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2017 Annual Spring Meeting

CONCURRENT SESSION

The Top 10 Issues to Be Aware of When Buying a Health Care Business, and How to Plan for the Inevitable Surprises

Hosted by the Asset Sales and Health Care Committees

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Of A Healthcare Business"

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The Panel

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The pending repeal and replacement of the Affordable Care Act has created at least anxiety and perhaps chaos in the healthcare industry in the United States. Whatever one's political views on the best course of action in this important policy choice, the uncertainty surrounding what America's healthcare policy is going to look like in 2020 makes this a difficult time for healthcare industry providers, suppliers of goods and services, financing entities, consultants and attorneys. It seems certain that one outcome will be more work for those who advise financially distressed entities in the healthcare industry.

Because these cases represent the intersection of a highly regulated industry and the unique rules that apply to companies in bankruptcy, they can present some difficult issues, especially for those unfamiliar with the unique issues that arise in the bankruptcy of a healthcare entity. This panel will address some of the "hot" topics in this area for practitioners and consultants.

1. ***Dealing with the Federal and Statement Governments***

    a. Federal and State Governments have roles as payors, creditors and/or regulator and those roles can be intertwined and sometimes confused.

    b. Disputes with the Centers for Medicare & Medicaid Services can frequently be the most pressing, if not case dispositive issues in a healthcare bankruptcy. The first issue one must be aware of are the jurisdictional challenges/limits which can arise from the interpretation of 42 U.S.C. § 405(h) which requires that a federal courts may take jurisdiction over Medicare disputes only after a party exhausts applicable appeal processes within the Medicare system. There is a circuit split

regarding the plain language and the bankruptcy courts' jurisdictional limitations because 405(h) only references sections 1331 and 1336 of title 28 of the United States Code, and does not refer to section 1334 of title 28 (which grants bankruptcy court jurisdiction). The Ninth Circuit in *In re Town & Country* held that bankruptcy courts are not limited by section 405(h) while in a 2016 decision in *In re Bayou Shores* the Eleventh Circuit held that bankruptcy courts are barred from proceeding by section 405(h). There is a petition for cert pending at the US Supreme Court in *Bayou Shores*, and this issue is also pending before the Sixth Circuit. Included in the written materials is the petition for cert in *Bayou Shores* and the briefs before the Sixth Circuit.

c. An interesting, but little litigated (at least in bankruptcy) argument is that the exhaustion requirement does not apply if forcing the provider to exhaust will result in no meaningful review. This is certainly an argument that providers should make in bankruptcy courts, as the Medicare appeals process is, simply, broken. Currently, HHS admits to there being over 600,000 appeals pending even though the Office of Medicare Hearings and Appeals is only staffed to resolve about 92,000 appeals annually. And HHS projects the number of appeals will rise 3% by the end of 2017 (to just over 687,000) and will rise to over 1 million claims by the end of 2021. Despite pending lawsuits by the American Hospital Association and others to compel HHS to address this issue (there is a statutory 90 day time limit for resolving these appeals which is, obviously, not being met) HHS says that it cannot cut the backlog because of "current funding and legislative authorities." This is not going to get better in the current political

climate. *American Hospital Assn. et al. v. Sebelius*, Case No. 1:12-cv-1770 (D.D.C. pending).

2. ***The Provider Agreement as a License or Contract?*** What is a Provider Agreement? The relationship between the Medicare or Medicaid programs and the providers of healthcare goods and services is captured in a document commonly referred to as a "provider agreement." Controversy arises when the Debtor seeks a sale of assets because to maximize value the buyer frequently wants to acquire the provider agreements. However, the government argues that the buyer of a provider agreement takes successor liability for any overpayments made to the seller and, perhaps, even for fraud committed by the seller. Needless to say, buyers are either reluctant to acquire assets in these circumstances, or greatly reduce the purchase price to accommodate this risk. Thus, the treatment of these provider agreements in a bankruptcy proceeding can be controversial and vital to the success of a bankruptcy case involving a sale of assets. The Government's position in bankruptcy cases is that the provider agreements are an executory contract, which means that defaults must be cured if assumed and that the buyer takes the assignment of the provider agreement cum onere. The debtor's preferred position would be that the provider agreement is a license, which can be sold free and clear of successor liability under section 363 of the Bankruptcy Code. This is a controversial issue because outside of bankruptcy the Government argues -- and is uniformly successful -- that the provider agreement is not a contract. Since the Bankruptcy Code does not define what is a contract, and because applicable non-bankruptcy law should control, it is hard to fathom why the filing of a bankruptcy petition

should alter a document that is not a contract before the petition is filed, into a contract after the petition is filed. To the contrary, judicial estoppel should apply.

