of no importance in the analysis. *Helfand*, 105 F.3d at 535 ("The greater weight of federal authority, however, supports the position that judicial estoppel applies to a party's stated position, regardless of whether it is an expression of intention, a statement of fact, or a legal assertion. … The integrity of the judicial process is threatened when a litigant is permitted to gain an advantage by the manipulative assertion of inconsistent positions, factual or legal."). Judicial estoppel applies within a case or across different forums. *Mull v. Motion Picture Indus. Health Plan*, 2014 WL 1514812, at *17 n. 11 (C.D. Cal. Feb. 4, 2014) ("Judicial estoppel is ... appropriate to bar litigants from making incompatible statements in two different cases.") (citations omitted).

The Ninth Circuit has held that the doctrine applies under the following factors: (a) a party's later position must be "clearly inconsistent" with its earlier position; (b) the party has succeeded in persuading a court to accept that party's earlier position, so that judicial acceptance of an inconsistent position in a later proceeding would create the perception that either the first or the second court was misled; and (c) whether the party seeking to assert an inconsistent position would derive an unfair advantage or impose an unfair detriment on the opposing party if not estopped. *Ah Quin v. County of Kauai Dept. of Trans*., 733 F. 3d 267 (9th Cir. 2013). Here all three factors are satisfied. The United States' argument that the Provider Agreement is a contract is "clearly inconsistent" with its argument in, for example, *United States v. Tenet Healthcare Corp.*, where it argued that the Provider Agreement is not a contract. Second, as shown above,

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the United States has most often prevailed in persuading courts, including the Ninth Circuit and the Central District of California, that the Provider Agreement is not a contract. Finally, the United States is using these inconsistent positions to derive an unfair advantage (by only attempting to bind parties to favorable "contractual" consequences and freeing itself from burdensome or inconvenient ones by arguing that statutory and not contractual law applies) in bankruptcy cases and to impose an unfair detriment on the Debtor if not estopped.

Further, the United States is clearly aware of its completely inconsistent arguments - and has recognized that whether a bankruptcy court is analyzing the issue does not affect whether Provider Agreements are contracts or not. *See Mull*, 2014 WL 1514812 at *19 ("our Circuit has held that a court considering judicial estoppel should consider whether the party to be estopped engaged in any 'chicanery or knowing misrepresentation' with regard to the change in position") (quoting *Milton H. Greene Archives, Inc. v. Marilyn Monroe, LLC*, 692 F.3d 983, 995 (9th Cir. 2012). For example, the United States responded in a non-bankruptcy case in this district to a provider's citation to a bankruptcy case holding that the Medicare Provider Agreement was an executory contract by saying: "in neither context, bankruptcy nor federal court, are Medicare Provider Agreements enforceable as contracts." United States Sur-Reply To Tenet's Reply To Its Motion For Summary Adjudication (Statute of Limitations), at 3, *United States v. Tenet Healthcare Corp*., 2005 WL 3784642 (C.D. Cal. Dec. 22, 2005).

III. The Provider Agreement Is Not A Contract, Or, Alternatively, Is Not Executory

The Ninth Circuit expressly holds that the Provider Agreement does not create any "contract right[s]" or a contractual relationship between the parties:

> We have, on occasion, stated that providers and others have contracts with the government in this area, but our decisions have turned on the regulatory regime rather than on contract principles. … As the Eleventh Circuit Court of Appeals held when hospitals complained of legislative impairment of their contract rights in this area because they had agreements with the Secretary: "Upon joining the Medicare program, however, the hospitals received a statutory entitlement, not a contract right."

PAMC, Ltd. v. Sebelius, 747 F.3d 1214, 1221 (9th Cir. 2014) *quoting Memorial Hosp. v. Heckler*, 706 F.2d 1130, 1136 (11th Cir. 1983). This is because Provider Agreements are creatures of statute which define benefits to certain parties, but do not create any rights in

contract. *Hollander v. Brezenoff*, 787 F.2d 834 (2d Cir. 1986) (characterizing the Medicare relationship with providers as a "statutory business relationship"); *U.S. ex rel. Acad. Health Ctr., Inc. v. Hyperion Foundation, Inc.*, 2014 U.S. Dist. LEXIS 93185 (S.D. Miss., July 9, 2014) (holding that Provider Agreements are not contracts); *U.S. ex rel. Roberts v. Aging Care Home Health, Inc.,* 474 F. Supp. 2d 810 (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.").

That the Provider Agreement is not a contract outside of bankruptcy resolves the issue of whether it is an executory contract inside of bankruptcy. The Bankruptcy Code does not define what is a contract for its purposes, *In re Frontier Properties, Inc*., 979 F.2d 1358 (9th Cir. 1992) ("The [bankruptcy] code does not define 'executory contract.'"), and, therefore, courts look to applicable non-bankruptcy law to determine what is a contract in bankruptcy, *see, e.g., Butner v. United States*, 440 U.S. 48 (1979) (noting that Congress has "generally left the determination of property rights in the assets of a bankrupt's estate" to applicable non-bankruptcy law). Here the applicable law is federal law and it is best interpreted according to the interpretation of the United States -- the Provider Agreement is a statutory entitlement and not a contract.

While the Debtors are mindful there are many decisions referring to the Provider Agreement as an executory contract in the bankruptcy context, in the vast majority of those cases the issue was not disputed by the debtor.[2] Bankruptcy courts which have actually addressed this

[2] The United States relies on such cases. In *United States v. Consumer Health Servs*., 108 F.3d 390 (D.C. Cir. 1997), the appellate court did not address the issue of whether the provider agreement was a contract, which the lower court had characterized as an "executory contract." The Third Circuit decision in *University Med. Ctr. v. Sullivan (In re University Med. Ctr.)*, 973 F.2d 1065 (3d Cir. 1992) ignores contrary binding precedent, and the issue was not litigated by the parties. *Cf. 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). In *In re Heffernan Mem'l Hosp. District*, 192 B.R. 228, 231 n.4 (Bankr. S.D. Cal. 1996), the issue was not litigated and the debtor appeared to concede that the provider agreement was an executory contract. In *In re*

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issue under the full adversarial process have concluded that the Provider Agreement is not a contract, and therefore can be sold under § 363. For example, the decision in *In re BDK Health Mgmt., Inc*., is directly on point, well-reasoned and persuasive, and concludes that the Medicare provider agreement is not an executory contract.

In *In re BDK Health Mgmt., Inc*., *Order Authorizing Sale of Assets Out Of The Ordinary Course of Business*, Case Nos. 98-609-B1, 1998 Bankr. LEXIS 2031 (Bankr. M.D. Fa., Nov. 16, 1998), the court addressed a motion to sell, pursuant to § 363(f), virtually all of the debtor's assets of various home healthcare agencies, including its Provider Agreements, free of all liens, claims and encumbrances. The United States opposed the sale by asserting, among other things, that (1) provider agreements are executory contracts that must be assumed and assigned; and (2) cure of any defaults prior to assumption included repayment of any alleged prepetition and postpetition overpayments. The court rejected the CMS argument and approved the sale, noting that outside of bankruptcy the United States expressly disclaimed that the Provider Agreements established contractual relationships between the government and a healthcare provider. The court also noted that the Provider Agreements imposed no obligations and conferred no benefits on the debtor or the government other than establishing that the debtor was entitled to operate and be reimbursed in accordance with the applicable Medicare statutes and regulations. Quoting the Eleventh Circuit, the court found that "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

