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Smooth Sailing: A Guide to Navigating the Choppy Waters of Health Care M&A

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Smooth Sailing: A Guide to Navigating the Choppy Waters of Health Care M&A

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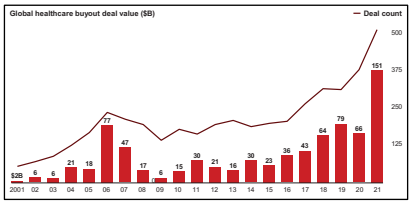
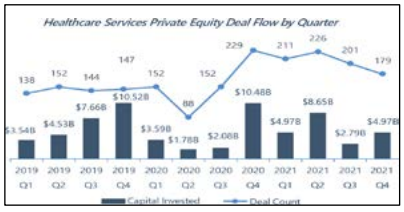
Health Care M&A Market



Bain & Company Global Healthcare Private Equity and M&A Report



- PE investment in health care businesses remains robust in 2022 after record breaking 2021
- The pursuit for scale to drive cost benefits and operating leverage continues to drive M&A.
- Provider / Health care services subsector drives significant M&A volume at attractive transaction multiples
- Roll ups and tuck in acquisitions by strategics offers the distressed seller an opportunity to maximize value.
- In the senior care market, average per bed price rose 23% in 2021 to $98,000 (The Senior Care Investor)

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Leading Indicators of Distress

Health care companies often exhibit these warning signs:	Some signs are less obvious and require a closer look to be identified, such as:
• Reimbursement Changes • Declining revenue / Loss of key payer contracts • Shrinking margins (especially at higher sales). • Wage pressures • Operating losses / Negative gross margins • Liquidity issues • Breached covenants / Loan defaults • Aging accounts receivable • Increasing past due accounts payable • No borrowing base availability / Over-advances • Collateral audit issues (for ABL loans) • Financial misstatements • Looming debt maturity • High Executive / Middle mgmt turnover	• Inability / Unwillingness to raise prices or pass along cost increases • Revenues increase without increase in profits • Profits without cash or availability • Poor integration of acquisitions • Unfavorable payer mix • Staffing shortages

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Senior Living Trends

- Capitol Hill/regulatory agenda, data and technology
  - National imperative to improve nursing home quality: honoring our commitment to residents, families, and staff (national academies of sciences, April 2022)
    - Person-centered care
    - Workforce development
    - Transparency and accountability
    - Financing
    - Quality assurance
    - Quality improvement
    - HIT (health information technology)
  - Care for our seniors act (AHCA/NCAL)
    - Clinical, workforce, oversight, structural

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Senior Living Trends

- Mergers And Acquisitions
  - Heavy amount of distress at the same time there is significant interest in the space
- Demographics And Consumer Demand
  - Demand for nursing facility care is expected to increase significantly over next 10 years (growth in 85+ age group and behavioral needs of younger residents)
  - By 2030, 1 in every 5 US residents will be retirement age and seniors will outnumber children for the first time in US history
- Payment Transformation
  - New PDPM structure
- PHE Funding And Compliance
  - COVID shifting from pandemic to endemic, but will still disrupt day-to-day activities

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Senior Living – leading indicators of distress

- Margin pressure
  - Nursing home occupancy (NHSN data)
    - Jan 2020: 80.2%
    - Jan 2021: 67.5%
    - Apr 2022: 73.7%
  - Labor
    - Licensed staff wages up 15% from 2019-2021
    - CNA wages up 19% from 2019-2021
    - Nursing and CNA shortages in greater than 20% of all facilities
    - Reduction of 200,000 staff (greater than 10%) in just one year
    - 15% reduction in nursing home staff
    - 6.7% reduction in assisted living staff
  - Inflation/interest rates
  - Increasing operating costs

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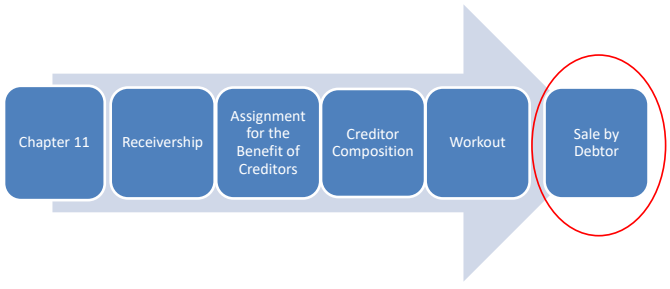
Restructuring Options