3. ***Setoff and Recoupment by the Government.*** Outside of bankruptcy, the federal and state government and their contractors routinely withhold Medicare and Medicaid payments when they determine that a healthcare provider has been overpaid. However, section 362 imposes an automatic stay on creditors' efforts to collect on prepetition obligations of the debtor or to exercise control over property of the estate. These withholdings can be characterized as either setoff or a recoupment. The Bankruptcy Code imposes strict rules on a creditor seeking to set off monies owed to a debtor against a claim against the debtor, but imposes no such restrictions on a creditor with a right of recoupment. While setoff is subject to the automatic stay and requires a creditor to obtain court approval, recoupment is not subject to the automatic stay and does not require court approval. There is currently a split in the circuits on the scope of what is allowed recoupment. In *In re University Medical Center* the Third Circuit held that Medicare's recoupment rights were limited to the overpayments and ongoing payments in the same cost report year. However, the Ninth Circuit in *TLC Hospitals* held that Medicare's recoupment rights were not so limited, and other circuits have agreed with the Ninth Circuit. Another interesting issue is the scope of what is applied as recoupment. Recoupment is meant to be limited to offsetting obligations arising out of the "same transaction or occurrence." However, the state and federal governments will frequently assert that any obligations remotely tied to the Medicare and or Medicaid programs are

subject to recoupment against ongoing payments under those programs for patient care.

4. ***Impact of Healthcare Business Bankruptcy On Healthcare Fraud Cases.*** The False Claims Act (31 U.S.C. §§ 3729–3733) applies to healthcare businesses and there is a widely held perception that the healthcare industry is full of "fraud, waste and abuse." Since the implementation in 1996 of the Health Care Fraud and Abuse Control Program under the joint control of the Secretary of HHS and the Attorney General there has been an ever increasing effort to deal with the perceived fraud against the Medicare and Medicaid programs. The result has been impressive: in FY 2016 the US Department of Justice opened 975 new criminal health care fraud cases, and 930 new civil health care fraud investigations. As of the end of 2016 DOJ had over 1400 civil healthcare fraud matters pending. The financial impact is significant: in FY 2016 the Government won or negotiated over $2.5 billion in healthcare fraud judgments or settlements. As a result of these efforts and the culmination of prior year's efforts, over $3.3 billion was paid to the Government from participants in the healthcare industry. In total, since 1997, this program has "recovered" over $31 billion from the healthcare industry. Many of these the False Claims Act cases are filed under seal, and the defendants do not know the law suit is pending, sometimes for years. However, filing a bankruptcy petition can "flush out" these law suits. First, although such litigation would usually be subject to the automatic stay imposed by section 362(a), which includes a stay of pending litigation, section 362(b)(4) of the Bankruptcy Code exempts acts by the government to enforce police or regulatory powers. False Claims Act are generally treated as exempt from the

automatic stay as an exercise of a police or regulatory power. However, if the Government wants to get a distribution as a result of the False Claims Act case, it is still required to file a proof of claim to obtain payment. This can result in the disclosure of previously unknown liabilities. Additionally, section 502(c) of the Bankruptcy Code permits a bankruptcy court to estimate a claims for the purposes of allowance of the claim as to amount, voting on a plan, feasibility of a plan, and distributions under a plan. Thus, once a law suit is disclosed, the debtor can seek a quick resolution of its liability for that law suit, and do so in a forum much more favorable than the federal district court.

5. ***Not for Profit Healthcare Business Rules.*** The Bankruptcy Code has three provisions that deal with the sale of not for profit assets. These provisions were added through BAPCPA in 2005 and directly arose out of the bankruptcy case of *In re Allegheny Health Education and Research Foundation*. The Provisions include: Section 363 was amended to provide that the trustee may only sell or lease property of not for profits in accordance with applicable non-bankruptcy laws governing the transfer of such assets; Section 1129(a)(16) was added to provide that, as part of confirming a plan of reorganization, the court must find that all transfers of not for profit assets is in accordance with applicable non-bankruptcy law; and Section 541(f) was added to provide that property of a debtor is a not for profit health care business may be transferred to a for profit entity but only under the same conditions as would apply if the debtor were not in bankruptcy. There are also two provisions of BAPCPA which were not codified into the Bankruptcy Code; they provide that the bankruptcy court need not wait for another court to decide on issues

related to the disposition of a not-for-profit asset, and that the Attorney General of the state of incorporation has standing. There are few cases dealing with the impact of these provisions, but in the recent case of *In re Gardens Regional Medical Center & Hospital*, Inc., the issue of whether the Attorney General can impose conditions effectively gutting the Bankruptcy Code's protections for debtors under these provisions, as long as those conditions would be acceptable under applicable non-bankruptcy law has arisen.

