When Health Care Goes on Life Support: The Intersection Between Health Care and Bankruptcy Law

Elizabeth A. Green, Moderator
BakerHostetler; Orlando, Fla.

Jane E. Jordan
Chief Counsel for Health Affairs, Emory University; Atlanta

Louis E. Robichaux, IV
Deloitte Transactions and Business Analytics LLP; Dallas

Thomas W. Waldrep, Jr.
Womble Carlyle Sandridge & Rice, LLP; Winston-Salem, N.C.

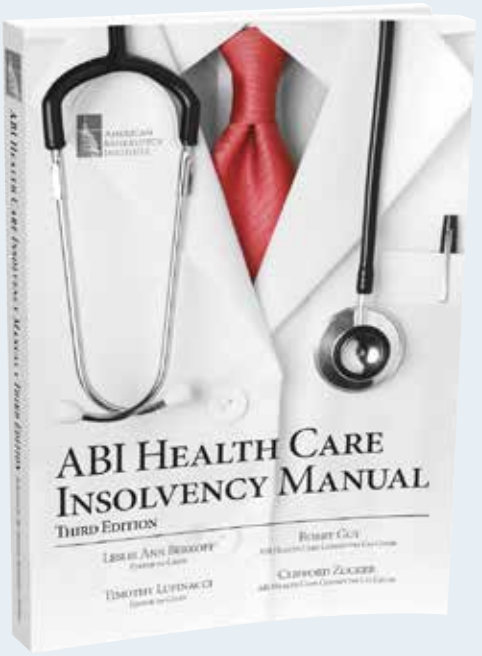
American Bankruptcy Institute

NOW! in the ABI Bookstore

ABI Health Care Insolvency Manual
Third Edition

When Congress passed the Patient Protection and Affordable Care Act on March 23, 2010, it represented "the largest overhaul of the health care delivery system since the enactment of Medicare and Medicaid," write the authors of this latest edition of the *ABI Health Care Insolvency Manual,* who include many members of ABI's Health Care Committee. This Third Edition includes updates reflecting the U.S. Supreme Court's decision on key components of the PPACA, but also details the many challenges confronting the health care system, reeling from a rising number of bankruptcies.

Filled with case law, practical tips and explanations of both the relevant Bankruptcy Code sections and the intricacies of the health care profession, the *ABI Health Care Insolvency Manual, Third Edition* is a vital resource for any bankruptcy practitioner dealing with a health care entity—such as a nursing home, hospital or HMO—that is teetering on the brink of insolvency.



Member Price: $60

Non-member Price: $85

Product #: 12_007

Order Your Copy Today!

bookstore.abi.org

When Health Care Goes on Life Support:

The Intersection Between Health Care and Bankruptcy Law

Presented By:

Elizabeth A. Green, Esq.
Baker & Hostetler LLP
Orlando, FL

Louis E. Robichaux, IV
Deloitte Financial
Advisory Services LLP
Dallas, TX

Jane Jordan, Esq.
Chief Counsel for Health Affairs
Emory University
Atlanta, GA

Thomas W. Waldrep, Jr.
Womble Carlyle
Sandridge & Rice, LLP
Winston-Salem, NC

Table of Contents

The Changing Health Care Industry: Old World "A" vs. New World "B"

Jane E. Jordan
Deputy General Counsel/Chief Counsel for Health Affairs
Office of the General Counsel
Emory University

EMORY UNIVERSITY

World "A": Healthcare Yesterday (and still somewhat today)…






Characteristics of the Old "World A"

- Variety of Community Hospitals; No Consolidation
- Separate medical records everywhere; no consolidation or communication; all in paper
- Independent Medical Staffs and Stand Alone Physician Practices (primary care and specialists)
- Independent Stand Alone Pharmacies; Laboratories; Home Health Agencies; Physical Therapy; Retirement Homes
- Fee for Service Payment Structure
- Paid "per click" regardless of quality, efficiencies or cost savings
- Inefficient behavior still rewarded (readmissions, hospital-acquired infections)
- Burden of Cost Mostly on Insurer (low deductibles for patients)

Healthcare Industry Today… (World B)

- Health Care Reform
- Right-shift decreased reimbursement from payers
- Baby boomers retiring and moving to Medicare
- Fierce and consolidating competition

- Rising health care costs
- Consumers are becoming educated and selective
- Health care is evolving into one of the toughest industries in the country

Consumerism Driving Force of Change

Meet Mary Jo & Family
Mary Jo Has Multi-Chronic Conditions

Household Income Spent on Healthcare:

2008: 7%
2013: 18%

Mary Jo & Family's Situation is Becoming Common - Even Without Chronic Conditions

Projected average family premium as a percentage of median family income, 2013–2021

Emory Healthcare©

Source: (right)Based on CPS ASEC 2001 – 12, Kaiser/HRET 2001-12, CMS OACT 2012-21

Transformation of Healthcare Industry

	World A - Fee for Service	World B - Value Based
Reimbursement	*Production Based - Episodic Acute Care*	*Value Based - Population Management*
Quality	*Perception Based*	*Demonstrated Performance*
Financial Structure	*Cross-Subsidization by Commercial Market*	*Ability to Generate Sustainable Operating Margins by Market Payer Class*
Patient Financial Responsibility	*Limited*	*Significant*
Transparency	*Limited*	*Demanded*
Market Segmentation	*One-Size Fits All*	*Targeted Segmentation*
Provider Alignment	*Independent*	*Consolidated*
Customer Focus	*Physician*	*Consumer*

Emory Healthcare©©

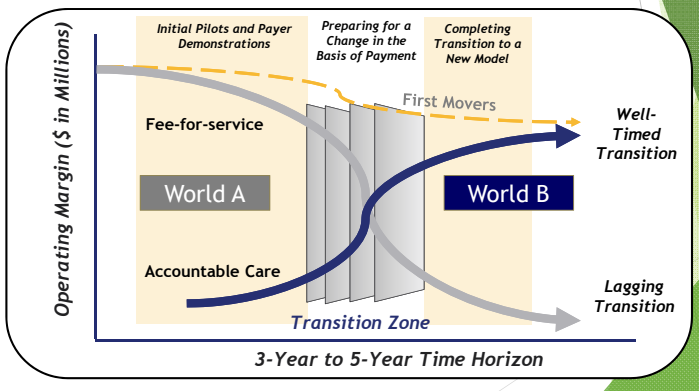
A better approach to Population and Disease Management in World B

Example Patient Type	Traditional Approach	New Approach
Healthy	Wellness programs and screening – but uneven PCP access and capacity, resulting in occasional ER visits	Walk-in clinics, retail clinics
Asymptomatic / early chronic conditions	PCP gatekeeper with barriers for access to specialists	***True*** medical homes with immediate access to first line specialists
Complex episodes	Focused on price, with no impact on wasteful variation – resulting in excessive utilization and poor end-of-life care	Comprehensive service lines, anchored to research for standard work

Emory Healthcare©

Managing Transition Economics

The pace of change to the new model varies significantly by market and health system



Emory Healthcare©

Transitioning to New Value Models: Moving from World A to World B

Managing Transition Economics

The pace of change to the new model varies significantly by market and health system

Characteristics of World A

- Fee-for-service payment structure
- Paid "per click" regardless of quality or efficiencies
- Could be paid for our inefficiencies (ex: readmissions, HACs)
- Burden of cost was primarily on insurer (patient had a low co-payment or deductible)

Characteristics of World B

- Declining reimbursement for providing the same service (Medicare rates for all payers?)
- Value-Based Reimbursement – must demonstrate high quality, safety, and patient experience at an affordable cost to the patient and insurer
- Revenue in World A = Cost in World B (ex: penalized for readmissions / HACs)
- Rise of Consumerism (burden of cost is primarily on the patient through high deductible plans)