Key Questions Driving Strategy for all Parties

- Will patients care that the company is having financial problems?
- How is the company's relationship with its key payers, vendors and employees?
- How competitive is the company's business?
- What is the liquidation value of the company ?
- What is the level of stakeholder support.
- What is the liquidity vs. cash burn – cash runway to a sale, operational restructuring or financial recapitalization.
- Do the lenders want to own the Company?

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Key Factors in an M&A Process

- Understanding of the Company value proposition and competitive position
- Are all stakeholders interests aligned to the same outcome
- Has management been appropriately retained through a process.
  Should the debtor hire an investment banker to market the company.
- Have all operational "fixes" been accomplished to ensure maximum value realization
- Who has hold up value?
- What is the transaction structure: out of court stock or asset sale, Article 9 sale, (strict) foreclosure, or Section 363 or other court oversight sale?
- What is the communication plan for employees
- Due diligence process: Does the seller have accurate and detailed financial information?

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Unique factors in a distressed health care M&A

1. **A dual track process, codified for nonprofit sellers**
   - Bankruptcy Code sections 363(d), 541(f) and 1129(a)(16)
   - State laws typically require notice and review of state's Attorney General
   - Separate CHOW and licensure requirements per CMS Regional Office
   - Other state or federal courts, or out of court ABC process concerns

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Unique factors in a distressed health care M&A

2. **Managing Liquidity During the M&A process**
   - Added costs for extended time to close for regulatory approvals
   - Added costs for Patient Care Ombudsperson (PCO) in Chapter 11
   - Safeguarding Patient Records before and after sale
   - Recoupment or setoff risks – scope of automatic stay

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Unique factors in a distressed health care M&A

3. **What is the Seller selling, and what liabilities are excluded?**
   - Medicare and Medicaid Provider Agreements – are they executory contracts or a statutory entitlement?
   - Why does it matter in a bankruptcy sale, and is there any difference in an out of court transaction?
   - Fraud or false claim liability
   - Other successor liability concerns

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Unique factors in a distressed health care M&A

4. Impact on Patient Care

- Role of the PCO; scope and costs and opportunities for cost savings
- Surveys, audits and final cost report requirements
- Risk of business cessation and need for adequate planning

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Unique factors in a distressed health care M&A

5. Competitive Sales and NFP's Mission

- When is highest not best?
- Risks to creditor recovery, and options to limit risks

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Unique factors in a distressed health care M&A

6. Sale Closing Concerns

- Closing price adjustments
- Rep & Warranty Insurance
- Escrows
- Transition Services Agreements
- Successor liability risks

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SELECT ISSUES FACING HEALTH CARE BUSINESSES IN CHAPTER 11

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I. TREATMENT OF MEDICARE AND MEDICAID PROVIDER AGREEMENTS IN HEALTH CARE BANKRUPTCY CASES

A. Introduction.

Medicare and Medicaid pay for approximately 50% of hospital stays in the United States[1], and respectively account for 20% and 16% of our national health care expenditures in 2020.[2] These programs are ultimately administered by the Centers for Medicare and Medicaid Services ("CMS"), a division of the United States Department of Health and Human Services ("HHS"), with Medicaid being administered by state agencies through medical assistance programs. *See* 42 C.F.R. § 400.200; *see also* 42 U.S.C. § 1396a. A health care provider will enter into a "provider agreement" that represents the relationship between the program and an enrolled provider.[3] Only an enrolled provider with an applicable provider number may receive Medicare or Medicaid payments. *See* 42 C.F.R. § 424.505; *see also In re Vitalsigns Homecare, Inc.,* 396 B.R. 232, 237 (Bankr. D. Mass. 2008) (citing cases). CMS or through applicable state agencies issue health care provider reimbursements through a Prospective Payment System based on a predetermined amount.[4] "Because the . . . program[s] mandate[] that only the reasonable cost of covered services