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Vitalsigns Homecare, Inc., 396 B.R. 232 (Bankr. D. Mass. 2008), the court decided that the United States had a right of recoupment based on the Medicare relationship, but did not hold that the provider agreement was an executory contract. Rather, it stated that "the provider number and the provider agreement are part and parcel of a complicated statutory scheme." In *In re St. Johns Home Health Agency, Inc*., 173 B.R. 238 (Bankr. S.D. Fla. 1994), the debtor conceded that the provider agreement was an executory contract. Also, the bankruptcy court did not address binding precedent from the Eleventh Circuit rejecting an argument that entering into a provider agreement gave the provider "a vested contractual right to Medicare reimbursement." *Mem. Hosp. v. Heckler*, 706 F.2d 1130 (11th Cir. 1983) ("Upon joining the Medicare program, however, the hospitals received 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 such as Hill-Burton costs.").

not obligate the Secretary to provide reimbursement for any particular expenses." *Id.* (quoting *Heckler*, 706 F.2d at 1136); *see also Harper-Grace Hospitals v. Schweiker*, 708 F.2d 199, 201 (6th Cir. 1983) ("[the health care provider] has not shown that the Medicare program established a contractual relationship between the hospital and federal government)*; Greater Dallas Homecare Alliance v. United States*, 10 F.Supp.2d. 638, 647 (N.D. Tex 1998) ("Plaintiffs argue that the Medicare participation agreements between [HCFA] and the [health care providers] are essentially contracts. The court disagrees and finds that the 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"); *Homecare Ass'n of America Inc. v. United States*, 1998 U.S. Dist. Lexis 20515 (W.D. Okla. Aug. 1998) (holding that no contractual obligation existed between government and provider of Medicare services).

These decisions are consistent with federal contract law. The federal law of contracts is generally consistent with the rules set out in the Restatement (Second) of Contracts. *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); *see generally 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."). The elements of a contract with the United States, as with any contract, include, among other things, consideration. *Hoag v. United States*, 99 Fed. Cl. 246, 253 (2011). As noted above, the United States and the provider receive no consideration from the Provider Agreement because the Provider Agreement merely requires both parties to adhere to existing statutes and regulations, and, therefore, 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." 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

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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.").

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Because there is no consideration to the parties to the Provider Agreement in that, according to the United States, the Provider Agreement (a) merely informs the provider to follow applicable rules and statutes, which it has a preexisting legal duty to do, (b) provides no benefits to the United States, and (c) imposes no duties on the United States other than to follow existing statutes and regulations, the Provider Agreement is not supported by consideration, and is therefore not a contract. *See generally* Samuel R. Maizel and Jody A. Bedenbaugh, *The Medicare Provider Agreement: Is It A Contract Or Not? And Why Does Anyone Care?,* 71 The Bus. Lawyer 1207 (Fall 2016); 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) (both discussing reasons why the Provider Agreement is not a contract).

Assuming that the Court were to conclude that the Provider Agreements are contracts, the arguments made repeatedly by the United States and repeated above would defeat the argument that the Provider Agreements are "executory." An executory contract is "[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." *In re Texscan Corp*., 976 F.2d 1269 (9th Cir. 1992) (adopting Countryman definition of executory contracts). If the United States' arguments are to be believed, the Provider Agreement imposes no obligations upon the United States and

imposes no obligations upon a provider that are not also embodied in the Social Security Act and regulations. These obligations are not excused by the other parties failure to perform, because they exist by statute or regulation. Thus, the Provider Agreement would not be executory, because it imposes no duties that, if unperformed, would be a "material breach." *Hall v. Perry (In re Cochise Coll. Park, Inc.),* 703 F.2d 1339, 1348 n.4 (9th Cir. 1983) (the materiality of the parties' remaining obligations depends on whether, under applicable non-bankruptcy law, one party's nonperformance would excuse the other party's obligation to perform).

IV. The Debtors Will Be Entitled To Sell The Provider Agreements Under § 363

That the Provider Agreements create a "statutory entitlement" to bill the Medicare Program effectively makes the Medicare Provider Agreement akin to a license to participate in the Medicare Program. Most courts have held that a license issued by a Government agency is property of the bankruptcy estate. *See, e.g., In re Tak Communications*, 985 F.2d 916 (7th Cir. 1993); *In re Fugazy Express, Inc*., 124 B.R. 426 (S.D.N.Y. 1991); *In re Smith*, 94 B.R. 220 (Bankr. M.D. Ga. 1988).[3] This is consistent with the general rule that all of a debtor's property, including all legal and equitable interests, becomes property of the bankruptcy estate. *See, e.g*., 11 U.S.C § 541; *Taylor v. Freeland & Kronz*, 503 U.S. 638, 642 (1992); *United States v. Whiting Pools, Inc*., 462 U.S. 198, 203-05 (1983). It is also consistent with the notion that licenses can be sold "free and clear" under § 363. *Licensing by Paolo, Inc. v. Sinatra (In re Gucci)*, 126 F.3d 380 (2d Cir. 1997) (rights to a trademark can be sold in a 363 sale "free and clear" of all prior interests of licensees and sublicensees); *ITOFCA, Inc. v. MegTrans Logistics, Inc*., 322 F.3d 928 (7th Cir.

[3] The Ninth Circuit decision in *In re Farmers Markets, Inc*., 792 F.2d 1400 (9th Cir. 1986) - a liquor license case - does not require a different result. In that case the Ninth Circuit decided whether a government licensor was entitled to proceeds for its claim of overdue taxes under the license - and determined the priority of the government's "interest within [the Bankruptcy Code] scheme" and did not deal with the issue of whether a license could be transferred without certain tax obligations. *Id.* at 1403. This decision did not address successor liability of a transferee/buyer, and here the question is whether the transfer between two parties is subject to successor liability imposed by government regulations, not who is entitled to proceeds from such transfer. *See generally*, *In re Aqua Pesca, LLC*, 588 B.R. 241, 251–52 (Bankr. D. Alaska 2018) ("The distribution of proceeds from the sale of a liquor license, however, remain governed by the Bankruptcy Code, subject to the creditors' property rights created under Alaska law. Accordingly, a trustee administering a liquor license may disburse the proceeds from a sale of a liquor license . . .to creditors with valid holds against the license . . .).

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2003) (a nonexclusive software license held by the copyright owner's bankrupt subsidiary was sold in a 363 sale "free and clear" of all encumbrances). This applies even if the Court agrees that the transfer requires government approval. *See, e.g., In re Barnes*, 276 F.3d 927, 928 (7th Cir. 2002) ("The sale of many goods require government approval and of course property can be taken away from a person for various reasons, for example because it has become a public or private nuisance. It is no surprise, therefore, that the few cases to address the issue hold that a liquor license, provided it is salable, is indeed property within the meaning of § 541 of the Bankruptcy Code.").

If the Debtors sells their Provider Agreement pursuant to § 363, they will argue that § 363(f) allows them to sell the Provider Agreement "free and clear of ***any interest*** in such property," including any successor liability (with creditors and parties free to make claims as to the allocation and priority of any proceeds).[4] Many courts have applied an expansive interpretation to include not only *in rem* interests in property, but also other obligations that may "arise from the property being sold." *See, e.g., Precision Indus., Inc. v. Qualitech Steel SBQ, LLC,* 327 F.3d 537 (7th Cir. 2003) ("As commentators have pointed out, the Supreme Court elsewhere has observed that the term 'interest' is a broad term no doubt selected by Congress to avoid 'rigid and technical definitions drawn from other areas of the law....'" quoting *Russello v. United States,* 464 U.S. 16, 21 (1983)); *Folger Adam Sec., Inc. v. DeMatteis/MacGregor, JV*, 209 F.3d 252, 258 (3d Cir. 2000) (holding that debtors "could sell their assets under § 363(f) free and clear of successor liability that otherwise would have arisen under federal statute"); *United Mine Workers of Am. 1992 Benefit Plan v. Leckie Smokeless Coal Co. (In re Leckie Smokeless Coal Co.)*, 99 F.3d 573, 585 (4th Cir. 1996) ("[T]he Bankruptcy Court may extinguish Coal Act