3-Year to 5-Y

Emory Healthcare©
Strategic Planning Office

Draft

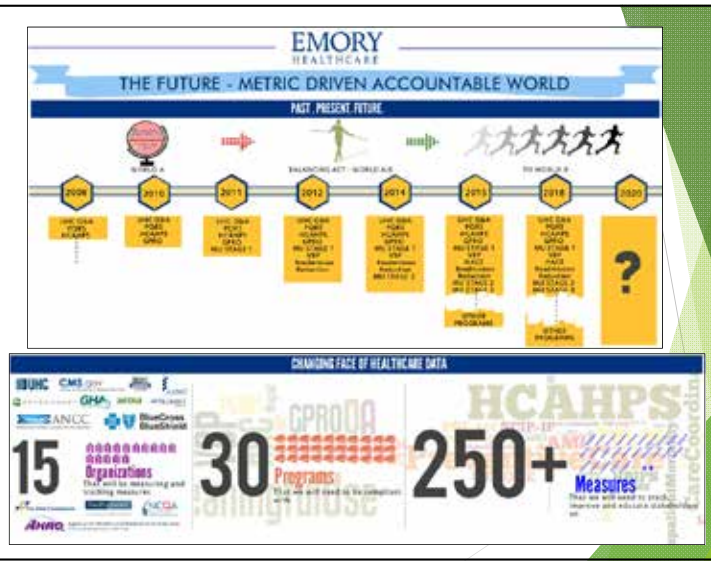
Key Take-Aways

- Now living in 2 worlds – World A and World B
- Must deliver Value to Patients and Payers
  - Now being reimbursed and/or penalized based on Value Performance
- Consumers: affordable care of high quality with convenient access
  - High deductible plans = Consumers are responsible for more health care costs *(and 75% of Americans have no savings)*
- Overall reimbursement per unit of work is declining
  - Shift to Medicare / Self Pay (from high deductible plans) from Commercial
- Increasing market share is key – but the competition is intense

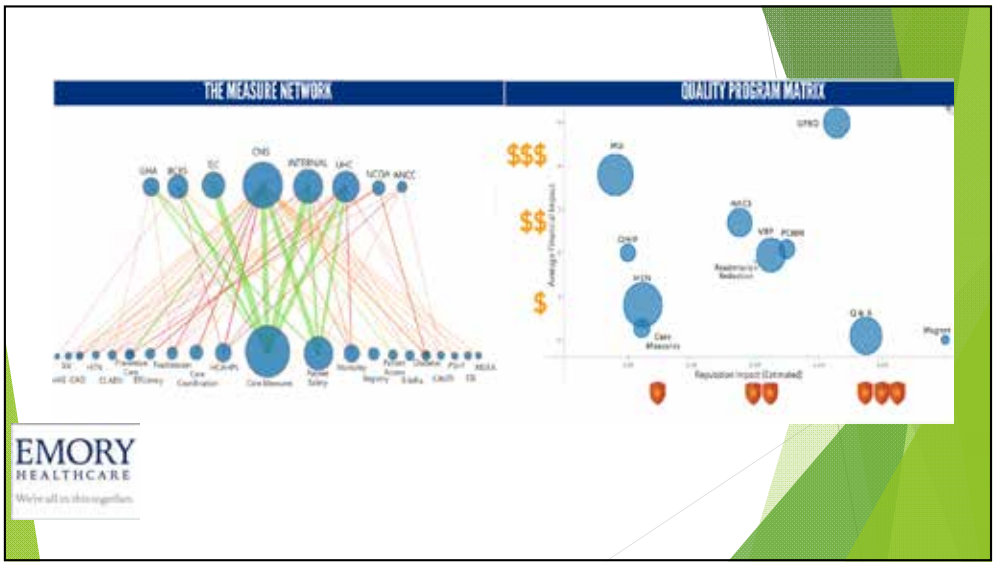
Driving lower reimbursement: The Right Shift

- A patient on a high deductible commercial plan looks very different from the traditional commercial – they are more like a self pay patient
- A baby boomer moving to Medicare might be wealthy, but we still receive the same Medicare rate as any other Medicare patient

27



7



What Does It Take to Transition from World A to World B?

- Robust and controlled management infrastructure
- Ability to implement and control performance metrics
- Ability to satisfy patient expectations of easy access, lower costs, higher (and proven) quality
- Excellent clinical documentation; dashboards
- Technology (EeMR; Patient Portals; Data Management)
- Capital Investments
- Efficiencies

▶$$$$$$$

2. Selling Healthcare Assets in Chapter 11[1]

As with other Chapter 11 bankruptcies, asset sales via Section 363 or a plan of reorganization are common. This section addresses a number of challenges unique to executing such healthcare transactions – primarily from the debtor's perspective.

A. Maintaining Value Before and During the Sale Process

Patient Referrals

The volume and "quality mix" of patient flow are significant drivers of value in most healthcare businesses (e.g. most often through physician referrals). In a distressed hospital setting, the mere mention of a potential sale could adversely impact physician referral patterns. The issue of lost physician support potentially becomes more acute if a physician-owned entity is involved. Typically, a buyer will often expect some loss of physician support (vis-à-vis pre-sale levels), and may even apply a purchase price reduction in anticipation thereof. Thus, in an effort to best position the debtor for a successful auction, the seller should carefully control the communication to staff / doctors and tightly manage the M&A process in order to minimize operational turbulence.

The seller must attempt keep the physicians engaged through the sale process be exploring potential new roles that the physicians owners might take with the successful buyer. Quite often, keeping the physician owners engaged and cooperating becomes pure finesse and salesmanship.

Patient A/R

Buyers of healthcare businesses with sufficient short-term working capital financing often prefer to leave behind the patient A/R of a distressed seller. Other times, buyers have inadequate short-term working capital to fund the post-sale build-up of A/R and, thus, seek to acquire the seller's patient A/R as part of the overall transaction. Valuing patient account receivables (A/R) presents several challenges, as "net" A/R contains a number of subjective management estimates and reserves. When a buyer plans to purchase the A/R, the most prudent approach is to set forth a clear methodology in the asset purchase agreement for determining the net A/R value as of the sale date – along with a clear post-closing adjustment mechanism.

---

[1] Adopted from: *On Life Support? Selling Healthcare Assets in Chapter 11*, XXCVIII ABI Journal 7, 12, 74-75 (Sept. 2009).

Medical Equipment

In a healthcare transaction, the medical equipment can be a significant component of the overall value of the ongoing enterprise; such equipment is often leased from third parties. Resolving issues with equipment lessors can be time-consuming and can require sufficient lead time to resolve. A gating consideration is whether the leases are "true lease" transactions or financed sales transactions. If the former, Section 365 requirements of assumption or rejection must be determined, including the cost of curing prior defaults and proof of financial wherewithal of the assignee to perform in the future. Considering the market for used medical equipment and the high rate of obsolescence for these types of assets, assumption of equipment leases is often uneconomical.

Many medical equipment leases contain dollar-buyout provisions, renewal options for modest consideration and other indicia of financing arrangements. Restructuring of the business based on the fair market value of the used equipment (vis-à-vis an adversary proceeding seeking to re-characterize) may be far more achievable than if the leases are required to be assumed or rejected and the equipment replaced. In hospital cases, in particular, the number of equipment leases may be significant. Consideration of an alternative dispute resolution (or ADR) procedure should reduce the cost of litigating these issues with numerous parties.

B. Special Considerations in Healthcare Asset Sales

Combination OTA / APA

An operations transfer agreement (OTA) is typically used to memorialize the allocation of responsibilities and timing of transfer of key elements in the sale of an ongoing healthcare business. The parties can combine, into one document, an asset purchase agreement (APA) and OTA.

The basic OTA / APA should clearly cover issues such as: (i) the assets, operations and liabilities being transferred or assumed, (ii) purchase consideration, (ii) timing of transfer, (iv) transfer of employees (including WARN Act issues), (v) regulatory filings / requirements, (vi) partitioning / collection of accounts receivable, (vii) ownership of, and access to, business and patient records, (viii) transfer and custody of patient funds / property, (ix) responsibility for filing final cost reports, (x) proration of operating costs, (xi) establishment of new vendor / contractor relationships, including resolution of vendor deposits and letters of credit,(xii) assignment of contracts, (xiii) agreements and leases, (xiv) electronic fund transfer ("EFT") / bank account control issues, and (xv) any other conditions to closing.