[1] *Fact Sheet: Majority of Hospital Payments Dependent on Medicare or Medicaid*, AHA, https://www.aha.org/fact-sheets/2022-05-25-fact-sheet-majority-hospital-payments-dependent-medicare-or-medicaid.
[2] National Health Expenditure Data Fact Sheet, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet#:~:text=Historical%20NHE%2C%202020%3A,16%20percent%20of%20total%20NHE.
[3] *Id.* The provider agreement is a uniform document by which the provider will conform to applicable law and is not subject to negotiation or alteration. *See Centers for Medicare and Medicaid Services, Health Insurance Benefit Agreement, Form CMS-1561 (2001), available at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012196.*
[4] *Prospective Payment Systems-General Information*, CMS, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen.

be paid," intermediaries "audit claims . . . to determine the appropriateness of payments requested and made." *Vitalsigns*, 396 B.R. at 237. An audit is typically conducted after payment to determine the precise amount of reimbursement due to the provider. If the provider is overpaid, HHS may require return of the overpayment. *See* 42 U.S.C. § 1395; *see also* 42 C.F.R. § 405.373(a)(2).

When a buyer purchases an entity enrolled in either a Medicare or Medicaid program, it results in a change of ownership, or CHOW. A CHOW, however, is defined more broadly than only a change in the equity of the company, but includes member substitutions, sale of assets, mergers, a change in the lease of all or part of the facility subject to the provider agreement. *See* 42 C.F.R. § 489.18(c). Outside of a bankruptcy case, upon the CHOW, the existing provider agreement is assigned to the new owner. While this transfer is important to the success of a health care bankruptcy transaction, it presents unique legal issues when the seller is a debtor in a bankruptcy case.

B. Bankruptcy Courts Generally Hold that a Provider Agreement is an Executory Contract; Minority Hold they are a Statutory Entitlement.

Whether a provider agreement is treated as an executory contract in a bankruptcy case will have a significant impact on the debtor's bankruptcy case and any buyer of its assets. The majority of bankruptcy courts considering whether the provider agreement is an executory contract or statutory entitlement have concluded that they are executory contracts. Courts that conclude the provider agreement is an executory contract, condition the transfer of the provider agreement pursuant to Bankruptcy Code section 365(a).[5] Under Section 365, in order to assume and assign most executory contracts, the debtor must cure all monetary defaults and the debtor or buyer must provide the contract counterparty adequate assurance of future performance. *Gatx Leasing Corp.*

[5] These materials presume the reader has a foundational understanding of the treatment of executory contracts in chapter 11. If a refresh is necessary, the readers should review the Supreme Court's recent decision of *Mission Prod. Holdings, Inc. v. Tempnology, LLC*, 139 S. Ct. 1652 (2019).

v. Airlift Int'l, Inc. (In re Airlift Int'l, Inc.), 761 F.2d 1503, 1508 (11th Cir. 1985). In brief, upon the assignment of a provider agreement, the assignee assumes successor liability for the debtor's Medicare and Medicaid overpayments, and potentially its Federal False Claims.

A minority of bankruptcy courts have criticized the majority line of cases as not reflective no controlling non-bankruptcy law. These courts hold that a provider agreement is a statutory entitlement that the debtor may transfer under Section 363 as an asset, potentially free and clear of claims and interests pursuant to Bankruptcy Code section 363(f).

C. The Majority of Bankruptcy Courts Hold that the Provider Agreement is an Executory Contract.

Most bankruptcy courts considering the issue whether a provider agreement is an executory contract or a license right have concluded that they are executory contracts subject to Section 365(a). *See Vitalsigns*, 396 B.R. at 236–37; *In re Santiago*, 563 B.R. 457, 474 (Bankr. D.P.R. 2017); *In re Bayou Shores SNF, LLC*, 525 B.R. 160, 169–70 (Bankr. M.D. Fla. 2014); *Matter of First Am. Health Care of Georgia, Inc.,* 219 B.R. 324, 328 (Bankr. S.D. Ga. 1998); *In re Heffernan Mem'l Hosp. Dist*., 192 B.R. 228, 231 (Bankr. S.D. Cal. 1996); *In re Univ. Med. Ctr.*, 973 F.2d 1065, 1076 (3d Cir. 1992); *In re Advanced Pro. Home Health Care Inc*., 94 B.R. 95, 97 (E.D. Mich. 1988); *In re Mem'l Hosp. of Iowa Cnty., Inc.*, 82 B.R. 478, 480 (W.D. Wis. 1988); *In re Monsour Med. Ctr*., 11 B.R. 1014, 1018 (W.D. Pa. 1981).