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[4] The issue here is whether the federal laws of bankruptcy cut off the successor liability that also transfers with the Provider Agreement, including that the new owner (a) is responsible for the former owner's Medicare liabilities, including any Medicare overpayments (CMS State Operations Manual § 3210.1B1); (b) will receive payments adjusted to account for prior overpayments (42 U.S.C. § 1395g(a)), including those relating to pre-CHOW periods; (c) assumes the seller's repayment obligations for any accrued, pre-sale overpayments (Medicare Fin. Mgmt. Manual, CMS Pub. 100-06, Chp. 3, § 130); and (d) will be responsible for the quality history of the provider and any unpaid civil money penalties resulting from quality of care deficiencies. As described above, § 363 is clear that the answer to this question is "yes."

successor liability pursuant to 11 U.S.C. § 363(f)(5)."); *PBBPC, Inc. v. OPK Biotech, LLC (In re PBBPC, Inc.)*, 484 B.R. 860 (1st Cir. B.A.P. 2013) (holding that debtor's assets could be sold free and clear of Commonwealth of Massachusetts's right to treat a purchaser of substantially all of the assets of chapter 11 debtor as a "successor employer" to which debtor's experience rating could be imputed to determine purchaser's unemployment insurance contribution); *Myers v. United States,* 297 B.R. 774, 784 (S.D. Cal. 2003) (holding "the Bankruptcy Code preempts California [successor liability] state law" with respect to an environmental tort).

Accordingly, the order approving the sale to the Buyer should state that the successful bidder is not liable as a successor under any theory of successor liability as related to the Provider Agreement.

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V. 41 U.S.C. § 6305 Does Not Preclude The Sale Of The Provider Agreement

The United States argues that 41 U.S.C. § 6305 precludes the sale of the Provider Agreement without its consent, which it declines to provide. However, this argument is inconsistent with the plain language of the statute, which only applies to "contracts or orders." *Lamie v. U.S. Tr.*, 540 U.S. 526, 534 (2004) (If a statute's text "is plain," courts must "enforce it according to its terms," so long as the result is not absurd.). As demonstrated above, the Provider Agreement is not a contract.

Further, the United States' argument ignores how Provider Agreements are transferred. If a corporation acquires all or most of the (provider-related) assets from another corporation, that is a change of ownership ("CHOW") under Medicare regulations. Not only is government consent not required to transfer a provider agreement, in a change of ownership the existing provider agreement ***is automatically assigned*** to the new owner. 42 C.F.R. § 489.18(c). An assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued. 42 C.F.R. § 489.18(d). Only after the assignment does the new provider submit a CHOW application. If the application is "denied" the provider is sent a notice of termination, not a denial of the assignment.

Moreover, CMS's argument relies on three older decisions, none applicable here. First, *In re West Elecs*., *Inc.*, 852 F.2d 79 (3d Cir. 1988) (a solvent contractor and an insolvent debtor in

possession going through bankruptcy are materially distinct entities") relies on the discredited "separate entity" theory. *See, e.g., NLRB v. Bildisco & Bildisco*, 465 U.S. 513, 528 (1984). Second, *Everex Sys., Inc. v. Cadtrak Corp. (In re CFLC, Inc.)*, 89 F.3d 673 (9th Cir. 1996), rested on adopting federal common law over state law as the "applicable nonbankruptcy law" to conclude that the use of state law would significantly conflict with federal patent policy by permitting patent licensees to assign their licenses even in the face of non-assignment provisions, thus depriving the IP licensors of the value of their IP monopoly. Any conflict of law in this situation arises from a federal statute interposed against federal agency regulations arising from a different statute. Finally, the decision in *In re Catapult Ent'mt., Inc.*, 165 F.3d 747 (9th Cir. 1999) rested on application of federal patent law as "applicable law" within the meaning of § 365(c), and that nonexclusive patent licenses are "personal and assignable only with the consent of the licensor." As shown earlier, § 365(c) is not the relevant source of the Debtor's authority to transfer the Provider Agreements. Because the Provider Agreements are not executory contracts, section 365 is not applicable in a sale under § 363 as section 365(c) focuses on a specific type of event — the assumption or rejection of an executory contract by the debtor in possession and spells out the rights of parties affected by that event. "It says nothing at all about sales of estate property, which are the province of § 363. The two statutory provisions thus apply to distinct sets of circumstances." *Pinnacle Restaurant at Big Sky LLC v. CH SP Acquisitions LLC (In re Spanish Peaks Holdings II LLC),* 872 F.3d 892 (9th Cir. 2017); *Precision Indus., Inc. v. Qualitech Steel SBQ, LLC*, 327 F.3d 537 (7th Cir. 2003).

VI. CONCLUSION

For the reasons stated, CMS's objection should be overruled.

Dated: October 17, 2018

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The Bankruptcy Protector

August 3, 2018

Fifth Circuit Reverses Dismissal of Complaint Seeking Injunction to Prevent Medicare Recoupment Prior to Conclusion of Administrative Appeal based on Violation of Procedural Due Process

By Michael D. Lessne

On March 27, 2018, the Fifth Circuit Court of Appeals in *Family Rehabilitation, Inc. v. Alex Azar, II, Sec. U.S. Dept. of Health & Human Services*, No. 17-11337, 2018 WL 1478052, at *1 (5th Cir. Mar. 27, 2018), reversed the decision of a Northern Texas district court, thereby permitting a plaintiff home health agency to proceed with a complaint seeking a temporary restraining order and injunction against recoupment of more than $7.6 million in Medicare overpayments pending the completion of the plaintiff's administrative appeal.

The district court had *sua sponte* dismissed the case for lack of subject matter jurisdiction because the plaintiff's hearing before an Administrative Law Judge ("ALJ") was pending and the plaintiff had accordingly not yet exhausted its administrative remedies. *See* 42 U.S.C. § 405(g) and (h). In reversing, the Fifth Circuit recognized that the plaintiff's *ultra vires* claims and its claims based on the government's violation of its procedural due process established jurisdiction under the "collateral-claim" exception to the channeling requirements of 42 U.S.C. § 405. Under the exception, first recognized in *Mathews v. Eldridge*, 424 U.S. 319 (1976), a court may have jurisdiction over claims (a) that are "entirely collateral" to a substantive agency decision and (b) for which full relief cannot be obtained at a post-deprivation hearing.

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Since the plaintiff sought only to have recoupment suspended until a hearing, and because it raised claims that were unrelated to the merits of the recoupment, the Fifth Circuit determined that the plaintiff's claims were collateral. Additionally, since the plaintiff alleged that it would go out of business if recoupment continued before the ALJ hearing, the Fifth Circuit determined that there would be irreparable injury to the plaintiff. Accordingly, the Fifth Circuit held that it had jurisdiction to hear the procedural due process and *ultra vires* claims. The Fifth Circuit dismissed two other avenues to jurisdiction sought by the plaintiff: first determining that there was no jurisdiction under 28 U.S.C. § 1331 because of futility, and second determining that there was no basis for mandamus jurisdiction because the plaintiff did not request that the government provide it with a timely ALJ hearing.

This case may leave the door open for healthcare providers/suppliers who may be put out of business by Medicare recoupment as they await a three- to five-year ALJ hearing through a constitutional procedural due process challenge and by seeking mandamus. The Eleventh Circuit, in *In re Bayou Shores SNF, LLC*, 828 F.3d 1297 (11th Cir. 2016), *cert. denied sub nom.* 137 S. Ct. 2214 (2017), held that the bankruptcy court lacked subject matter jurisdiction to enjoin the termination of the debtor skilled nursing facility's provider agreement because the debtor had not exhausted its administrative remedies. However, the Eleventh Circuit did not consider the collateral claims exception and declined to consider mandamus jurisdiction. Seeking temporary relief and a timely ALJ hearing may be sufficient to impart jurisdiction on the district court while the healthcare business awaits adjudication through the administrative process that the Fifth Circuit in *Family Rehabilitation* described as a "harrowing labyrinth."