Medicare / Medicaid "Change of Ownership" Issues

Regardless of the identity of the legal entity that is currently billing under a particular Medicare provider agreement, CMS functionally takes the position that the provider agreement has a life of its own until effectively terminated by CMS or by the provider. Practically speaking, CMS disavows any duty to match or offset overpayments claims or reimbursement credits to any particular entity in the "chain of title"[2] of a provider agreement. As noted in an article published in the ABI Journal in May, 2009,[3] even though the Medicare statues prohibit sale of a Medicare provider number upon a change of ownership (CHOW), the provider agreement is *automatically assigned* to the new owner.[4] As long as a provider agreement, and its concomitant provider number[5] is not terminated, CMS views the agreement as essentially having a separate "corporate" life—one that allows CMS essentially to ignore the private contractual dealings between buyers and sellers and impose upon the purchasing entity choosing to accept (or failing to terminate) the agreement upon the CHOW, any liabilities, known or unknown, that have already attached to the agreement, as well, of course, as any future liabilities arising after the CHOW. In contrast, Medicaid agreements are administered at a state level, and issues of successor liability and duties of a successor are treated differently from state to state. States can provide for the preservation of a state's security against overpayments pending filing of a final cost report by stopping payment on a Medicaid contract held by the existing provider as soon as information regarding a pending CHOW is received.

Separately licensed healthcare facilities generally have distinct Medicare and Medicaid provider agreements (and therefore separate provider IDs), irrespective of ownership structure or common management. Therefore, it follows that cost report settlements are resolved on an individual provider basis, rather than on a portfolio basis. In structuring the APA, Debtors should be aware of this concept, as well as the limitation of Medicare and Medicaid to recover cost report overpayments only on an individual provider basis, and not on a portfolio basis. The concept of separateness does not necessarily extend to commercial and managed care payors as "corporate level" contracts are commonly utilized.

---

[2] Although useful in discussing the "single provider" concept, "chain of title" is a misnomer in the sense that the provider agreement cannot, in CMS' view, be bought or sold.

[3] See *Transfer of Medicare Provider Numbers in Bankruptcy: Executory Contract or Saleable Asset*, by Frank A. Oswald and Howard P. Magaliff, ABI Journal 18 May 2009.

[4] S*ee* 42 CFR §489.18(c) and *U.S. v. Vernon Home Health, Inc.*, 21 F.3d 693, 694 (5th Cir. 1994).

[5] Although generally the same number stays with the provider agreement, there are certain situations in which a new number is assigned by CMS. See the State Operations Manual at 3210.4C. (Certain changes, for example, in an End State Renal Disease facility classification.)

Medicare Provider Agreement NOT Assigned to the Buyer

Generally, a provider agreement with its potential liabilities and credits is "automatically" assigned to the new provider in a CHOW.[6] However, the successor provider at a Medicare certified facility may refuse to accept assignment of the previous owner's provider agreement, which means that the existing provider agreement terminates as of the CHOW date. The CMS State Operations Manual[7] provides that "the [facility's new owner's] refusal to accept assignment must be put in writing by the new owner and forwarded to the Regional Office 45 calendar days prior to the CHOW data to allow for the orderly transfer of any beneficiaries that are patients of the provider."[8] Needless to say, when a healthcare business is sold in connection with a bankruptcy, it may be difficult or impossible to meet those notice requirements. The State Operations Manual states that "[ ]it is the responsibility of the prospective purchaser to know that it can refuse to accept assignment of the provider agreement and that it should formally indicate its choice in that regard. If, however, the CHOW goes into effect without a refusal or acceptance of assignment on record, the RO concludes that the agreement has been automatically assigned to the new owner and completes processing of the CHOW." *Id*.

Written Policies vs. Actual Practice

It is important to remember that any government program is operated by individual regulators who often retain an important degree of discretion regarding the details of how their program will operate with regard to your bankrupt client. It is always advisable to contact CMS to discuss any needed variation in usual CMS practice. For example, timing of recoupment amounts and any offset by pending credits can sometimes be negotiated. It may even be fruitful to discuss from which entity, in the "chain of title" for a particular provider agreement, CMS will first seek recoupment of any outstanding amounts. Because bankruptcy impacts the normal procedures (and timelines) utilized by CMS and its contractors, it is important to not only review and become familiar with the directives in the CMS Medicare Financial Management Manual (see Chapter 3 – Overpayments, Section 140, Bankruptcy), but to be aware of CMS attitudes with regard to any administrative freeze that might be placed on payments to a provider. These issues can make or break the sale of a healthcare business in bankruptcy because they affect the timing and flow of critical income streams to a facility.

---

[6] See 42 CFR §489.18(c).
[7] See 3210.5 *et seq*. [New Owner Refuses to Accept Assignment of the Provider Agreement].
[8] See §3210.5A, CMS State Operations Manual.

C. Medicare / Medicaid Cost Report and Recoupment Issues

Successor Liability

As noted elsewhere in this article, assignment of (whether intentional, or by failure to properly reject) a Medicare provider agreement can result in successor liability to the purchaser of a healthcare business. Sometimes buyers attempt to contract around this successor liability. Such an attempt by a buyer to deny liability was considered in February of 2009 by the United States Bankruptcy Court for the Northern District of Texas, Dallas Division, in a Chapter 11 proceeding involving the sale of skilled nursing facilities in Texas. The buyers sought payment (or reimbursement) from the plan agent for CMS' recoupment of Medicare payments based upon prior alleged overpayments to the seller *and* to the seller's predecessor. The buyers' relied on theories of statutory and equitable subrogation.

The OTA did not contain an indemnification provision, but did contain an express statement that the buyers were not assuming any of the debtor's Medicare overpayment liabilities. The court rejected the buyers' claim, ruling that under applicable law[9] by assuming the provider agreements, the buyers became primarily liable for the recoupment payments. The court rejected both the buyers' 11 U.S.C. §509 statutory subrogation argument[10] and the buyers' equitable subrogation argument[11] because neither basis for subrogation is available to a party who satisfies a debt for which that party was primarily obligated, and the recoupment liabilities were assumed when the buyers assumed the provider numbers. In granting summary judgment to the plan agent, the court further noted that nothing in the OTA can contradict controlling federal law, but also, that the OTA recited that the facilities were purchased "as is, where is" by the buyers. The court commented: "Due to the wealth of case law and regulations in this area, the Court finds it hard to believe that [buyers] did not understand this [that the liabilities were assumed with the provider numbers] when entering into the Operations Transfer Agreement, and factor the possibilities into their valuation and purchase price of the facilities, finding that possible liabilities were outweighed by the inability to operate the facilities and collect Medicare payments in the interim without assuming the provider numbers."[12]

---

[9] *Vernon Home Health, Inc*., 21 F.3d at 696

[10] Citing *In re Celotex Corp*., 472 F.3d 1318, 1322 (11th Cir. 2006)

[11] Citing *Berliner Handels-Und Frankfurter Bank v. East Texas Steel Facilities, Inc.* (*In re East Texas Steel Facilities, Inc.*), 117 B.R. 235, 241 (Bankr. N.D. Tex. 1990).

[12] *In re Senior Management Services of Treemont, Inc., et al*, Chapter 11 Case No. 07-30230-HDH-11 (Order entered February 27, 2009).

Cost Report Receivables & Overpayments

Since most healthcare providers are now paid by Medicare and Medicaid under various forms of "prospective payment" methodologies[13] (versus the "cost based" reimbursement schemes of the past), the magnitude of yearly overpayments or underpayments have decreased substantially. Nonetheless, there are reimbursement items that are subject to "true-up" upon filing of the annual cost report. For hospitals, these items include reimbursement for (i) disproportionate share, (ii) Medicare bad debt and (iii) graduate medical education. Generally, these annual settlements are considered separate and distinct from "accounts receivable" and are frequently retained by the seller even if A/R is sold. [14]

Medicare and Medicaid cost reports are generally filed annually. [15] There is ordinarily a requirement to file a "stub period" cost report if a change of ownership occurs during the cost report year.[16] The APA should clearly address which party is responsible for meeting cost report filing requirements.