In making this determination, the *Vitalsigns* court held that a provider should not "accept the benefits [of acquiring provider agreements] without the attendant burdens." *Vitalsigns*, 396 B.R. at 240. Moreover, the *Vitalsigns* court held that "continuing to pay a . . . provider to whom an excess has already been paid violates HHS' public charge to effectively administer" its programs. *Id*. Thus, treating the provider agreement as an executory contract in a bankruptcy case assists HHS in funding care for qualified beneficiaries.

Courts holding that provider agreements are executory contracts have reasoned that the provider agreement fits within the Countryman definitions of an executory contract. *See In re Provident Hosp. & Training Ass'n*, No. 87 B 11069, 1987 WL 383355, at *2 (Bankr. N.D. Ill. Sept. 16, 1987), *on reconsideration in part*, No. 87 B 11069, 1988 WL 525008 (Bankr. N.D. Ill. Jan. 6, 1988) (reasoning that the provider agreement "fits neatly within [the Countryman approach]."). More recently, the *In re Bayou Shores SNF, LLC* court held that under either the Countryman definition or the functional approaches, the provider agreement is an executory contract pursuant to Section 365(a). The *Bayou Shores* court reasoned that "Congress' failure to legislate special treatment for the assumption or rejection of Medicare provider agreements indicates that assumption of these agreements, like that of other executory contracts, should be deemed subject to the requirements of section 365, unless and until Congress decides otherwise.'" *Bayou*, 525 B.R. at 169–70 (quoting *Univ. Med. Ctr.*, 973 F.2d at 1077).

D. A Minority of Bankruptcy Courts Have Recognized that the Provider Agreement are a Statutory Entitlement Subject to § 363(f).

A minority of bankruptcy courts have held that the provider agreement is a statutory entitlement, subject to the debtor's transfer as an asset, which may be free and clear of claims and interests under Bankruptcy Code section 363(f). *See e.g.*, *In re Verity Health Sys. of California, Inc.*, 606 B.R. 843, 850–51 (Bankr. C.D. Cal. 2019), *vacated*, No. 18-BK-20151-ER, 2019 WL 7288754 (Bankr. C.D. Cal. Dec. 9, 2019); *see also In re Saint Joseph's Hosp*., 103 B.R. 643, 656 (Bankr. E.D. Pa. 1989) (noting that provider agreement "seems to be merely a form document envisioned to memorialize a hospital's participation in the Medicaid program."); *In re Ctr. City Healthcare LLC*, Case No. 19-11466 (KG) (Bankr. D. Del. Sept. 10, 2019) (unpublished). The minority view follows a long line of non-bankruptcy court rulings that have consistently held that a provider agreement is not a contract. *See, e.g., PAMC, Ltd. v. Sebelius,* 747 F.3d 1214, 1221

(9th Cir. 2014); *Hollander v. Brezenoff*, 787 F.2d 834, 838 (2d Cir. 1986); *Mem'l Hosp. v. Heckler,* 706 F.2d 1130, 1136 (11th Cir.1983); *Germantown Hos. & Med. Ctr. v. Heckler*, 590 F. Supp. 24, 30-31 (E.D. Pa. 1983), *aff'd*, 738 F.2d 631 (3d Cir. 1984); *Harper-Grace Hosps. v. Schweiker*, 708 F.2d 199, 201 (6th Cir. 1983); *Southeast Ark. Hospice, Inc. v. Sebelius*, 1 F. Supp. 3d 915, 925-26 (E.D. Ark. 2014); *United States ex rel. Roberts v. Aging Care Home Health Inc*., 474 F. Supp. 2d 810, 820 (W.D. La. 2007); *United States v. Medica-Rents Co.,* 285 F. Supp. 2d 742, 777 (N.D. Tex. 2003). In addition, certain of this case law criticizes the majority view as not resolving a disputed issue, but rather parties simply accepting that provider agreements are executory contracts by consensus without the court engaging in any material substantive analysis.