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886 F.3d 496
United States Court of Appeals, Fifth Circuit.

FAMILY REHABILITATION, INCORPORATED, Doing Business as Family Care Texas, Doing Business as Angels Care Home Health, Plaintiff–Appellant,
v.
Alex M. AZAR, II, Secretary, U.S. Department of Health and Human Services; Seema Verma, Acting Administrator for the Centers for Medicare and Medicaid Services, Defendants–Appellees.

No. 17-11337
|
Filed March 27, 2018

Synopsis

Background: Medicare services provider which was assessed for about $7.6 million in Medicare overpayments brought action seeking injunction to prevent recoupment by the federal government pending an administrative hearing before the Office of Medicare Hearings and Appeals (OMHA). The United States District Court for the Northern District of Texas dismissed for lack of subject matter jurisdiction. Provider appealed.

Holdings: The Court of Appeals, Jerry E. Smith, Circuit Judge, held that:

[1] District Court had jurisdiction under collateral-claim exception to the Medicare Act's administrative exhaustion requirement over provider's procedural due process and ultra vires claims;

[2] District Court lacked federal question jurisdiction; and

[3] mandamus jurisdiction over action did not exist.

Affirmed in part, reversed in part, and remanded.

West Headnotes (13)

[1] **Federal Courts**
Jurisdiction

The Court of Appeals reviews jurisdictional issues de novo.

Cases that cite this headnote

[2] **Federal Courts**
Presumptions and burden of proof

The proponent of federal jurisdiction has the burden of establishing it.

Cases that cite this headnote

[3] **Administrative Law and Procedure**
Exhaustion of administrative remedies

When a plaintiff asserts a collateral challenge to an administrative decision that cannot be remedied after the exhaustion of administrative review, courts shall deem the administrative exhaustion requirement waived.

4 Cases that cite this headnote

[4] **Health**
Exhaustion of administrative remedies

For a claim to be collateral, as will permit waiver of the Medicare Act's administrative exhaustion requirement and allow judicial review, it must not require the court to immerse itself in the substance of the underlying Medicare claim or demand a factual determination as to the application of the Medicare Act. Social Security Act §§ 205, 1869, 42 U.S.C.A. §§ 405(g), 405(h), 1395ff(b)(1)(A).

3 Cases that cite this headnote

[5] **Health**
Exhaustion of administrative remedies

For a claim to be collateral, as will permit waiver of the Medicare Act's administrative exhaustion requirement and allow judicial review, the claim may not request relief that would be administrative, that is, the substantive, permanent relief that the plaintiff seeks or should seek through the agency appeals process; instead, the claim must seek some form of relief that would be unavailable through the administrative process. Social Security Act §§ 205, 1869, 42 U.S.C.A. §§ 405(g), 405(h), 1395ff(b)(1)(A).

3 Cases that cite this headnote

[6] Health

Exhaustion of administrative remedies

If the court must examine the merits of the underlying dispute, delve into the Medicare Act and regulations, or make independent judgments as to plaintiffs' eligibility under the Medicare Act, the claim is not collateral, as will permit waiver of the Medicare Act's administrative exhaustion requirement and allow judicial review. Social Security Act §§ 205, 1869, 42 U.S.C.A. §§ 405(g), 405(h), 1395ff(b)(1)(A).

4 Cases that cite this headnote

[7] Health

Exhaustion of administrative remedies

If plaintiffs request relief that is proper under the Medicare Act by requesting benefits or that a provider status be permanently reinstated, the claim is not collateral, as will permit waiver of the Medicare Act's administrative exhaustion requirement and allow judicial review; but plaintiffs may obtain judicial review over claims that sound only in constitutional or procedural law and request that benefits be maintained temporarily until the administrative agency follows the statutorily or constitutionally required procedures. Social Security Act §§ 205, 1869, 42 U.S.C.A. §§ 405(g), 405(h), 1395ff(b)(1)(A).

Cases that cite this headnote

[8] Health

Exhaustion of administrative remedies

District Court had jurisdiction under collateral-claim exception to the Medicare Act's administrative exhaustion requirement over procedural due process and ultra vires claims asserted by Medicare services provider which was assessed for about $7.6 million in Medicare overpayments, seeking temporary suspension of recoupment by the federal government pending an administrative hearing before the Office of Medicare Hearings and Appeals (OMHA); provider sought only a hearing before recoupment, not any determination that the assessment or recoupment were wrongful under the Act, and claims only required Court to determine how much process was required under the Constitution and federal law before recoupment, and provider raised at least colorable claim that recoupment before hearing would cause it to go out of business, and have detrimental effects on its employees and patients. U.S. Const. Amend. 14; Social Security Act §§ 205, 1869, 42 U.S.C.A. §§ 405(g), 405(h), 1395ff(b)(1)(A).

8 Cases that cite this headnote

[9] Injunction

Likelihood of success on merits

To obtain a preliminary injunction, the plaintiff must establish a likelihood of success on the merits.

Cases that cite this headnote

[10] Administrative Law and Procedure

Exhaustion of administrative remedies

The channeling exception to the administrative exhaustion requirement is narrow and applies to allow federal court jurisdiction over unexhausted claims only when channeling a claim through the agency would result in the complete preclusion of

judicial review; a plaintiff seeking judicial review under this exception must show either that bringing its claim administratively is a legal impossibility or that it faces a serious practical roadblock to having its claims reviewed in any capacity, administratively or judicially. 28 U.S.C.A. § 1331.

1 Cases that cite this headnote

[11] Health

Exhaustion of administrative remedies

District Court lacked federal question jurisdiction over claim asserted by Medicare services provider which was assessed for about $7.6 million in Medicare overpayments, challenging the three to five year delay between the assessment and the provider's administrative hearing before the Office of Medicare Hearings and Appeals (OMHA), under narrow channeling exception to the Medicare Act's administrative exhaustion requirement; although judicial review would be delayed due to colossal backlog in administrative Medicare challenges, and provider would likely be prejudiced by the delay, judicial review of provider's claim would not be precluded. U.S. Const. Amend. 14; 28 U.S.C.A. § 1331; Social Security Act §§ 205, 1869, 42 U.S.C.A. §§ 405(g), 405(h), 1395ff(b)(1)(A).

4 Cases that cite this headnote

[12] Federal Courts

Mandamus

Mandamus jurisdiction did not exist over action asserted by Medicare services provider which was assessed for about $7.6 million in Medicare overpayments, seeking injunction to prevent recoupment by the federal government pending an administrative hearing before the Office of Medicare Hearings and Appeals (OMHA); the action sought only to enjoin recoupment, and did not seek to compel the defendants to grant provider a timely hearing or otherwise affirmatively perform any presently existing duty. 28 U.S.C.A. § 1361; Social Security Act §§ 205, 1869, 42 U.S.C.A. §§ 405(g), 405(h), 1395ff(b)(1)(A).

Cases that cite this headnote

[13] Federal Courts

Mandamus

Mandamus jurisdiction exists if the action is an attempt to compel an officer or employee of the United States or its agencies to perform an allegedly nondiscretionary duty owed to the plaintiff; such jurisdiction is limited to requests that the court order the defendant to complete affirmative actions, and does not exist for other types of relief, such as injunctive relief. 28 U.S.C.A. § 1361.

1 Cases that cite this headnote

***498** Appeal from the United States District Court for the Northern District of Texas

Attorneys and Law Firms

Thomas F. Allen, Jr., James A. Cox, Jones Day, Dallas, TX, Rebekah N. Plowman, Jones Day, Atlanta, GA, for Plaintiff-Appellant.

Brian Walters Stoltz, U.S. Attorney's Office, Northern District of Texas, Dallas, TX, for Defendants-Appellees.

Before REAVLEY, SMITH, and OWEN, Circuit Judges.