Post-Sale Collection of A/R

Resolution of A/R retained by the seller is one of the most important aspects of the OTA. In practice, collection of A/R in an "ordinary course environment" always yields a higher value than selling the A/R to a third-party. The buyer is usually in the best position to collect the retained A/R, particularly if the seller's billing and collection employees were included in the transferred operations. Therefore, it is critical that an agreement to collect the retained A/R be reached early in the overall OTA negotiation process, and not dealt with as an afterthought. Note that until the buyer's change of ownership process has been finalized by Medicare and Medicaid (typically 75 – 90 days), all EFT payments for both pre-sale and post-sale A/R will continue to flow to the seller's bank accounts. After the buyer's change of ownership has been finalized, all EFT payments will then flow to the buyer's bank accounts. Obviously, the OTA must contain a clear methodology for identifying and segregating collections of pre-sale and post-sale A/R.

Regulatory Approvals – brief listing

Required regulatory approvals vary according to the type of healthcare entity being sold. Sale of a hospital, for example, would include, in addition to filing any Medicare and Medicaid

---

[13] One notable exception is hospitals with a designation of critical access facility, which are reimbursed on a cost basis.

[14] Recall that Medicare has a "single provider" view. Therefore, if any interest in Medicare A/R or cost report settlements are retained by the seller, beware that Medicare will not acknowledge this partition and will view the buyer as the sole counterparty for all payments or recoveries once the provider agreement has been assigned.

[15] Cost report year can be determined by the provider and need not correspond to a calendar year.

[16] Exception being a provider's ability to file a 13-month cost report. Slippage of more than a month into a subsequent cost report year usually triggers the requirement to file a stub period cost report.

CMS 855 applications, notification to and approval by the state agency in charge of licensure (as distinct from government payor certification), CLIA registration, application to the DEA and other pharmacy-related regulators in the state, filings with state radiation control regulators as applicable, and fire marshal, food service, and boiler registration notifications. Contact with any applicable accreditation organizations is also desirable.

Employee Issues / WARN Act

The WARN Act[17] requires a qualifying employer to provide its employees with 60 days' notice of a plant closing or mass layoff. As a rule of thumb, WARN is triggered if more than 49 people are laid off from a facility. There are two exceptions in the Act, which may result in the allowance of less than 60 days' notice: (a) the unforeseen business circumstance, and (b) the faltering business exception. These exceptions are not as straightforward as they may appear at first blush. For example, if the company has suffered losses for an extended time period or otherwise had a period of warning signs, the exceptions may not be available.[18] A bankruptcy trustee may succeed to WARN obligations if he or she operates the business of the company; otherwise, if the trustee is merely a "liquidating fiduciary," compliance with WARN is not necessary. If the business is sold as a going concern, with no or minimal reductions in force, the WARN notice obligations may not be applicable.

Medical Records: State Law Considerations

Custody of patient medical records should be addressed in the OTA and a responsible person should be designated as the custodian of those records with the place of retention specified. Further, to the extent the outgoing provider retains any responsibility for cost report preparation, or must otherwise defend any action related to a patient or patients receiving care during the tenure of the provider, conditions of access to the records by the outgoing provider should be spelled out by the parties. Specific requirements for the quality and retention of medical records vary according to each state's law and in many cases by type of healthcare business.

Medical records: Bankruptcy Code Provisions

Section 351 of the Bankruptcy Code addresses the disposal of patient records. It provides a mechanism for a trustee to dispose of such records if the estate lacks sufficient funds to pay storage costs of patient records in the manner required by state or federal law. This statute involves a 365-day process and should be carefully followed; likewise, the cost of such maintaining the records for this period should be determined. Obviously, buyers of a going concern healthcare business are in the best position to take possession of a debtor's patient files.

---

[17] 29 U.S.C. § 2101, et seq.
[18] See, e.g., *In re United Healthcare Systems Inc.*, 200 F.2d 170 (3d Cir. 1999).

Review by Patient Care Ombudsman

It has been well chronicled in the pages of this publication that the specific roles and responsibilities of court-appointed Patient Care Ombudsman (PCO) representatives continue to evolve. Debtors should be aware that court-appointed Patient Care Ombudsman (PCO) representatives may consider a detailed review of asset sales within their prevue, citing concerns over patient privacy and the patient care track record of the buyer.

Selling Not For Profit Assets

Attorneys general in numerous states have become increasingly involved in the disposition of nonprofit healthcare operations. The AGs have premised their involvement by asserting that the "assets of a nonprofit healthcare system are held not by a private corporate property, but pursuant to a constructive or implied charitable trust for the benefit of the community or communities that the nonprofit organization serves."[19] For instance, in New York[20] there is a 2-prong statutory standard applied to NFP asset sales: (i) that the consideration and the terms of the transaction are fair and reasonable to the corporation, and (ii) that the purposes of the corporation or the interests of its members will be promoted. In additional to these statutory standards, there are other requirements including, *inter alia*, board approval, creditor notification and use of proceeds. NFP hospitals may have deed restrictions on donated real estate that complicate real estate transactions. The use of proceeds from the sale of property acquired through charitable donations (as opposed to debt issuance) will receive a higher degree of scrutiny from regulators, and may be severely limited. This intervention by various states' AGs offices, particularly with multi-site transactions, must be carefully considered in Chapter 11 cases as well.[21]

D. Dealing with Medical Malpractice Liabilities

Section 101(5)(A) of the Bankruptcy Code is an expansive definition of "claim" including a right to payment, "whether or not such right is reduced to judgment, liquidated, unliquidated, fixed, contingent, matured, unmatured, disputed, undisputed, legal, equitable, secured, or unsecured;..." 11 U.S.C. § 101(5)(A). Known and unknown medical malpractice claims are encompassed in this definition. To cast a broad web, notice to known and unknown med mal claimants is critical, albeit expensive. Notice of the bankruptcy filing and proof of claim bar date should be provided to current and former patients. Further, this is an instance

---

[19] For a concise article on this trend, see "The 'Charitable Trust' Doctrine: Lessons and Aftermath of Banner Health," ABI Health Care Committee Newsletter, (Vol. 1, No. 1) (2004).

[20] As regulation of not-for-profit corporations is a state government function, requirements will vary.

[21] By way of example, the Texas Attorney General's office was particularly active in *In re Nat'l Benevolent Ass'n of the Christian Church (Disciples of Christ), et al.*, Case No. 04-50948-RBK (Bankr. W.D. Tex.).

where approval of publication notice in the market(s) where the healthcare facility operates is critical. Sellers should anticipate in advance that buyers of healthcare businesses will be concerned about "cutting off" successor medical malpractice liability and set forth a clear strategy for doing so.

Bottom line … there no cookie-cutter template for all healthcare transactions. The above should be useful in guiding a debtor's consideration of the myriad unique issues involved in selling a complex, ongoing healthcare business.

3. Other Issues in Health Care Bankruptcies.

A. Can a Bankruptcy Filing Preserve Medicare and Medicaid Provider Agreements?

Medicare and Medicaid provider agreements are often the primary source of income for troubled health care organizations.[22] Accordingly, any threatened or actual termination of a provider agreement can be financially devastating for the affected health care organization. Whether or not a bankruptcy filing can preserve a provider agreement where termination has been threatened may depend upon whether or not the provider agreement has finally and irreversibly terminated on or before the petition date.[23]

Governmental authorities are often not enthusiastic about appearing in bankruptcy court in connection with a provider's election to file a petition for relief and often argue that the Medicare "jurisdictional bar" of 42 U.S.C. § 405(h) precludes a bankruptcy court from reviewing any issue involving a provider agreement regarding termination or otherwise. The bankruptcy court for the Southern District of Georgia analyzed this issue and concluded that bankruptcy courts have jurisdiction over Medicare issues pursuant to 28 U.S.C. § 1334.