Notably, in 2019 the bankruptcy court in *In re Verity Health Sys. of California, Inc.* issued a lengthy opinion recognizing that a Medicare provider agreement is a statutory entitlement akin to a license and, therefore an asset a debtor can transfer free and clear of obligations under Bankruptcy Code section 363(f). Although the *Verity* decision was subsequently vacated pursuant to a stipulation between the parties regarding the assumption and assignment of the provider agreements and may be seen as having limited value, the underpinning of the Court's analysis is worthy of review and potential application in developing case law. *See Verity,* 2019 WL 7288754, at *1 (Bankr. C.D. Cal. Dec. 9, 2019). In the underlying bankruptcy court opinion in *Verity*, the debtors sought to transfer their provider agreements free and clear of claims and interest. The California Department of Health Care Services ("DHCS") challenged the debtors' position and claimed the provider agreements were subject to $30 million in hospital quality assurance fees that must be cured upon assumption and assignment to the buyer. *Verity* argued that it was unnecessary for the debtors to assume the provider agreements (and the corresponding cure obligations) in order to transfer them to the buyer because the provider agreements were not executory contracts, but

rather were a statutory entitlement. In support of their contention, the Verity debtors argued that the provider agreements do not fall within the Countryman or functional approach definitions of executory contracts because they do not impose any obligations upon DHCS. Verity maintained that the only obligations existing under the provider agreements are those that are already imposed under applicable law, and that an agreement to comply with applicable law "is a gratuitous promise which does not provide the consideration necessary to make a contract enforceable." *In re Gardens Reg'l Hosp. & Med. Ctr., Inc.*, 569 B.R. 788, 797 (Bankr. C.D. Cal. 2017), aff'd , No. 2:16-BK-17463-ER, 2018 WL 1354334 (9th Cir. BAP Mar. 12, 2018).

In its vacated ruling, the *Verity* court relied on several non-bankruptcy court cases in concluding that provider agreements are not contracts. *Verity*, 606 B.R. at 851. For instance, the *Verity* court cited *PAMC,* 747 F.3d at 1221, which held that contract doctrine should not be imported into complex statutory and regulatory schemes like Medicare. *Id.* at 849. Additionally, the *Verity* court noted, "Provider Agreements lack a key feature found in all contracts—obligations imposed on both parties to the agreements." *Id*. at 850. The Court recognized that "[t]he Provider Agreements impose no obligations upon the DHCS. The only obligations spoken of in the Provider Agreements pertain to the Debtors. Even these obligations do not constitute consideration for contract purposes, since they merely restate the Debtors' pre-existing legal obligations." *Id*. Accordingly, the court held provider agreements could not be subject to § 365(a). *Id.*

While not following the minority view, certain earlier case law has taken an incremental approach and recognized a limitation on the scope of provider agreements as executory contracts. For example, a bankruptcy court in Massachusetts concluded that a nursing home's Medicaid provider agreements for 1975, 1976, and 1980 were not single executory contracts but instead a series of executory contracts and explaining that "the provider agreements exist only for a term

not to exceed 12 months. … There is no material performance due from [Medicaid] at the expiration of the term. … The obligations of the provider are completed at the end of the contract term as well. … At the end of the 12 month contract term, the contracts are fully executed, not executory." *In re Dartmouth House Nursing Home, Inc.*, 24 B.R. 256, 260 (Bankr. D. Mass. 1982), *aff'd*, No. CIV. A. 84-667-Z, 1985 WL 17642 (D. Mass. Sept. 25, 1985).

E. Treatment of a Provider Agreement is an Important Part of any Bankruptcy Sale.

How a bankruptcy court treats the provider agreement can profoundly affect the value of the debtor's assets in a bankruptcy sale.[6] While the buyer can apply for a new provider agreement, this process can take months to complete. During that period, the buyer risks treating patients without assurance of getting paid. Accordingly, having access to another entity's existing provider number is critical to avoid gaps in pay.