Opinion

JERRY E. SMITH, Circuit Judge:

****1** Family Rehabilitation, Incorporated ("Family Rehab"), a Medicare services provider, was assessed for about $7.6 million in Medicare overpayments. It appealed under Medicare's Byzantine four-stage administrative appeals process but has completed only the second stage, at which point its Medicare revenue became subject to recoupment; it timely requested a hearing before an administrative law judge ("ALJ"), i.e., the third stage. Yet there is a massive backlog in Medicare appeals. Family Rehab likely will not receive an ALJ hearing for at least three years and soon will go bankrupt if

recoupment continues. Accordingly, Family Rehab sued for an injunction against recoupment until it receives an ALJ hearing. The district court dismissed for lack of subject-matter jurisdiction. We reverse and remand in regard to Family Rehab's procedural due process and *ultra vires* claims; in all other respects, we affirm.

***499** I.

Family Rehab provides home healthcare services to patients in Texas, serving approximately 280 patients as of October 2017. Nearly all of its revenue—between 88 and 94 percent—comes from Medicare-reimbursable services. To be reimbursed, Family Rehab is required to perform an initial home health certification for each patient in conformity with various regulatory requirements. 42 C.F.R. § 424.22.

The Centers for Medicare and Medicaid Services ("CMS") is a division of the U.S. Department of Health and Human Services ("HHS") and is responsible for overseeing the Medicare program. CMS contracts with Medicare Administrative Contractors ("MACs"), which are private government contractors, to process and make these reimbursements.[1] *See* 42 U.S.C. § 1395kk-1; 42 C.F.R. §§ 405.904(a)(2), 405.920–405.928. Such payments may then be audited by Zone Program Integrity Contractors ("ZPICs"). When a ZPIC identifies an overpayment, it notifies the relevant MAC, which then issues a demand letter to the provider.

In 2016, Family Rehab's ZPIC audited 43 claims and determined that Family Rehab had overbilled Medicare on 93% of them, primarily a result of documentary deficiencies related to the initial home health certification. The ZPIC then used a statistical method to extrapolate the alleged overbilling rate and concluded that Family Rehab had received $7,885,803.23 in excess reimbursements. Family Rehab's MAC sent it a demand for that amount, and Family Rehab entered the harrowing labyrinth of Medicare appeals.

A provider must go through a four-level appeals process. First, it may submit to the MAC a claim for redetermination of the overpayment. 42 U.S.C. § 1395ff(a)(3)(A). Second, it may ask for reconsideration from a Qualified Independent Contractor ("QIC") hired by CMS for that purpose. *Id.* § 1395ff(c), (g); 42 C.F.R. § 405.904(a)(2). If the QIC affirms the MAC's determination, the MAC may begin recouping the overpayment by garnishing future reimbursements otherwise due the provider. 42 U.S.C. § 1395ddd(f)(2); 42 C.F.R. § 405.371(a)(3).[2]

****2** Third, the provider may request *de novo* review before an ALJ within the Office of Medicare Hearings and Appeals (OMHA), an agency independent of CMS. 42 U.S.C. § 1395ff(d); 42 C.F.R. § 405.1000(d). The ALJ stage presents the opportunity to have a live hearing, present testimony, cross-examine witnesses, and submit written statements of law and fact. 42 C.F.R. § 405.1036(c)–(d). The ALJ "shall conduct and conclude a hearing ... and render a decision ... not later than" 90 days after a timely request. 42 U.S.C. § 1395ff(d)(1)(A). Fourth, the provider may appeal to the Medicare Appeals Council ("Council"), an organization independent of both CMS and OMHA. 42 C.F.R. § 405.1100. The Council reviews the ALJ's decision *de novo* and is similarly required to issue a final decision within 90 days. *Id.* Furthermore, if the ALJ fails to issue a decision within 90 days, the provider may "escalate" the appeal ***500** to the Council, which will review the QIC's reconsideration. *Id.*

Family Rehab, challenging both the initial audit results and the extrapolation methodology, exhausted the first two stages of that administrative appeals process. It sought redetermination from the MAC and reconsideration from a QIC, which calculated its liability as $7,622,122.31. After the MAC indicated it intended to begin recoupment on November 1, 2017, Family Rehab, on October 24, 2017, timely requested an ALJ hearing.

Yet an ALJ hearing is not forthcoming—not within 90 days, and not within 900 days. According to Family Rehab—and effectively conceded by the government—it will be unable to obtain an ALJ hearing for at least another three to five *years*. And based on HHS's own admissions to a federal judge, the logjam of Medicare appeals shows no signs of abating anytime soon.[3] Thus, the earliest Family Rehab could complete administrative review would be through escalation—which could be as late as July 24, 2018, or 270 days after October 24, 2017.

Accordingly, Family Rehab sued for a temporary restraining order and an injunction to prevent the MAC from recouping the overpayments until its administrative appeal is concluded. Family Rehab alleges that, well

before the end of its administrative appeal, it will be forced to shut down from insufficient revenues because of the MAC's recoupment. This situation, Family Rehab asserts, (1) violates its rights to procedural due process, (2) infringes its substantive due-process rights, (3) establishes an "*ultra vires*" cause of action, and (4) entitles it to a "preservation of rights" injunction under the Administrative Procedure Act, 5 U.S.C. §§ 704–05.

The district court *sua sponte* held that it lacked subject-matter jurisdiction because Family Rehab had not exhausted administrative remedies. *See* 42 U.S.C. § 405(g). Family Rehab appeals.

II.

[1] **[2]** We review jurisdictional issues *de novo*. *Physician Hosps.*, 691 F.3d at 652. The proponent of jurisdiction has the burden of establishing it. *Id.* Because the district court dismissed at the Rule 12(b)(1) stage, Family Rehab only need "allege a plausible set of facts establishing jurisdiction." *Id.*

III.

Under 42 U.S.C. § 405(g) and (h), federal courts are vested with jurisdiction over only a "final decision" of HHS when dealing with claims "arising under" the Medicaid Act. [4] Ordinarily, this means that a provider may come to district court only after either (1) satisfying all four stages of ***501** administrative appeal, i.e., after the Council has rendered a decision, or (2) after the provider has escalated the claim to the Council and the Council acts or fails to act within 180 days. *Id.* §§ 405(g), (h); 42 C.F.R. § 405.1132. Neither has occurred here, and Family Rehab concedes that its claims "arise under" the Medicare Act. [5]

****3** Yet both the Supreme Court and this court have recognized exceptions to the channeling requirements of § 405, which Family Rehab now invokes as bases for jurisdiction. First, Family Rehab claims that its procedural due-process and *ultra vires* claims are collateral to the agency's appellate process, invoking *Mathews v. Eldridge*, 424 U.S. 319, 326–32, 96 S.Ct. 893, 47 L.Ed.2d 18 (1976). [6] Second, Family Rehab insists that § 405 "would not simply channel review through the agency, but would mean no review at all," thereby reasoning that jurisdiction is proper under 28 U.S.C. § 1331. *See Ill. Council*, 529 U.S. at 19, 120 S.Ct. 1084. Third, Family Rehab maintains that the court has mandamus jurisdiction. *See Randall D. Wolcott, M.D., P.A. v. Sebelius*, 635 F.3d 757, 764 (5th Cir. 2011).

A.

[3] We turn first to the collateral-claim exception, first articulated in *Eldridge*, 424 U.S. at 330, 96 S.Ct. 893. There, the Court held that jurisdiction may lie over claims (a) that are "entirely collateral" to a substantive agency decision and (b) for which "full relief cannot be obtained at a postdeprivation hearing." *Id.* at 330–32, 96 S.Ct. 893. As the Court explained, HHS has the power to "waive the exhaustion requirement" and determine when finality has occurred. *Id.* at 330, 96 S.Ct. 893. Thus, "when a plaintiff asserts a collateral challenge that cannot be remedied after the exhaustion of administrative review," courts shall deem exhaustion waived. [7] Family Rehab contends that its procedural due-process and *ultra vires* claims meet both requirements. We agree.