In *First American Health Care of Georgia, Inc., et al, v. U.S. Dept. of Health and Human Services*, 208 B.R. 985 (Bankr. S. D. Ga. 1996), the Bankruptcy Court for the Southern District of Georgia confirmed that, "[a]s originally drafted, 42 U.S.C. Section 405(h) precluded bankruptcy jurisdiction over all disputes arising out of the Medicare program by "prohibiting any action under 'section 24 of the Judicial Code of the United States,' which section (codified at 28

---

[22] Medicare and Medicaid are programs created by the Social Security Act, as amended in 1965. Medicare is a federal health insurance program for the elderly and disabled. 42 U.S.C. §§1395 *et seq.*. Medicaid is a health insurance program operated under a Federal-State partnership. 42 U.S.C. §§ 1396 *et seq.* Congress authorized the Secretary of Health and Human Services to enter into Medicare provider agreements with health care organizations. 42 U.S.C. § 1395cc. A Medicare provider agreement comprehensively incorporates among its governing terms all applicable Medicare statutory and regulatory provisions.

[23] *See, e.g., In re Bayou Shores SNF, LLC*, Bankr. Case No. 8:14-bk-09521-MGW, Doc. No. 285, pp. 1, 13-14 (evaluating whether provider agreements could be assumed by debtor pursuant to 11 U.S.C. § 365(b) and concluding that because termination was "not complete and irreversible until the appeals process was complete" the debtor had contract rights in the provider agreement subject to being assumed).

U.S.C. § 41) contained virtually all of the jurisdictional grants to the district courts *including bankruptcy jurisdiction*."[24] Such preclusion effectively remained the case until 1984. *Id.* In 1984, however, Congress significantly changed the jurisdictional playing field in enacting 28 U.S.C. § 1334, which supplied broad jurisdiction to bankruptcy courts. As best explained by the court:

> [I]n 1984, in an effort to completely revise and expand the scope of bankruptcy jurisdiction, Congress enacted 28 U.S.C. Section 1334 which took effect on July 10, 1984. When enacting Section 1334 Congress had the opportunity to exclude actions covered by 405(h), but instead omitted any reference to the Medicare jurisdictional preclusion provisions and, therefore, granted concurrent jurisdiction of Section 405(h) matters to bankruptcy courts. *See In re Shelby County Healthcare Services of Al., Inc.* 80 B.R. 555, 560 (Bankr.N.D.Ga.1987); *In re Town & Country Home Nursing Services, Inc.*, 963 F.2d 1146, 1155 (9th Cir.1992) (Section 1334 is a broad jurisdictional grant over matters that have an effect on the estate and it "allows a single court to preside over all of the affairs of the estate, which promotes a 'congressionally-endorsed objective: the efficient and expeditious resolution of all matters connected to the bankruptcy estate' ") (citations omitted). Moreover, effective July 18, 1984, only eight days subsequent to the enacting of Section 1334, Congress revised Section 405(h) and substituted "section 1331 or 1346 of title 28, United States Code," for Section 24 of the Judicial Code of the United States. Pub.L. 98–369, § 2663(a)(4)(D), 98 Stat. 1162 (1984). Obviously, the language of Section 405(h) omits any reference to the preclusion of Medicare claim jurisdiction from cases arising under 28 U.S.C. Section 1334. Although the possibility exists that the exclusion was unintentional, when considering the proximity of the enactment of both statutes along with the significant changes in bankruptcy jurisdiction that Section 1334 established, I hold that the plain meaning of Section 405(h) should be enforced, and clearly, this Court's jurisdiction under Section 1334 was not circumscribed. See Healthmaster Home Health Care, Inc. v. Shalala (In re Healthmaster Home–Health Care, Inc.), Case No. 95–10548, Adv.Pro. 95–1031, slip op. at 3–4 (Bankr.S.D.Ga., April 13, 1995). In short, within a period of eight days, Congress, when presented with two opportunities, failed to exclude from the jurisdiction of the bankruptcy courts all actions arising under the Medicare program.

As such, because Section 1334 took effect on July 10, 1984 and because just eight days after Congress enacted Section 1334, it revised Section 405(h) and included 28 U.S.C. § 1331 and 28 U.S.C. § 1346, but did not include 28 U.S.C. § 1334, the bankruptcy court concluded it had jurisdiction over actions arising under the Medicare program.[25]

---

[24] 208 B.R. at 988. *citing In re St. Johns Home Health Agency, Inc*., 173 B.R. 238, 244 (Bankr.S.D.Fla.1994)
[25] 208 B.R. at 988.

Involuntary termination of a provider agreement generally occurs via a notice of involuntary termination served on the health care organization by the Center for Medicare and Medicaid Services ("CMS"). The notice typically provides that the provider agreement will be terminated effective on some future date. Whether or not termination of a provider agreement is subject to the automatic stay provided in 11 U.S.C. § 362(a) or whether termination is a "police or regulatory power" excepted from the automatic stay pursuant to 11 U.S.C. § 362(b)(4) is factually driven. The phrase "police or regulatory power" in 11 U.S.C. § 362(b)(4) 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.[26] Section 362(b)(4) is construed to balance the government's need to enforce its police or regulatory power with the estate's need to preserve its assets for the reorganization of the debtor.[27] A bankruptcy court's decision in on issues arising pursuant to 11 U.S.C. §362 are reviewed for abuse of discretion.[28] Care should be taken to develop facts necessary, where possible, to permit a bankruptcy court to conclude that proceeding further with termination during the bankruptcy case is in line with a governmental authority's pecuniary interests rather than an exercise of its powers to enforce laws affecting health, welfare, morals and safety.

In addition to the potential protections afforded by the automatic stay, bankruptcy courts have powers pursuant to 11 U.S.C. §105(a) to protect property of the estate which would include provider agreements. In *N.L.R.B. v. Superior Forwarding, Inc.*, 762 F.2d 695, 698 (8th Cir. 1985), the United States Court of Appeals for the Eighth Circuit agreed with decisions issuing out of the Seventh, Ninth, and Eleventh Circuits ruling that Section 105 grants a bankruptcy court the discretion and authority to enjoin federal regulatory proceedings when those proceedings "threaten" the assets of the debtor's estate.[29] In *Superior Forwarding,* the Court held that the bankruptcy court has the discretion and authority to enjoin federal regulatory proceedings under § 105 when those proceedings would threaten the debtor's estate, and when the court has jurisdiction over a petition in bankruptcy under 28 U.S.C. § 1471. (28 U.S.C. § 1471 was later repealed in connection with enactment of 28 U.S.C. 1334).

Moreover, *In re Beker Indus. Corp.,* 57 B.R. 611, 621 (Bankr. S.D.N.Y. 1986) the Bankruptcy Court for the Southern District of New York recognized that bankruptcy courts

---

[26] *Hillis Motors, Inc. v. Hawaii Auto. Dealers' Ass'n,* 997 F.2d 581, 591 (9th Cir.1993).
[27] *Brock v. Marysville Body Works*, 829 F.2d 383 (3rd Cir. 1987).
[28] *In re Eastburg*, 447 B.R. 624, 630-31 (B.A.P. 10th Cir. 2011); *Pursifull v. Eakin*, 814 F.2d 1501, 1504 (10th Cir. 1987); *Matter of Boomgarden,* 780 F.2d 657, 660 (7th Cir.1985); *In re Castlerock Properties,* 781 F.2d 159, 163 (9th Cir.1986).
[29] *In re Shippers Interstate Serv., Inc.,* 618 F.2d 9, 13 (7th Cir.1980), *quoting In re Bel Air Chateau Hosp., Inc.,* 611 F.2d 1248, 1251 (9th Cir.1979); *In re J & G Express, Inc.,* No. J84-0623(B) slip op at 5. (Bankr.S.D.Miss. Oct. 17, 1984) (unpublished); *In re Brada Miller Freight Sys. Inc.,* 16 B.R. 1002, 1012, 1013 (N.D.Ala.1981), *vacated on other grounds, In re Brada Miller Freight Sys., Inc.,* 702 F.2d 890 (11th Cir.1983); *In re Seeburg Corp.,* 5 B.R. 364, 368 (Bankr.N.D.Ill.1980), *quoting, Shippers,* 618 F.2d at 13. *See also In re King Memorial Hosp. Inc.,* 4 B.R. 704, 709 (Bankr.S.D.Fla.1980); *Missouri v. United States Bankruptcy Ct.,* 647 F.2d 768, 776-77, 776-77 n. 14 (8th Cir.1981), *cert. denied,* 454 U.S. 1162, 102 S.Ct. 1035, 71 L.Ed.2d 318 (1982).