6. ***Discrimination Against Healthcare Business by Governmental Entities.*** Section 525 of the Bankruptcy Code provides that a governmental unit may not "deny, revoke, suspend, or refuse to renew a charter, franchise, or other similar grant to, condition such grant to discriminate with respect to such grant against…a person that is or has been a debtor under the Bankruptcy Code or a person associated with a debtor." Courts have held this applies to contractual relationships even though contracts are not included in the list. Additionally, some courts have extended section 525 of the Bankruptcy Code to protect purchasers as "persons associated with a debtor." This provision has created an issue with regard to the interaction with the rights granted to an Attorney General to impose conditions on the sale of not-for-profits discussed above, and this anti-discrimination provision of the Bankruptcy Code. In the Gardens Hospital case, the Attorney General threatened to refuse to allow a buyer of a hospital and provider agreement the right to continue to participate in a government program for hospitals unless and until either the debtor or the buyer paid a multi-million dollar prepetition unsecured debt owed by the hospital-debtor to the state. Is this a violation of section 525 or a valid application of the rights granted the Attorney General under the 2005 amendments to section 363?

7. ***Ombudsman***. BAPCPA and its amendments to the Bankruptcy Code introduced two new players – the Patient Care Ombudsman and the Consumer Privacy Ombudsman – in bankruptcy cases involving healthcare companies. Although appointed under the Bankruptcy Code in different scenarios, the Patient Care and Consumer Privacy Ombudsmen both serve to protect the interests of and advocate on behalf of patients who stand to be impacted by the bankruptcy of their healthcare provider. Section 333(a) of the Bankruptcy Code provides for the appointment of a Patient Care Ombudsman ("PCO") by the United States Trustee "to monitor the quality of patient care and to represent the interests of the patients" in any case under chapter 7, 9, or 11 in which the debtor is a "health care business. It is the duty of the Patient Care Ombudsman to: (1) monitor the quality of patient care provided to patients of the debtor, to the extent necessary under the circumstances, including interviewing patients and physicians.

8. Consumer Privacy Ombudsmen. Section 332 of the Bankruptcy Code provides for the appointment of a Consumer Privacy Ombudsman ("CPO") in more limited circumstances involving a sale or lease of property of the debtor which includes personally identifiable information ("PII") of customers or patients pursuant to section 363 of the Bankruptcy Code. Section 363(b)(1) of the Bankruptcy Code allows a trustee or debtor-in-possession, after notice and a hearing, to sell or lease property of the bankruptcy estate which includes personally identifiable information ("PII") of customers or patients only if (A) the sale or lease of such PII is consistent with the debtor's policy restricting the transfer of PII to a third party or (B) a CPO has been appointed under

section 332 of the Bankruptcy Code and the court finds after notice and a hearing that the sale or lease would not violate applicable nonbankruptcy law. Thus, if a hearing is required under section 363(b)(1)(B) of the Bankruptcy Code, the court "shall order" the United States Trustee to appoint a CPO to "provide to the court information to assist the court in its consideration of the facts, circumstances, and conditions of the proposed sale or lease of [PII]." The information which the CPO is charged with providing may include: (1) the debtor's privacy policy; (2) the potential losses or gains of privacy to consumers if such sale or such lease is approved by the court; (3) the potential costs or benefits to consumers if such sale or such lease is approved by the court; and (4) the potential alternatives that would mitigate potential privacy losses or potential costs to consumers. It is the role of the CPO to protect the interests of consumers in the privacy of their PII. As patient records are normally subject to transfer in a sale of the assets of a healthcare company pursuant to section 363 of the Bankruptcy Code, the consumer privacy requirements of section 363(b)(1) are often applicable. Where a proposed sale of a healthcare company does not appear to adhere to the healthcare company's policy regarding transfer of patient PII, the appointment of a CPO is necessary. Once a CPO has been appointed, the CPO's determinations regarding the treatment of PII under the terms of the proposed sale weigh heavily on the bankruptcy court's decision to approve or reject the sale.