1.

[4] **[5]** For a claim to be collateral, it must not require the court to "immerse itself" in the substance of the underlying Medicare claim or demand a "factual determination" as to the application of the Medicare Act. *Affiliated Prof'l*, 164 F.3d at 285–86. Nor can the claim request relief that would be "administrative," i.e., the substantive, permanent relief that the plaintiff seeks or should seek through the agency appeals process. *Id.* at 286. Instead, ***502** the claim must seek some form of relief that would be unavailable through the administrative process. *Eldridge*, 424 U.S. at 330–32, 96 S.Ct. 893. Because these requirements have led to disharmony among our district courts, we explicate them through the relevant caselaw. [8]

In *Eldridge*, the Court held that the plaintiff could bring a procedural due-process claim requesting an evidentiary hearing before the termination of disability benefits. *Id.* at 319, 330–32, 96 S.Ct. 893. [9] The plaintiff "sought an immediate reinstatement of benefits pending a hearing," *id.* at 324–25, 96 S.Ct. 893; the Court reasoned that such a

claim for relief was collateral to the underlying dispute as to whether disability benefits were proper under the Social Security Act. *Id.* at 330–32, 96 S.Ct. 893.

**4 Similarly, in *Bowen v. City of New York*, 476 U.S. 467, 473–74, 106 S.Ct. 2022, 90 L.Ed.2d 462 (1986), the plaintiffs alleged that HHS "had adopted an unlawful, unpublished policy" which resulted in wrongful benefit denials and that the undisclosed nature of the policy violated "due process of law." The Court held that the claim was collateral because the plaintiffs "neither sought nor were awarded benefits" under the Social Security Act "but rather challenged the Secretary's failure to follow the applicable regulations." *Id.* at 483, 106 S.Ct. 2022. [10]

Conversely, in *Heckler v. Ringer*, 466 U.S. 602, 610, 104 S.Ct. 2013, 80 L.Ed.2d 622 (1984), the plaintiffs alleged that HHS improperly issued a rule that violated both "constitutional due process and numerous statutory provisions." Yet unlike the *Eldridge* or *Bowen* plaintiffs, the *Ringer* plaintiffs sought a declaration that HHS's policy was unlawful and that certain claims were reimbursable under the Medicare Act. *Id.* at 614, 104 S.Ct. 2013. That, the Court reasoned, was nothing more than "a claim that they should be paid" for certain procedures; as such, the claim was " 'inextricably intertwined' with [their] claims for benefits" under the administrative process. *Id.* Even though the plaintiffs had alleged certain procedural claims, the relief they sought from those claims was still substantive. *Id.*

Our circuit applied those decisions in *Affiliated Professional*, 164 F.3d at 285–86. There, the plaintiff alleged that HHS had violated its "right to due process and equal protection" by terminating its provider status through the improper and arbitrary enforcement of "various Medicare rules and regulations." *Id.* at 284. We held that the claim was not collateral. In line *503 with *Ringer*, we noted that the plaintiff sought essentially substantive relief: a reinstatement of its provider status and Medicare payments, plain and simple. *Id.* at 285. And we explained that, to determine whether the regulations were truly enforced arbitrarily, the court "would necessarily have [had] to immerse itself in those regulations and make a factual determination as to whether [plaintiff] was actually in compliance." *Id.* at 285–86. [11]

[6] [7] These cases confirm the aforementioned maxims. If the court must examine the merits of the underlying dispute, delve into the statute and regulations, or make independent judgments as to plaintiffs' eligibility under a statute, the claim is not collateral. *See Ringer*, 466 U.S. at 614, 104 S.Ct. 2013; *Affiliated Prof'l*, 164 F.3d at 284–85. And if plaintiffs request relief that is proper under the organic statute—by requesting that benefits or a provider status be *permanently* reinstated—the claim is not collateral. *See Ringer*, 466 U.S. at 614, 104 S.Ct. 2013; *Affiliated Prof'l*, 164 F.3d at 284–85. But plaintiffs may bring claims that sound only in constitutional or procedural law (such as the *Kelly* claim at issue in *Eldridge*) and request that benefits be maintained temporarily until the agency follows the statutorily or constitutionally required procedures. *Eldridge*, 424 U.S. at 330–32, 96 S.Ct. 893; *Bowen*, 476 U.S. at 483, 106 S.Ct. 2022. [12]

**5 [8] Under these principles, Family Rehab's procedural due-process and *ultra vires* claims are plainly collateral. Like the plaintiffs in *Eldridge*, Family Rehab seeks only a hearing before the recoupment of its Medicare revenues. In its complaint, Family Rehab does not seek a determination that the recoupments are wrongful under the Medicare Act, thus distinguishing it from *Ringer* and *Affiliated Professional*. And Family Rehab's procedural due-process and *ultra vires* claims will not require the court to wade into the Medicare Act or regulations; those claims only require the court to determine how much process is required under the Constitution and federal law before recoupment. Because Family Rehab asks only that recoupment be suspended until a hearing, and because it raises claims unrelated to the merits of the recoupment, its claims are collateral.

[9] The government's rebuttals are unavailing. First, it contends that by attempting to prevent the recoupment of its Medicare payments, Family Rehab effectively seeks substantive relief. Not so. Family Rehab seeks only the temporary suspension of recoupment until a hearing, which is quite different from a permanent reinstatement of benefits. [13] Second, the government reasons that Family Rehab has put the merits of its underlying Medicare Act claims in dispute through its complaint and motion. But even if Family Rehab's pleadings are inartful, and its motion *504 raises issues not properly before court, we construe pleadings liberally at the Rule 12(b) stage. [14] Ultimately, Family Rehab seeks only the suspension of

recoupment before a hearing, which is plainly collateral to the result of that hearing.

2.

Family Rehab has also "raised at least a colorable claim" that erroneous recoupment will "damage [it] in a way not recompensable through retroactive payments." *Eldridge*, 424 U.S. at 331, 96 S.Ct. 893. According to Family Rehab, if recoupment continues before it gets an ALJ hearing, it will go out of business.[15] Moreover, Family Rehab maintains that its bankruptcy will have detrimental effects on its employees and patients. The government insists that those are not irreparable injuries,[16] but we must "be especially sensitive" to irreparable injury "where the Government seeks to require claimants to exhaust administrative remedies merely to enable them to receive the [rights] they should have been afforded in the first place." *Bowen*, 476 U.S. at 484, 106 S.Ct. 2022. The combined threats of going out of business and disruption to Medicare patients are sufficient for irreparable injury.[17] Therefore, the court has jurisdiction to hear Family Rehab's procedural due-process and *ultra vires* claims.

B.

6 **[10] Second, Family Rehab relies on *Illinois Council*, 529 U.S. at 19, 120 S.Ct. 1084, to assert that jurisdiction lies because § 405 "would not simply channel review through the agency, but would mean no review at all." In such situations, jurisdiction is available under 28 U.S.C. § 1331. *Ill. Council*, 529 U.S. at 17, 120 S.Ct. 1084. This exception is narrow and applies only when channeling a claim through the agency would result in the ***505** "*complete* preclusion of judicial review." *Id.* at 23, 120 S.Ct. 1084. Thus, Family Rehab must show either that bringing its claim administratively is "a legal impossibility," or that it faces "a serious practical roadblock to having [its] claims reviewed in any capacity, administratively or judicially." *Physician Hosps.*, 691 F.3d at 655, 659 (internal quotations omitted).