"have long had subject matter jurisdiction to issue injunctive relief to *protect the administration of an estate and the opportunity to reorganize independent of the existence of a property interest,* (emphasis added) *citing Continental Illinois National Bank & Trust Co. v. Chicago, Rock Island & Pacific Ry. Co.,* 294 U.S. 648, 675–676 (1934), and that such "ability is continued under 28 U.S.C. § 1334."[30]

The party seeking relief under 11 U.S.C. § 105(a) carries the burden of demonstrating the following elements:

1. A substantial likelihood of success on the merits;
2. A substantial threat that the movant will suffer irreparable harm;
3. The potential injury the movant may suffer without an injunction is greater than the potential injury the opposing party would suffer if the injunction were issued; and
4. The preliminary injunction will not adversely impact the public interest.[31]

B. Appointment of a Patient Care Ombudsman in Health Care Business Cases

Pursuant to 11 U.S.C. § 333(a)(1), the Bankruptcy Court is required to order the appointment of a "patient care ombudsman" in a health care business commenced under Chapter 7, 9, or 11, not later than 30 days after the petition date in order to "monitor the quality of patient care and to represent the interests of the patients" … unless the court finds that such appointment is not necessary for the protection of patients under the specific facts of each case. 11 U.S.C. § 333(a)(1). The term "health care business" is defined in 11 U.S.C. § 101(27A)(A) to include a public or private entity that is primarily engaged in offering to the general public services for (i) the diagnosis or treatment of injury, deformity, or disease; and (ii) surgical, drug treatment, psychiatric, or obstetric care, and includes any general or specialized hospital, ancillary ambulatory, emergency, or surgical treatment facility; hospice, home health agency; and, other healthcare institution that is similar to any of these entities. 11 U.S.C. §

---

[30] 57 B.R. at 621 *citing In re Baldwin-United Corporation Litigation,* 765 F.2d at 348; *National Labor Relations Board v. Superior Forwarding Inc.,* 762 F.2d 695, 698 (8th Cir.1985); *Lesser v. A–Z Associates (In re Lion Capital Group),* 44 B.R. 690, 700–701 (Bankr.S.D.N.Y.1983) (limitation on injunctive relief under former Bankruptcy Act to protection of property held inapplicable under the Bankruptcy Code and jurisdictional grants); *see also, In re Richmond Paramedical Servs., Inc.*, 94 B.R. 881, 882 (Bankr. E.D. Va. 1988) (noting that its jurisdiction is founded upon the authority granted by 28 U.S.C. §§ 1334 and 157, and not upon 42 U.S.C. § 405(g)) *aff'd,* No. CIV. A. 89-0081-R, 1989 WL 149144 (E.D. Va. May 3, 1989) *on reh'g sub nom. In re Richmond Paramedical Servs.*, No. CIV. A. 88-0558-R, 1989 WL 149150 (E.D. Va. May 17, 1989).

[31] *In re Hillsborough Holdings, Corp.*, 123 B.R. at 1015 *citing N.L.R.B. v. State of Fla. Dept. of Business Regulation,* 868 F.2d 391, 393 (11th Cir.1989); *National Distrib. Co. v. James B. Beam Distilling Co.,* 845 F.2d 307, 309 (11th Cir.1988); *In re Provincetown Boston Airline, Inc.,* 52 B.R. 620 at 624–25 (Bankr.M.D.Fla.1985).

101(27A)(B)(i). In addition, the definition encompasses any long term care facilities, including those for skilled nursing, intermediate care, assisted living, homes for the aged, domiciliary care, and health care institutions related to any of these entities if they offer certain services. 11 U.S.C. § 101(27A)(B)(ii)(I) – (VI).

More than one bankruptcy court has recognized that the definition of "health care business" presents uncertainties. In such circumstances, bankruptcy courts are not bound to decide first whether a particular debtor is health care business within the definition of 11 U.S.C. 101(27A) and then decide whether an ombudsman is required pursuant to 11 U.S.C. 333(a)(1).[32] Instead, a court may assume that section 101(27A) has been met for the purpose of analyzing section 333(a)(1).[33]

If the court orders the appointment of an ombudsman pursuant to 11 U.S.C. § 333(a)(1), the United States trustee is required to appoint one [1] "disinterested person" (other than the United States trustee) to serve as ombudsman. 11 U.S.C. § 333(a)(2)(A). There are special rules for health care businesses that provide long term care. 11 U.S.C. § 333(a)(2)(B) and (C). For those health care businesses which do not provide long term care, an appointed ombudsman is required to monitor the quality of patient care provided to patients of the debtor, and to interview patients and physicians. 11 U.S.C. § 333(b)(1). The bankruptcy court must specifically approve in advance any request by an ombudsman to review confidential patient records. 11 U.S.C. § 333(c)(1). The bankruptcy court will impose restrictions on the ombudsman to protect the confidentiality of the patient records. 11 U.S.C. § 333(c)(1).

After an ombudsman is appointed, not later than 60 days after the date of appointment, and not less frequently than at 60-day intervals thereafter, the ombudsman must report to the court at a hearing or in writing regarding the quality of patient care being provided to the debtor's patients. 11 U.S.C. § 333(b)(2). If the ombudsman determines that the quality of patient care is declining significantly or is otherwise being materially compromised, the ombudsman is required to notify the court in writing and to immediately notice parties in interest of that determination. 11 U.S.C. § 333(b)(3).

In a bankruptcy case where quality of care issues are present pre-petition, certainly the appointment of a patient care ombudsman is necessary to ensure the debtor is adequately and satisfactorily providing patient care in accordance with applicable regulatory requirements. However, in bankruptcy cases where quality of care is not an issue and if certain other factual

---

[32] *In re Smiley Dental Arlington, PLLC*, 503 B.R. 680, 689 (Bankr. N.D. Tex. 2013) (explaining that the "patient care ombudsman analysis is not lock-step").

[33] *Smiley Dental,* 503 B.R. at 689 (assuming debtors qualified as health care businesses, an ombudsman was not necessary to protect patients under the specific facts presented) *citing In re Vartanian,* No. 07–10790, 2007 WL 4418163, at *2 (Bankr.D.Vt. Dec. 13, 2007) (holding that factors weighed against appointing ombudsman even assuming that the debtor qualified as a health care business); *In re Banes,* 355 B.R. at 532 (same); In *re Total Woman Healthcare Ctr., P.C* , No. 06-52000, 2006 WL 3708164, at *3 (Bankr. M.D. Ga. 2008) (holding that no analysis of section 101(27A) was necessary because no ombudsman was required).

circumstances are present, a bankruptcy court can excuse the appointment of a patient care ombudsman. In determining whether an ombudsman should be excused, courts analyze nine primary (but not exclusive) factors: (i) the cause of the bankruptcy; (ii) the presence and role of licensing or supervising entities; (iii) debtor's past history of patient care; (iv) the ability of the patients to protect their rights; (v) the level of dependency of the patients on the facility; (vi) the likelihood of tension between the interests of the patients and the debtor; (vii) the potential injury to the patients if the debtor drastically reduced its level of patient care; (viii) the presence and sufficiency of internal safeguards to ensure appropriate level of care; and (ix) the impact of the cost of an ombudsman on the likelihood of a successful reorganization.[34] Some additional factors courts have considered include whether (i) the facility's patient care is of high quality; (ii) the debtor has adequate financial strength to maintain high-quality patient care; (iii) the facility already has an internal ombudsman program in operation; (iv) or the situation at the facility is adequately monitored by federal, state, local or professional association programs so that the ombudsman would be redundant.[35]

A bankruptcy court's initial decision that the specific facts of a particular case do not demonstrate any need for the appointment of a patient care ombudsman can be reconsidered at any time. If the debtor experiences any negative trend which indicates the need for the appointment of an ombudsman in the future, the bankruptcy court can reconsider the appointment of an ombudsman upon the filing of an appropriate motion. See Fed. R. Bankr. P. 2007.2(b) ("[T]he court, on motion of the United States trustee, or an party in interest, may order the appointment at any time during the case if the court finds that the appointment of an ombudsman has become necessary to protect patients.")