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Intensive Care

By Suzanne Koenig and Nancy A. Peterman

PCOs and the Ongoing Debate over Cost: 10 Years Later

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In 2005, the Bankruptcy Code was amended to include the "health care bankruptcy provisions," which included a requirement that a patient care ombudsman (PCO) be appointed in all chapter 7, 9 or 11 cases filed by a health care business[1] "unless the court finds that the [PCO] appointment ... is not necessary for the protection of patients under the specific facts of the case."[2] In most health care business cases (even when there is opposition), a PCO is appointed. However, there continues to be significant opposition to the appointment of PCOs due to one of the main criticisms of the bankruptcy process today: cost.

Chapter 11 offers significant benefits to any small or large business attempting to reorganize — whether through a going-concern sale, a right-sizing of the balance sheet or a combination of both. However, for a small business, the cost of chapter 11 might be a deterrent to seeking such relief. In a health care bankruptcy case, in addition to the cost of debtor's professionals, committee's professionals, lender's professionals and other chapter 11-related costs, these businesses must also cover the cost of the PCO and the PCO's professionals. While that latter cost is typically a fraction of all other professionals in the case, this concern can often be addressed through careful management of the appointment process and cooperation with the PCO.

As many debtors are beginning to understand, the PCO can be a valuable ally in the bankruptcy case in helping with a sale process, helping address regulatory issues with governmental agencies or otherwise assisting on key case issues impacting patient care. For example, a PCO may take a position on plan negotiations,[3] contract terminations (such as service contracts for an emergency room),[4] funding needs[5] or a sale process, all of which impact patient care. The PCO's voice can be very powerful in representing the patient's interests and helping with the debtor's reorganization, when those interests are aligned.

This article highlights some practices developed over the past 10 years to streamline the appointment process for a PCO and help eliminate the perception that the PCO cost will be a concern — primarily by reducing the legal costs otherwise incurred by a PCO. Ultimately, in a health care bankruptcy case, it is highly likely that a PCO will be appointed. Therefore, instead of opposing that appointment or the PCO's efforts to do his/her job, which will also be a cost to the estate, implement some of these ideas to streamline the PCO appointment process, and cooperate with and view the PCO as your ally. As a health care business, both the debtor and PCO have the same thing in mind: the patient's interests.

The Appointment Order and Notice

With certain exceptions, a PCO must be appointed in any health care business bankruptcy case within 30 days after commencement of the case.[6] The court will typically enter an order requiring the appointment of a PCO (the "appointment order"), whether *sua sponte*, as a result of a motion by the Office of the U.S. Trustee or as a result of a debtor's motion to excuse a PCO's appointment. Once the appointment order is entered, the U.S. Trustee will

1 "Health care business" is defined in 11 U.S.C. § 101(27A).
2 11 U.S.C. § 333(a)(1).
3 *In re El Paso Children's Hosp. Corp.*, Case No. 15-30784 (Bankr. W.D. Tex., El Paso Division), Docket No. 383 (Patient Care Ombudsman's Statement Relating to (A) El Paso County Hospital District d/b/a University Medical Center of El Paso's Emergency Motion to Terminate Exclusivity Period Pursuant to 11 U.S.C. § 1121(d) and (B) the Debtor's Response Thereto).
4 *Christ Hosp. v. Emergency Med. Assocs. of N.J. PA (In re Christ Hosp.)*, Adv. Pro. No. 12-1542 (MS), Case No. 12-12906 (MS) (Bankr. D.N.J.), Docket No. 10 (Statement of Suzanne Koenig as PCO in Support of the Debtor's Verified Complaint Seeking Continuation of Emergency Medical Services by Emergency Medical Associates of New Jersey PA).
5 *In re Brotman Med. Ctr. Inc.*, Case No. LA 07-19705 (BB) (Bankr. C.D. Cal., Los Angeles Division), Docket No. 463 (Response of PCO to Emergency Motion to Compel Debtor-in-Possession Funding and for Immediate Authority to Use Cash Collateral).
6 11 U.S.C. § 333(a)(1).

file a notice identifying the individual appointed as the PCO (the "appointment notice").