If a provider agreement is treated as an executory contract, the buyer assumes all teh rights and liabilities under the contract and is subject to successor liability under Bankruptcy Code section 365(a), becoming responsible for the attending Medicare and Medicaid overpayments, and potentially federal False Claims.[7] *See In re Our Lady of Mercy Med. Ctr.*, No. 07-10609 (Bankr. S.D.N.Y. Jul. 8, 2008). Additionally, because the government has "years to review and audit cost reports," the buyer may face "enormous . . . contingent liabilities."[8] These contingent liabilities will most likely impact value paid for the health care business.

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[6] Samuel R. Maizel, Jody A. Bedenbaugh, *The Medicare Provider Agreement: Is it a Contract or Not? And Why Does Anyone Care?,* 71 BUS. LAW. 1207, 1223 (Fall 2016).

[7] *Id*.; In *Our Lady of Mercy*, the debtor filed a motion in bankruptcy court to transfer its provider agreement to the buyer free and clear of government claims, pursuant to §363(f). In opposition, the government argued that the provider agreement was an executory contract, making the buyer responsible for the debtor's pre-sale False Claims. While the case resulted in settlement, it may be indicative of the government's arguments for False Claims liability under §365(a) in future bankruptcy litigation.

[8] *Id.* at 1224.

If a provider agreement is treated as a statutory entitlement, the buyer may seek to transfer the provider agreement to a buyer free and clear of liabilities upon an adequate showing that one or more of the conditions specified at Bankruptcy Code section 363(f)(1)-(5) is satisfied. In the vacated *Verity* decision, the court concluded that the debtor satisfied Section 363(f)(5), which provides that property may be sold free and clear of an interest, if the entity holding the interest "could be compelled, in a legal or equitable proceeding, to accept a money satisfaction of such interest." *Verity*, 606 B.R. at 853-54.

The *Verity* court stated that the interest held by DHCS is its right to receive payment of the quality assurance assessment. Then the *Verity* court reasoned that "DHCS could be compelled to accept a money satisfaction of its interest in a legal or equitable proceeding. In fact, receiving a money satisfaction is and has been DHCS' objective all along." *Id*. at 853. *See also In re P.K.R. Convalescent Centers, Inc.*, 189 B.R. 90, 91 (Bankr. E.D. Va. 1995) (court approved the sale of a nursing home, free and clear of the interest held by the Virginia Department of Medical Assistance Service, pursuant to § 363(f)(5)).

F. Conclusion

The way courts treat a provider agreements can substantially impact a bankruptcy case. Most courts treat a provider agreements as a contract subject to Bankruptcy Code section 365(a). Because section 365(a) imposes successor liability on a buyer that assumes an executory contract, a debtor may receive less value for the assets. Developing bankruptcy case law holding that provider agreements are not executory contracts but are statutory entitlements that may be transferred free and clear of claims and interests will continue to shape the increasingly competitive chapter 11 sale landscape for health care assets.

II. RECOUPMENT OR SETOFF?; AND WHY IT MATTERS IN CHAPTER 11 HEALTH CARE CASES

A. Introduction

Chapter 11 debtors seeking to sell a portion or substantially all of their business assets often require additional liquidity to operate through both an expensive Section 363 sale process and the state regulatory sale approval process. Even with an identified stalking horse bidder and a bidding procedures motion filed on the first day of the chapter 11 case, it is not uncommon for a health care debtor to take several months to close on a sale of its assets due to extended state regulatory approval process. In addition, delays in government approvals due to Covid-19 continue to impact the regulatory process, adding weeks and often months to the transaction timeline. Both debtors and secured lenders should evaluate and closely consider the potential impact of any recoupment rights on the ultimate value of the debtor's assets. Depending on the magnitude of any recoupment risk, there may be a negative impact on both the ultimate sale process and liquidity during the chapter 11 case that would require additional debtor in possession financing to support a sale timeline for a health care business.