[11] Family Rehab alleges that bringing its claim administratively faces serious obstacles from the colossal backlog in Medicare appeals and HHS's ostensibly Sisyphean attempts to combat the problem. But it is not enough to assert that judicial review will be delayed and that Family Rehab itself will be prejudiced by that delay.[18] Indeed, we have required channeling so long as "there potentially were other parties with an interest and a right to seek administrative review."[19] Given the thousands of ongoing Medicare appeals—including by providers who have come already to our circuit[20]—there is no dearth of third parties with both the incentive and capacity to challenge the timeliness of ALJ hearings. Jurisdiction is not available under § 1331.

C.

[12] Finally, Family Rehab maintains that the court has mandamus jurisdiction. As we held in *Wolcott*, 635 F.3d at 764, "§ 405(h) does not preclude mandamus jurisdiction" under 28 U.S.C. § 1361 "to review otherwise unreviewable procedural issues."[21] Section 1361 provides jurisdiction over "any action in the nature of mandamus to compel an officer or employee of the United States or any agency thereof to perform a duty owed to the plaintiff." As stated above, because the district court resolved this case at the Rule 12(b)(1) stage, we accept "all well-pleaded facts as true." *Wolcott*, 635 F.3d at 763 (quoting *Gonzalez v. Kay*, 577 F.3d 600, 603 (5th Cir. 2009)).

[13] "[M]andamus jurisdiction exists if the action is an attempt to compel an officer or employee of the United States or its agencies to perform an allegedly nondiscretionary duty owed to the plaintiff." *Id.* at 766.[22] Such jurisdiction is limited to requests that the "court order the defendant to complete affirmative actions." *Id.* Conversely, § 1361 does not provide jurisdiction ***506** over requests "for other types of relief—such as injunctive relief." *Id.*

**7 We pause to note that the district court rejected § 1361 as a basis for jurisdiction because Family Rehab has yet to exhaust all other avenues of relief. The government insists that exhaustion is a prerequisite to mandamus jurisdiction, citing *Jones v. Alexander*, 609 F.2d 778, 781 (5th Cir. 1980). In *Jones*, we stated that "[t]he test for jurisdiction is whether mandamus would be an appropriate means of relief." *Id.* Because one element of mandamus relief is the lack of other adequate remedies,

id., the government reasons that exhaustion is required for mandamus jurisdiction. [23]

Although the government's reading of *Jones* is not implausible, we disagree. We have cautioned to "avoid tackling the merits under the ruse of assessing jurisdiction." [24] To say that exhaustion is a jurisdictional requirement would only further conflate jurisdiction with the merits. [25] Nor does *Jones* compel such a result—it is consistent with *Jones* to relegate exhaustion to the merits and hold that mandamus jurisdiction lies wherever a plaintiff seeks "to compel an officer ... to perform an allegedly nondiscretionary duty owed to the plaintiff." *See Wolcott*, 635 F.3d at 763. For such requests, mandamus is plainly the "appropriate means of relief," and jurisdiction may obtain. *See Jones*, 609 F.2d at 781.

But even without a requirement of exhaustion for mandamus jurisdiction, Family Rehab cannot establish § 1361 jurisdiction because it seeks only injunctive, not mandamus, relief. In its complaint, Family Rehab requested that the court enjoin HHS and CMS "from recouping from Family Rehab's Medicare payments." Now on appeal, Family Rehab attempts to re-frame its petition as one for an order that defendants provide it with a timely ALJ hearing. The government rightly notes that that request is found nowhere in the complaint.

Similar to the complaint in *Wolcott*, 635 F.3d at 767, Family Rehab's complaint asks the court to "prohibit the defendants from acting in a certain manner in the future rather than compel the defendants to affirmatively perform a presently existing duty." Also as in *Wolcott*, that relief is fundamentally injunctive in nature. *Id.* [26] Therefore, § 1361 does not confer jurisdiction because Family Rehab's complaint does not seek mandamus relief. *Id.*

**8 *507 For the first time in its reply brief, Family Rehab characterizes its failure to request mandamus as a mere pleading defect. It asks that we order the district court to permit it to amend its complaint per 28 U.S.C. § 1653. [27] Yet "[w]e will not consider issues raised for the first time in an appellant's reply brief." *United States v. Anderson*, 5 F.3d 795, 801 (5th Cir. 1993).

Accordingly, the judgment is REVERSED and REMANDED as to Family Rehab's procedural due-process and *ultra vires* claims and AFFIRMED in all other respects.

All Citations

886 F.3d 496, 2018 WL 1478052, Med & Med GD (CCH) P 306,259

Footnotes

1 The MAC covering Family Rehab during the relevant time was Palmetto GBA, LLC.

2 If the repayment would constitute hardship, as defined by statute, then the provider may enter a repayment plan with HHS. 42 U.S.C. § 1395ddd(f)(1). Although the government suggests that is a viable option here, Family Rehab insists that a repayment plan is infeasible both because it could not develop one with CMS and because Family Rehab's other contractual obligations preclude that course of action. At the Rule 12(b)(1) stage, we take Family Rehab's allegations as true. *See Physician Hosps. of Am. v. Sebelius*, 691 F.3d 649, 652 (5th Cir. 2012).

3 Maria Castellucci, *HHS Says It Can't Clear Medicare Appeals Backlog by 2021 Deadline*, MODERN HEALTHCARE (Mar. 8, 2017), *available at* http://www.modernhealthcare.com/article/20170308/NEWS/170309902 (discussing a report by HHS made to the U.S. District Court for the District of Columbia). *See also Maxmed Healthcare, Inc. v. Price*, 860 F.3d 335, 344–45 (5th Cir. 2017) (noting the serious backlog of agency appeals, the lack of resources to deal with the problem, HHS's admissions in federal court, and the "redundant, time-consuming, and costly procedures" that mire providers).

4 Although § 405(g) is a provision of the Social Security Act, it has been made applicable to Medicare by 42 U.S.C. § 1395ff(b)(1)(A). *Cf. Shalala v. Ill. Council on Long Term Care, Inc.*, 529 U.S. 1, 12–13, 120 S.Ct. 1084, 146 L.Ed.2d 1 (2000); *Physician Hosps.*, 691 F.3d at 653 (holding that 42 U.S.C. § 1395ii "makes Section 405(h) applicable to Medicare"). Accordingly, Medicare cases usually are excluded from the general grant of federal-question jurisdiction in 28 U.S.C. § 1331 absent exhaustion of the agency appeals.

5 *See RenCare, Ltd. v. Humana Health Plan of Tex., Inc.*, 395 F.3d 555, 557 (5th Cir. 2004) ("A claim arises under the Medicare Act if 'both the standing and the substantive basis for the presentation' of the claim is the Medicare Act." (quoting *Heckler v. Ringer*, 466 U.S. 602, 606, 104 S.Ct. 2013, 80 L.Ed.2d 622 (1984))); *see also Ill. Council*, 529 U.S. at 11, 120

S.Ct. 1084 (noting that § 405 also governs constitutional claims); *Physician Hosps.*, 691 F.3d at 656 ("The Supreme Court has also explicitly rejected the argument that constitutional challenges are free from Section 405(h)'s requirements." (citing *Weinberger v. Salfi*, 422 U.S. 749, 760–61, 95 S.Ct. 2457, 45 L.Ed.2d 522 (1975) (holding that a constitutional claim seeking "a judgment directing the Secretary to pay Social Security benefits" arises under the Social Security Act))).

6 Family Rehab concedes that its substantive due-process and APA claims are not collateral; thus, we must address all three asserted bases of jurisdiction.

7 *Affiliated Prof'l Home Health Care Agency v. Shalala*, 164 F.3d 282, 285 (5th Cir. 1999) (per curiam); *Eldridge*, 424 U.S. at 330–32, 96 S.Ct. 893. There is a first prong of the collateral-claim exception: "[T]here must have been presentment to the Secretary." *Affiliated Prof'l*, 164 F.3d at 285. There is no dispute that Family Rehab has met this requirement.