Both the appointment order and notice represent key opportunities to save costs associated with the PCO. First, in order to do his/her job, the PCO must have access to patient records. Under the Bankruptcy Code, the PCO can only access patient records if the bankruptcy court approves such review in advance and imposes restrictions to ensure the confidentiality of those records.[7] Under the Bankruptcy Rules, a motion to access patient records must be served on the patient, family member or other contact person (all of the information is confidential), and a hearing on such motion cannot occur any earlier than 14 days after service of the motion.[8] Therefore, once the PCO is appointed, the PCO has to file a motion to obtain access to patient records, provide at least 14 days' notice of such motion and provide extensive notice of such motion.

The PCO will also necessarily require the assistance of an attorney to draft that motion and present the motion to the court, which can sometimes be costly. Over the years, working with several U.S. Trustee offices and various attorneys representing debtors, we have been able to streamline this process and obtain, in the appointment order or notice,[9] the necessary language to grant the PCO immediate access to patient records (with the necessary confidentiality restrictions).[10] Not only does this save the cost of a motion and court hearing, but it also allows the PCO to immediately begin work upon appointment.

In addition, the PCO is required to provide written or oral reports to the bankruptcy court every 60 days as to patient care issues. The Bankruptcy Rules require the PCO to provide at least 14 days' notice that a report will be made (the report notice), unless the court orders otherwise.[11] The report notice must be posted conspicuously at the health care business and served on the debtor, U.S. Trustee, any committee and all patients.[12]

Depending on the type of health care business, service on patients might be costly or practically impossible. If the health care business is a hospital, the patients are changing every day and the volume can be significant. The appointment order and notice represent another opportunity to address this issue because this notice process can be altered to make it clear that the PCO simply needs to file the report notice and post it at the health care facility.[13] Absent addressing this issue in the appointment order or notice, the PCO will have to file a motion asking the court to alter the process of providing the report notice if the list of patients is lengthy or changes every day. Again, the PCO likely would have to hire counsel to draft this motion and attend the court hearing on the PCO's behalf.

The Early Orders

In many chapter 11 cases, two key orders are entered at the beginning of the case: (1) an order authorizing use of cash collateral and/or authorizing debtor-in-possession financing (the "cash collateral/DIP financing order"); and (2) an order establishing monthly procedures for the payment of professionals (the "monthly fee procedures order"). In health care bankruptcy cases, these orders often do not address the PCO, who is typically appointed after these orders have become final orders, or the PCO's professionals.

Why is this important? Just like any professional in the case, the PCO and the PCO's professionals need to be paid. The cash collateral/DIP financing order will likely contain a carve-out for professionals, which should cover the PCO and the PCO's professionals. The monthly fee procedures order will typically provide a monthly process to pay the debtor's and committee's professionals and should include, within that monthly process, the PCO and the PCO's professionals.

In the early stages of the case, the debtor, the U.S. Trustee or the court needs to protect the yet-to-be-appointed PCO to ensure that the PCO and the PCO's professionals can be paid and are treated in substantially the same way as any other professionals in the bankruptcy case. Absent this occurring, the PCO will incur the time and expense (likely with assistance of counsel) to address these issues through motion practice or negotiation after the PCO's appointment. This is yet another cost of the process that can be easily addressed and avoided early in the case.

In addition, recently, in two cases, the PCO's fee-application process was streamlined to yet again save cost: the cost of preparing fee applications and attending hearings every three months. Generally, the cost of the PCO and the PCO's professionals is negligible in comparison to the cost of debtor's professionals and committee's professionals. In one case, the PCOs were excused from filing any fee applications.[14] Instead, the PCOs circulated their invoices monthly to the debtor, com-

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7 11 U.S.C. § 333(c).

8 Fed. R. Bankr. P. 2015.1(b).

9 Ideally, these provisions would be included in the appointment order so that there is a court order that can be enforced and relied upon. However, in certain cases, a PCO may be contacted after the appointment order is entered, and therefore, unless the U.S. Trustee or debtor's counsel is willing to incur the cost of modifying the original appointment order, these provisions may be included in the appointment notice. While the appointment notice does not have the force of a court order, it is noticed to all parties-in-interest and can certainly be relief if this procedure is acceptable to the U.S. Trustee and other major parties in the case. If such provisions are in the appointment notice, the PCO can highlight such provisions to the court in each report and obtain the written consent of patients to access records, if possible.