B. Setoff

Both the doctrine of recoupment and setoff "trace their origins back to 'the era of common law pleading,' when they allowed a defendant to assert certain countervailing claims that might not otherwise have been allowed under the then-stricter joinder rules." *Lee v. Schweiker*, 739 F.2d 870, 875 (3d Cir. 1984). The doctrine of "setoff" allows entities that owe each other money to apply their mutual debts against each other, thereby avoiding 'the absurdity of making A pay B when B owes A.' " *Citizens Bank of Maryland v. Strumpf*, 516 U.S. 16, 18 (1995) (quoting *Studley v. Boylston Nat'l Bank*, 229 U.S. 523, 528 (1913). The common law doctrine of setoff is expressly recognized at Bankruptcy Code section 553. Section 553 does not, however, create a right of

setoff, but rather it sets forth certain federal law limitations on the exercise of setoff rights in bankruptcy and provides that each debt or claim sought to be offset must have arisen prior to the filing of the bankruptcy petition. 11 U.S.C. § 553(a). Section 553(a) also limits setoff in bankruptcy to the setting off of "'a *mutual* debt' owed by a creditor to the debtor against the creditor's claim against the debtor," and this "mutuality requirement" is "strictly construed." *In re Gardens Reg'l Hosp. & Med. Ctr.*, Inc., 975 F.3d 926, 933 (9th Cir. 2020). Most critically in the context of a bankruptcy case, a creditor's right to assert a "setoff" is expressly stayed by operation of the Bankruptcy Code's automatic stay provision. *See* 11 U.S.C. § 362(a)(7).

C. Recoupment

The right of recoupment is an equitable doctrine closely related to the right of setoff, but distinguishable in certain key attributes. Recoupment is the right to reduce the amount of a claim or debt owed to a debtor. Like setoff, recoupment operates to reduce a creditor's claim against the debtor's estate by application of debts and credits owed between parties. However, a valid recoupment claim must arise out of the *same transaction*. Unlike the right of setoff that is codified (yet limited) under the Bankruptcy Code, recoupment is as an equitable remedy that is neither mentioned nor defined in the Bankruptcy Code, but has been long recognized in bankruptcy case law. *Univ. Med. Ctr.*, 973 F.2d at 1079-80 ("Recoupment is the setting up of a demand arising from the same transaction as the plaintiff's claim or cause of action, strictly for the purpose of abatement or reduction of such claim.").

While "[r]ecoupment and setoff have much in common," the differences between these two doctrines have important consequences in the bankruptcy context, and particularly in a health care case. *Sims v. U.S. Dep't of Health & Human Servs. (In re TLC Hosps., Inc.)*, 224 F.3d 1008, 1011 (9th Cir. 2000). [T]he chief importance of the recoupment doctrine in bankruptcy is that,

unlike setoff, recoupment is often thought not to be subject to the automatic stay'" and is not so constrained to the requirement of mutuality as is setoff. *Gardens Reg'l*, 975 F.3d at 932. Thus, a creditor seeking to exercise a right of setoff would not be precluded by the automatic stay under Bankruptcy Code section 362, and may recoup against a chapter 11 debtor on account of the same transaction that may relate to the debtor's prepetition period. In addressing whether the countervailing claims or rights asserted by the creditor arise from the same transaction or occurrence—and therefore qualify as a permissible recoupment for federal bankruptcy purposes—courts "have held that the crucial factor ... is the '**logical relationship' between the two**.'" *Sims,* 224 F.3d at 1012 (quoting *Newbery Corp. v. Fireman's Fund Ins. Co.*, 95 F.3d 1392, 1403 (9th Cir. 1996)).