---

[34] *In re Pediatrics at Whitlock, P.C.*, 507 B.R. 10 (Bankr. N.D. Ga. 2014) *citing In re Alternate Family Care*, 377 B.R. 754, 758-59 (Bankr. S.D. Fla. 2007).

[35] *Smiley Dental*, 503 B.R. at 689 *citing* 3 COLLIER ON BANKRUPTCY ¶ 333.02[2] (Alan N. Resnick & Henry J. Sommer eds., 16th ed. 2012). *See e.g., In re Total Woman Healthcare Ctr*, 2006 WL 3708164 (Bankr. M.D. Ga. Dec. 14, 2006) (finding appointment of ombudsman unnecessary where debtor provided outpatient care at her office or performed medical procedures at area hospitals where hospital staff provided additional patient care, where no complaints had been received since bankruptcy filing, and where neither office staff nor patient scheduling had changed due to bankruptcy); *In re Genesis Hospice Care, LLC*, No. 08-15576-NPO, 2009 WL 467265 (Bankr. N.D. Miss. Feb. 24, 2009) (ombudsman unnecessary where Debtor provided only outpatient care and had implemented a basic internal ombudsman program); *In re RAD/ONE, P.A.*, No. 08-15517-NPO, 2009 WL 467286 (Bankr. N.D. Miss. Feb.24, 2009) (debtor provided only outpatient radiological services); *In re N. Shore Hematology–Oncology Assocs., P.C.,* 400 B.R. 7, 9, 12 (Bankr.E.D.N.Y.2008) (debtor's health care practice providing services in areas of cancer treatment and blood disorders did not provide any in-patient services).

C. Medicare Fraud

Introduction

Increasingly, bankruptcy lawyers must deal with the legal and practical issues associated with Medicare fraud. As regulators get serious about auditing and containing fraudulent practices, and as employees of medical providers are encouraged to bring whistleblower actions pursuant to 31 U.S.C. § 3730, providers and their creditors struggle for solutions, even amid charges of Medicare overpayments.

Once caught, providers often look to insolvency professionals to address the pressing economic issues resulting from the misconduct, whether such conduct was intentional or inadvertent. To provide good counsel to such clients, it is necessary for insolvency professionals to have a working knowledge of the legal landscape for Medicare fraud and to know enough to know to bring in an expert. In the worst cases, that expertise may be in the form or criminal counsel.

These materials are intended to just touch the surface of the federal framework in which Medicare providers operate and to facilitate issue spotting by insolvency professionals.

Key Federal Laws and Regulations

Medicare Act – 42 U.S.C. §§ 1395 et seq. and Regulations

Congress established the Medicare program to assist elderly and disabled persons in purchasing necessary health care. 42 U.S.C. §§ 1395 et seq. ("Medicare Act"). Under the Medicare Act, the Secretary of Health and Human Services reimburses medical providers for covered services. The Center for Medicare and Medicaid Servicers ("CMS") oversees the system.

For a provider to be reimbursed for services, it must enter into a contract with CMS, which incorporates various provisions of the Medicare Act and its implementing regulations.

Under the Medicare payment system, providers are reimbursed for medical services provided to Medicare beneficiaries based on billing categories known as diagnosis-related groups, for which Medicare usually reimburses providers a certain fixed amount. These payments are based on a predetermined schedule, and for most claims, providers receive a fixed payment regardless of what the provider lists as its actual charges for a given service.

When a provider submits its bill to Medicare (usually through an intermediary), even though the reimbursement from Medicare for the procedure is usually predetermined by the procedure's diagnostic-related group, the provider nevertheless includes its own stated charge for the service. An automated computer system created by CMS takes these submitted charges and calculates its own estimate of the provider's costs using a provider-specific "cost-to-charge ratio." The cost-to-charge ratio is calculated based on a provider's overall report of its total costs for services and its overall report of its charges. Before 2003, only "settled" cost reports were

used for this purpose but after 2003, either "settled" or "tentative" cost reports could be used to calculate a facility's cost-to-charge ratio.

42 C.F.R. 424.535 – Revocation of Medicare Enrollment and Billing Privileges

CMS may revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement or supplier agreement for a number of reasons, including the following set forth in 42 C.F.R. 424.535:

> (1) Noncompliance. The provider or supplier is determined not to be in compliance with the enrollment requirements described in this section, or in the enrollment application applicable for its provider or supplier type, and has not submitted a plan of corrective action as outlined in part 488 of this chapter. The provider or supplier may also be determined not to be in compliance if it has failed to pay any user fees as assessed under part 488 of this chapter. All providers and suppliers are granted an opportunity to correct the deficient compliance requirement before a final determination to revoke billing privileges, except for those imposed under paragraphs (a)(2), (a)(3), or (a)(5) of this section.
>
> > (i) CMS may request additional documentation from the provider or supplier to determine compliance if adverse information is received or otherwise found concerning the provider or supplier.
> >
> > (ii) Requested additional documentation must be submitted within 60 calendar days of request.
>
> (2) Provider or supplier conduct. The provider or supplier, or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier is--
>
> > (i) Excluded from the Medicare, Medicaid, and any other Federal health care program, as defined in § 1001.2 of this chapter, in accordance with section 1128, 1128A, 1156, 1842, 1862, 1867 or 1892 of the Act.
> >
> > (ii) Is debarred, suspended, or otherwise excluded from participating in any other Federal procurement or nonprocurement program or activity in accordance with the FASA implementing regulations and the Department of Health and Human Services nonprocurement common rule at 45 CFR part 76.
>
> (3) Felonies. The provider, supplier, or any owner of the provider or supplier, within the 10 years preceding enrollment or revalidation of enrollment, was convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries.
>
> (4) False or misleading information. The provider or supplier certified as "true" misleading or false information on the enrollment application to be enrolled or maintain

enrollment in the Medicare program. (Offenders may be subject to either fines or imprisonment, or both, in accordance with current law and regulations.)

(5) On-site review. CMS determines, upon on-site review, that the provider or supplier is no longer operational to furnish Medicare covered items or services, or is not meeting Medicare enrollment requirements under statute or regulation to supervise treatment of, or to provide Medicare covered items or services for, Medicare patients. Upon on-site review, CMS determines that--

(i) A Medicare Part A provider is no longer operational to furnish Medicare covered items or services, or the provider fails to satisfy any of the Medicare enrollment requirements.

(ii) A Medicare Part B supplier is no longer operational to furnish Medicare covered items or services, or the supplier has failed to satisfy any or all of the Medicare enrollment requirements, or has failed to furnish Medicare covered items or services as required by the statute or regulations.

(6) Grounds related to provider and supplier screening requirements.

(i)(A) An institutional provider does not submit an application fee or hardship exception request that meets the requirements set forth in §424.514 with the Medicare revalidation application; or

(B) The hardship exception is not granted and the institutional provider does not submit the applicable application form or application fee within 30 days of being notified that the hardship exception request was denied.

(ii)(A) Either of the following occurs:

(1) CMS is not able to deposit the full application amount into a government-owned account.

(2) The funds are not able to be credited to the U.S. Treasury.

(B) The provider or supplier lacks sufficient funds in the account at the banking institution whose name is imprinted on the check or other banking instrument to pay the application fee; or

(C) There is any other reason why CMS or its Medicare contractor is unable to deposit the application fee into a government-owned account.

(7) Misuse of billing number. The provider or supplier knowingly sells to or allows another individual or entity to use its billing number. This does not include those providers or suppliers who enter into a valid reassignment of benefits as specified in § 424.80 or a change of ownership as outlined in § 489.18 of this chapter.

(8) Abuse of billing privileges. The provider or supplier submits a claim or claims for services that could not have been furnished to a specific individual on the date of service. These instances include but are not limited to situations where the beneficiary is deceased, the directing physician or beneficiary is not in the State or country when services were furnished, or when the equipment necessary for testing is not present where the testing is said to have occurred.

(9) Failure to report. The provider or supplier did not comply with the reporting requirements specified in § 424.516(d)(1)(ii) and (iii) of this subpart.

(10) Failure to document or provide CMS access to documentation.

. . .