10 *See, e.g., In re El Paso Children's Hosp. Corp.*, Case No. 15-30784 (Bankr. W.D. Tex., El Paso Division), Docket No. 79 (Appointment Order); *In re ICL Holding Co., et al.*, Case No. 12-13319-KG (Bankr. D. Del.), Docket No. 515 (Second Amended Appointment Order); *In re Arnold W. Klein, MD*, Case No. 02:11-bk-13868-RN (Bankr. C.D. Cal., Los Angeles Division), Docket No. 114 (Appointment Order); *In re Meridian Behavioral Health LLC, et al.*, Case No. 11-10860 (SHL) (Bankr. S.D.N.Y.), Docket No. 20 (Appointment Order); *In re Johnny Kumar Jain, MD*, Case No. 02:10-bk-24550-ER (Bankr. C.D. Cal., Los Angeles Division), Docket No. 88 (Appointment Order); *In re Brotman Med. Ctr. Inc.*, Case No. 02:07-bk-19705-BB (Bankr. C.D. Cal., Los Angeles Division), Docket No. 190, 218 (Appointment Order and Appointment Notice).

11 Fed. R. Bankr. P. 2015.1(a).

12 *In re El Paso Children's Hosp. Corp.*, Case No. 15-30784 (Bankr. W.D. Tex., El Paso Division), Docket No. 79 (Appointment Order); *In re ICL Holding Co., et al.*, Case No. 12-13319-KG (Bankr. D. Del.), Docket No. 515 (Second Amended Appointment Order); *In re Meridian Behavioral Health LLC, et al.*, Case No. 11-10860 (SHL) (Bankr. S.D.N.Y.), Docket No. 20 (Appointment Order).

13 *See supra*, n.9.

mittee and U.S. Trustee, and were paid within a short time thereafter unless objections were raised. In another case, the PCO and her professionals were allowed to circulate their invoices monthly to a short list of key parties-in-interest, and absent objection, the debtor was allowed to pay 80 percent of the fees and 100 percent of the expenses.[15] The PCO and her professionals were excused from filing interim fee applications and were only required to file final fee applications to obtain the 20 percent holdback on fees. Again, this helps control cost.

PCO's Retention of Legal Counsel

For various reasons, a PCO may wish to retain legal counsel, which may review reports for confidentiality concerns, consult concerning possible patient care issues, file reports or represent the PCO in court on matters impacting patient care. The PCO's efforts to retain counsel are often met with significant resistance, at a significant cost to the estate. Rather than fight the PCO's request to hire legal counsel and incur the associated costs, a debtor, U.S. Trustee or committee might consider imposing a budget on counsel and/or limiting the scope of any services. By carefully negotiating a budget and limiting the scope of services, costs can be controlled.

As an alternative, there have been suggestions that a PCO forgo counsel. Instead, the PCO has been asked to rely on debtor's counsel to file and serve reports and rely on state regulatory agencies to represent the interests of the PCO if there are patient care issues. While these are creative ideas, the PCO is supposed to be an independent, disinterested party in the bankruptcy case representing the interests of patients. The PCO's interests may or may not be aligned with the debtor or the state regulatory agencies. Therefore, to eliminate any issues, the PCO should be allowed to retain counsel on a limited basis with appropriate cost-control procedures in place.

Termination of the PCO's Appointment

Neither the Bankruptcy Code nor Bankruptcy Rules addresses when or how the PCO's appointment is to be terminated. Logically, the PCO's appointment should be terminated, for example, upon completion of a sale (if all operations are sold to a third party, all patient records are properly accounted for and all patients are transferred), upon confirmation of a reorganization plan, upon case dismissal and possibly upon conversion to chapter 7 (assuming that patients have been transferred and records properly stored or destroyed). If a motion to sell, dismiss or convert is being filed, the PCO's appointment could be terminated as part of any order granting such motion. If a reorganization plan is proposed, the PCO's appointment could be terminated as part of the plan. Absent addressing the termination of the PCO's appointment in this manner, the PCO will have to file a motion to authorize his/her termination, at an additional cost to the estate.[16]

Conclusion

Patients and quality of care are critical to any health care business. Without sufficient patients, a health care business's cash flow will suffer. Without adequate patient care, a health care business's license to operate might be in jeopardy, or its Medicare or Medicaid provider numbers might also be in jeopardy. The PCO plays a critical role in any health care business bankruptcy case by ensuring that the quality of patient care is maintained during the bankruptcy case and that the interests of patients are represented. This is important for the patients and for all constituents, who are counting on ongoing cash flow from the business. The PCO can be an effective advocate for the patients and the debtor, and the cost of the PCO and the PCO's professionals should not negatively impact any bankruptcy case. These costs can certainly be controlled through a carefully planned appointment process and good working relationship between the PCO and all constituents in the case. abi

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14 *In re Sears Methodist Ret. Sys. Inc., et al.*, Case No. 14-32821-11 (Jointly Administered) (Bankr. N.D. Tex., Dallas Division).