For health care businesses in financial distress, they will not likely be successful in asserting that Medicare or Medicaid's exercise of their rights to recover prepetition overpayments from postpetition payments is stayed by the Bankruptcy Code's automatic stay. This is because the overwhelming majority of courts have recognized the government's right of recoupment. *See Univ. Med. Ctr.*, 973 F.2d at 1065 (holding that offset within the same cost report year was recoupment, but otherwise Medicare withholding was setoff); *Sims,* 224 F.3d at 1008 (holding that Medicare offset was recoupment); *United States v. Consumer Health Servs. of Am., Inc*., 108 F.3d 390 (D.C. Cir. 1997) (same); *Slater Health Center, Inc. v. United States (In re Slater Health Center, Inc.)*, 398 F.3d 98 (1st Cir. 2005) ("The answer to this question is controlled by our recent decision in *In re Holyoke Nursing Home, Inc*. In that case we held, in conformity with the majority of other circuits to consider the question, that Medicare's adjustment for an overpayment constitutes a recoupment, not a setoff ...."); *In re Holyoke Nursing Homes, Inc*., 372 F.3d 1 (1st Cir. 2004) (same).; *Fischbach v. Centers for Medicare and Medicaid Services, et. al*., 2013 WL

1194850 (D.S.C. Mar. 22, 2013) (following "majority rule" that Medicaid's offset is properly characterized as recoupment); *Ravenwood Healthcare, Inc. v. State*, 2007 WL 1657421 (D. Md. June 5, 2007) (finding prepetition and postpetition Medicaid payments amount to one transaction); *In re Dist. Mem'l Hosp. of Sw. N. Carolina, Inc.*, 297 B.R. 451, 456 (Bankr. W.D.N.C. 2002) (same).

D. Limitations on Recoupment if No "Logical Relationship"

While recoupment of prepetition overpayments may not be avoided and lead to additional liquidity concerns for the chapter 11 debtor, not all payments under a Medicaid program will be subject to recoupment. However, claims that are not related to overpayments are not recoupment claims but, rather, are setoff claims. Recently, two Circuit Courts of Appeal have considered whether Medicaid programs can offset hospital quality assurance program payments to recover amounts owed due to overpayments with regard to fee for service Medicaid payments, and vice-versa. In rejecting Medicaid's attempt to offset against hospital quality assurance program payments, the courts held that such payments do not have a sufficient "logical relationship" between the quality assurance program payments and the fee for services payments to support a claim for recoupment. *Gardens Reg'l*, 975 F.3d at 926 (holding that deduction of unpaid Hospital Quality Assurance Fee assessments from fee-for-service payments constituted setoff not recoupment); *St. Catherine Hospital of Indiana v. Indiana Family and Social Services Administration*, 800 F. 3d 312 (7th Cir. 2015).

E. Sales Free and Clear of Recoupment Claims.

In a 2008 bankruptcy court decision for the District of Massachusetts, the *Vitalsigns* court limited the rights of HHS to recover on its recoupment rights by stating the order of priority by which the government could recover.). In *Vitalsigns*, the debtor filed a voluntary petition pursuant to chapter 11, and after the case converted to chapter 7, the chapter 7 trustee filed a motion to sell

the Medicare provider number and the entitlements associated therewith "free of liens, claims, and encumbrances to" the potential purchaser. The trustee expressly requested that it was seeking court authority to transfer the assets free and clear of HHS's "right to recoup overpayments from future Medicare payments." *Vitalsigns*, 396 B.R. at 241.

The *Vitalsigns* court held that HHS can recoup overpayments from the buyer only after it first recoups (1) "overpayments from any payments due to the Debtor's estate" (2) "against funds held by the Trustee if such funds were generated by the past interim Medicare payments" and (3) "against any sale proceeds generated by the sale of the provider number." *Id.*

Other bankruptcy courts have declined to follow the incremental approach endorsed in *Vitalsigns*. Courts in California, Florida and Delaware have ruled that a provider agreement is a statutory entitlement. For example, *In re B.D.K. Health Management, Inc*. rejected HHS's argument that the provider agreements are executory contracts but rather are statutory entitlements that could be sold "free and clear of HHS recoupment interest in [the debtors'] property. . . . . Moreover, HHS' entitlement to recoup overpayments is similarly statutory and does not arise under these arrangements. *In re B.D.K. Health Mgmt., Inc*., No. 98-00609-6B1, 1998 WL 34188241, at *6 (Bankr. M.D. Fla. Nov. 16, 1998) (citing *Mem'l Hosp.,* 706 F.2d at 1136; *In re Kings Terrace Nursing Home and Health Related Facility*, 1995 WL 65531, at *8 (Bankr.S.D.N.Y.)).

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