(11) Initial reserve operating funds. CMS or its designated Medicare contractor may revoke the Medicare billing privileges of an HHA and the corresponding provider agreement if, within 30 days of a CMS or Medicare contractor request, the HHA cannot furnish supporting documentation verifying that the HHA meets the initial reserve operating funds requirement found in 42 CFR § 489.28(a).

(12) Medicaid termination.

False Claims Act – 31 U.S.C. §§ 3729-33 (a criminal law)

The False Claims Act establishes liability when any person or entity improperly receives from or avoids payment (reverse false claims) to the federal government (tax fraud is excepted). The act provides liability where a person:

(A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

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

(C) conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G);

(D) has possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property;

(E) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

(F) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge property; or

(G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government, is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation.[36]

"The False Claims Act […] prohibits submitting false or fraudulent claims for payment to the United States, § 3729(a), and authorizes *qui tarn* suits, in which private parties bring civil actions in the Government's name, § 3730(b)(1)."[37] In order to establish liability a plaintiff must show "that defendants (1) made a claim, (2) to the United States government, (3) that is false or fraudulent, (4) knowing of its falsity, and (5) seeking payment from the federal treasury." [38]

The False Claims Act does not require specific intent to defraud, and defines "knowingly" as either: (1) possessing "actual knowledge"; (2) acting in "deliberate ignorance" of the truth or falsity of the information; or (3) acting in "reckless disregard" of the truth or falsity of the information.[39]

Stark Law (aka Physician Self-Referral Act)
42 U.S.C. § 1395nn (civil penalties)

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

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

(a) Prohibition of certain referrals

---

[36] 31 U.S.C. § 3729*; See generally*, Merritt and Rose, "*Pleading 'Healthcare Fraud and Abuse' Under the False Claims Act,*" 60 Fed. Law 62 (May 2013)

[37] *Schindler Elevator Corp. v. U.S.*, 131 S.Ct. 1885, 1889 (2011).

[38] *United States ex rel. Mikes v. Straus,* 274 F.3d 687, 695 (2d Cir.2001).

[39] *See* 31 U.S.C. § 3729(b)(1). *See generally, U.S. v. Huron Consulting Group*, 2013 WL 856370 (S.D.N.Y. 2013).

(1) In general

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

> (A) the physician may not make a referral to the entity for the furnishing of designated health services for which payment otherwise may be made under this subchapter, and
>
> (B) the entity may not present or cause to be presented a claim under this subchapter or bill to any individual, third party payor, or other entity for designated health services furnished pursuant to a referral prohibited under subparagraph (A).

(2) Financial relationship specified

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

> (A) except as provided in subsections (c) and (d) of this section, an ownership or investment interest in the entity, or
>
> (B) except as provided in subsection (e) of this section, a compensation arrangement (as defined in subsection (h)(1) of this section) between the physician (or an immediate family member of such physician) and the entity.

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

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

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

(1) Physicians' services

. . .

(2) In-office ancillary services

. . .

(3) Prepaid plans

. . .

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

(5) Electronic prescribing

. . .

(g) Sanctions

(1) Denial of payment

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

(2) Requiring refunds for certain claims

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

(3) Civil money penalty and exclusion for improper claims

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

…

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

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

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

Whoever–

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

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

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized,

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

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

(6) for a fee knowingly and willfully counsels or assists an individual to dispose of assets (including by any transfer in trust) in order for the individual to become eligible for medical assistance under a State plan under subchapter XIX of this chapter, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1396p(c) of this title,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under the program, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, conversion, or provision of counsel or assistance by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance

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

(b) Illegal remunerations

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

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

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

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

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

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

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

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

…

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

> Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution, facility, or entity in order that such institution, facility, or entity may qualify (either upon initial certification or upon recertification) as a hospital, critical access hospital, skilled nursing facility, nursing facility, intermediate care facility for the mentally retarded, home health agency, or other entity (including an eligible organization under section 1395mm(b) of this title) for which certification is required under subchapter XVIII of this chapter or a State health care program (as defined in section 1320a-7(h) of this title), or with respect to information required to be provided under section 1320a-3a of this title, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Illegal patient admittance and retention practices

Whoever knowingly and willfully–

> (1) charges, for any service provided to a patient under a State plan approved under subchapter XIX of this chapter, money or other consideration at a rate in excess of the rates established by the State (or, in the case of services provided to an individual enrolled with a Medicaid managed care organization under subchapter XIX of this chapter under a contract under section 1396b(m) of this title or under a contractual, referral, or other arrangement under such contract, at a rate in excess of the rate permitted under such contract), or
>
> (2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under subchapter XIX of this chapter, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)–
>
> > (A) as a precondition of admitting a patient to a hospital, nursing facility, or intermediate care facility for the mentally retarded, or
> >
> > (B) as a requirement for the patient's continued stay in such a facility,

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

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

(e) Violation of assignment terms

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

Medicare Program Integrity Manual- http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019033.html

Medical Audits

Medical audits are the tools now used for detecting Medicare fraud. Such audits can lead to the recoupment of overpayments and in egregious situations the suspension or revocation of privileges from the Medicare Program. The need for insolvency assistance can arise at any stage of the audit process and, if assistance is sought early enough, it is possible to address billing problems at an early stage and avoid insolvency proceedings.

1. **Who is Auditing**

   i. "Medicare administrative contractors." 42 U.S.C. §§ 1395h, 1395kk-1; and recovery audit contractors and comprehensive error rate testing contractors

   ii. Some auditors paid on contingency, some paid via contract

2. **Why are they Auditing**

   i. Medicare improper payments totaled $44 billion in 2012 alone

      Representing about 38% of all Medicare payments

   ii. Government health care fraud prevention recovered nearly $4.2 billion in 2012

   iii. Audits are thought to be not only a means to recoup these improper overpayments, but also an attempt to extend the life of Medicare and Medicaid

Medicare has approximately $34 billion in unfunded liabilities.

3. Procedures

Auditor sends Medical Record Request Letters for Complex Reviews

Provider has time (typically 45 days) to submit copied charts

Auditor must notify provider of decision within specified time period of receipt of records (typically 60 days)

"Demand Letters" are sent when an overpayment is identified with reason for determination

Provider can pay by check, opt for recoupment, appeal or declare bankruptcy

4. Appeals

Level 1: Request for Redetermination

Made to Fiscal Intermediary

30 days from receipt of demand to freeze money!

Level 2: Request for Reconsideration

Made to Qualified Independent Contractor

60 days from receipt of redetermination to freeze money!

Level 3: Administrative Law Judge (ALJ)

60 days from receipt of reconsideration

Level 4: Medicare Appeals Council (MAC)

60 days from receipt of ALJ decision

Level 5: Federal District Court

60 days from MAC decision

Medical Fraud Issues Arising in Bankruptcy Cases

In re Edgewater Medical Center, 332 B.R. 166 (Bankr. N.D. Ill. 2005) (using a plea agreement for medical fraud to establish a breach of fiduciary claims against former officers and directors).

In re Precedent Health Center Operations, LLC, 392 Fed. Appx. 618 (10th Cir. 2010)(Chapter 7 Trustee sued intermediary and the Dept. of Health and Human Services to recover Medicare reimbursements. The reference was withdrawn and the case dismissed for failure to comply with administrative appeals).

In re Doctors Hosp. of Hyde Park, Inc., 2013 WL 3779657 (Bankr. N.D. Ill. 2013) (discussion of how medical fraud can impact solvency analysis in fraudulent transfer litigation).

In re Horras, 443 B.R. 159 (8th Cir. BAP 2011)(civil assessment of $673,212.00 imposed by the United States Department of Health and Human Services against Chapter 7 debtor, the former officer of a home health agency who was found to have knowingly presented or caused to be presented false or fraudulent claims for payment to Medicare and Medicaid, fell within the discharge exception for debts for a fine, penalty, or forfeiture payable to and for the benefit of a governmental unit for medical fraud – 11 U.S.C. § 523(a)(7) does not have a deadline for bringing such actions).

In re Haven Eldercare, LLC, 2012 WL 1357054 (Bankr. D. Conn. 2012)(illustrates successor liability issues when a CMS contract is assigned as part of a 363 sale of a medical facility).