8 *Compare, e.g.*, *Timberlawn Mental Health Sys. v. Burwell*, 2015 WL 4868842, at *2, *4 (N.D. Tex. Aug. 13, 2015) *with* *D&G Holdings, LLC v. Burwell*, 156 F.Supp.3d 798, 803, 814–15 (W.D. La. 2016).

9 In *Eldridge*, the plaintiffs asserted that a hearing consistent with *Goldberg v. Kelly*, 397 U.S. 254, 90 S.Ct. 1011, 25 L.Ed.2d 287 (1970), was required before the termination of Social Security disability benefits. 424 U.S. at 325 & n.4, 96 S.Ct. 893 (defining a *Kelly* hearing as including: "(1) 'timely and adequate notice detailing the reasons for a proposed termination'; (2) 'an effective opportunity [for the recipient] to defend by confronting any adverse witnesses and by presenting his own arguments and evidence orally'; (3) retained counsel, if desired; (4) an 'impartial' decisionmaker; (5) a decision resting 'solely on the legal rules and evidence adduced at the hearing'; [and] (6) a statement of reasons for the decision and the evidence relied on" (quoting *Kelly*, 397 U.S. at 266–71, 90 S.Ct. 1011)).

10 The Court also noted that the nature of the undisclosed policy gave rise to "unique circumstances" such that "there was nothing to be gained from permitting the compilation of a detailed factual record, or from agency expertise." *Bowen*, 476 U.S. at 485, 106 S.Ct. 2022.

11 *See also* *Edwards v. Burwell*, 657 Fed.Appx. 242, 244–45 (5th Cir. 2016) (per curiam) (applying *Affiliated Professional* to substantially similar facts and claims), *cert. denied*, —— U.S. ——, 137 S.Ct. 639, 196 L.Ed.2d 521 (2017); *Marsaw v. Thompson*, 133 Fed.Appx. 946, 948 (5th Cir. 2005) (same).

12 For these reasons, the analysis in *D&G Holdings* is persuasive.

13 *Compare* *Eldridge*, 424 U.S. at 324–25, 96 S.Ct. 893, *with* *Ringer*, 466 U.S. at 614, 104 S.Ct. 2013. Similarly, the government insists that Family Rehab is gaming our jurisdiction through clever labeling. But the fact that Family Rehab seeks only the temporary abatement of recoupment barring certain procedures is far from a labeling act.

14 *See* *Lowrey v. Tex. A & M Univ. Sys.*, 117 F.3d 242, 247 (5th Cir. 1997). To obtain a preliminary injunction, the plaintiff must establish a likelihood of success on the merits. *See* *Affiliated Prof'l*, 164 F.3d at 285. But because Family Rehab seeks only to prevent recoupment under it receives certain procedures, a likelihood of success on the merits would require showing that those procedures are required before recoupment—rather than showing that the outcome of those procedures will likely be favorable in a specific case. *See* *Eldridge*, 424 U.S. at 335, 96 S.Ct. 893 (describing the factors used to determine "the specific dictates of due process").

15 The government disputes that averment, but at this stage Family Rehab need raise only a "colorable" claim. *Eldridge*, 424 U.S. at 331, 96 S.Ct. 893. "The requirement of a colorable claim is not a stringent one." *Abraham v. Exxon Corp.*, 85 F.3d 1126, 1129 (5th Cir. 1996) (quoting *Panaras v. Liquid Carbonic Indus. Corp.*, 74 F.3d 786, 790 (7th Cir. 1996)). A plaintiff need show nothing more than "some possible validity." *Richardson v. United States*, 468 U.S. 317, 326 n.6, 104 S.Ct. 3081, 82 L.Ed.2d 242 (1984). This Family Rehab has done. As it alleges, Medicare payments represent 94% of its revenues, while it makes approximately $6 million annually and faces over $7.5 million in recoupment; thus recoupment will decrease its revenues by about 91%.

16 In the alternative, the government contends that Family Rehab would not face irreparable injury if it either escalates its administrative appeal to the Appeals Council, *cf.* 42 C.F.R. § 405.1100, or seeks a repayment plan with CMS, *cf.* 42 U.S.C. § 1395ddd(f)(1). But again, Family Rehab alleges that a repayment plan is infeasible, and the district court expressed incredulity at the notion that CMS would agree to any repayment plan that could stave off Family Rehab's financial ruin. And the timeline for escalation—combined with the massive backlogs at CMS—means that escalation would be similarly insufficient to avoid irreparable injury.

17 *Cf.* *Affiliated Prof'l*, 164 F.3d at 286 (indicating that the potential loss of health care to Medicare patients may help establish irreparable injury under *Eldridge*).

18 *See* *Ill. Council*, 529 U.S. at 13, 120 S.Ct. 1084 (recognizing that "individual, delay-related hardship[s]" are part of the cost of channeling).

19 *Physician Hosps.*, 691 F.3d at 657. In *Physician Hospitals*, 691 F.3d at 652, a group of physician-owned health care providers planning to build a new hospital challenged a Medicare rule prohibiting reimbursement to such hospitals. The

providers argued that § 405 effectively precluded judicial review of their claims because channeling them through the agency would require it first to build the hospital at great cost and then file a reimbursement request. *Id.* at 656. We held that the providers failed to show that no similarly situated entity could bring the same claims or whether it would be economically feasible for other hospitals to challenge the regulation. *Id.* at 658. Family Rehab's situation is similar in many respects. *See also Nat'l Athletic Trainers' Ass'n, Inc. v. U.S. Dep't of HHS*, 455 F.3d 500, 504–05 (5th Cir. 2006); *Council for Urological Interests v. Sebelius*, 668 F.3d 704, 712–13 (D.C. Cir. 2011).

20 *See, e.g.*, *Maxmed Healthcare, Inc.*, 860 F.3d at 339–40 (explaining that the provider had exhausted appellate review and then sought judicial review of the Appeals Council's decision).

21 As explained in *Wolcott*, 635 F.3d at 765, the federal circuits are in near-unanimous agreement on this point.

22 *See also Ingalls Shipbuilding, Inc. v. Asbestos Health Claimants*, 17 F.3d 130, 132 (5th Cir. 1994); *McClain v. Pan. Canal Comm'n*, 834 F.2d 452, 454 (5th Cir. 1987).

23 The other two elements for warrant mandamus relief are that "the plaintiff must have a clear right to the relief, [and] the defendant must have a clear duty to act." *Jones*, 609 F.2d at 781.

24 *Wolcott*, 635 F.3d at 763 (quoting *Jones*, 609 F.2d at 781); *see also McClain*, 834 F.2d at 454.

25 Moreover, our caselaw generally has tackled the jurisdictional inquiry as distinct from the merits. Thus, even in *Jones*, 609 F.2d at 781, 783, the court found that mandamus jurisdiction was proper but that mandamus was inappropriate. *See also McClain*, 834 F.2d at 455, 460 (same); *Carter v. Seamans*, 411 F.2d 767, 773–75 (5th Cir. 1969) (per curiam) (same); *cf. also Ingalls*, 17 F.3d at 132–34 (breaking out the inquiry but finding that mandamus was appropriate).

26 Thus, in *Wolcott*, 635 F.3d at 767, the court held that asking "the court to order the defendants to cease denying its new claims for reasons that have been held invalid in previous administrative decisions" is injunctive in nature. There is no material difference between that petition and Family Rehab's complaint. Conversely, *Wolcott* found mandamus jurisdiction over a request that "compel the defendants to process and pay claims ... adhere to payment deadlines ... [and] remove [the plaintiff] from prepayment review." *Id.* at 766; *see also Ingalls*, 17 F.3d at 132 (similar); *McClain*, 834 F.2d at 454 (similar). Family Rehab's complaint does not contain such a demand.

27 Section 1653 provides, "Defective allegations of jurisdiction may be amended, upon terms, in the trial or appellate courts."

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