15 *In re El Paso Children's Hosp. Corp.*, Case No. 15-30784 (Bankr. W.D. Tex., El Paso Division), Docket No. 170.

16 A PCO and the PCO's professionals will typically receive exculpation and certain protections from further discovery upon termination of the PCO's appointment. Again, these provisions can be built into any sale order, dismissal order, conversion order and, perhaps more easily, a reorganization plan.

HEALTHCARE

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

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

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

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

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

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

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

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

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

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

Violation of Automatic Stay or Lawful Condition?

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

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

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

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

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

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

Conflict with Section 525?

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

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

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

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

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

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

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

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

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

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

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

Unresolved Issue

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Samuel R. Maizel[*]
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ABSTRACT

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

INTRODUCTION

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

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

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

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

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

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

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

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

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

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

A. Section 405(h) and Its Legislative History

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

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

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

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

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

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

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

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

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

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

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

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

> The findings and decision of the Board after a hearing shall be binding upon all individuals who were parties to such hearing. No- findings of fact or decision of the Board shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Board, or any officer or employee thereof shall be brought under section 41 of Title 28 to recover on any claim arising under sections 401–09 of this chapter.

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

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

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

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

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

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

[14] *In re* Nurses' Registry & Home Health Corp., 533 B.R. 590, 594 (Bankr. E.D. Ky. 2015) (citing Weinberger v. Salfi, 422 U.S. 749, 756 n.3 (1975) ("The literal wording of this section bars actions under 28 U.S.C. § 41. At the time § 405(h) was enacted, and prior to the 1948 re-codification of Title 28, § 41 contained all of that title's grants of jurisdiction to United States district courts, save for several special-purpose jurisdictional grants of no relevance to the constitutionality of Social Security statutes.")).

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

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

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

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

> Except to the extent otherwise specifically provided in this subtitle, the amendments made by section 2663 shall be effective on the date of the enactment of this Act; *but none of such amendments shall be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date*.[19]

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

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

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

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

[18] Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2663(a)(4)(D), 98 Stat. 1162 ("Section 205(h) of such Act is amended by striking out 'section 24 of the Judicial Code of the United States' and inserting in lieu thereof 'section 1331 or 1346 of title 28, United States Code . . . .'"). Changes to a statute by the Law Revision Counsel are not binding absent enactment by Congress.

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

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

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

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

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

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

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

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

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

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

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

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

[29] *Id*.

[30] *See id.* at 1141–42.

[31] *Id.* at 1142.

[32] Shalala v. Ill. Council on Long Term Care, Inc., 529 U.S. 1, 14 (2000) ("Claims for money, claims for other benefits, claims of program eligibility, and claims that contest a sanction or remedy may all similarly rest upon individual fact-related circumstances, may all similarly dispute agency policy determinations, or may all similarly involve the application, interpretation, or constitutionality of interrelated regulations or statutory

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

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

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

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

[35] *Id*.

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

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

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

[39] *Id.* at *7.

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

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

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

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

A. Steps in the Medicare Appeals Process

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

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

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

[43] 42 C.F.R. § 405.942(a) (2015).

[44] 42 C.F.R. § 405.962(a).

[45] 42 C.F.R. § 405.1000.

[46] 42 C.F.R. § 405.1100.

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

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

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

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

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

[48] 42 C.F.R. § 413.20.

[49] 42 C.F.R. § 405.1803.

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

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

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

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

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

B. A Hospital's Dilemma

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

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

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

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

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

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

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

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

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

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

[58] *E.g.*, *In re* Nurses' Registry & Home Health Corp., 533 B.R. 590, 595 (Bankr. E.D. Ky. 2015); *In re* Bayou Shores SNF, LLC, 525 B.R. 160, 166 (Bankr. M.D. Fla. 2014); *In re* Consol. Med. Transp., Inc., 300 B.R. 435, 445 (Bankr. N.D. Ill. 2003); *In re* Slater Health Ctr., Inc., 294 B.R. 423, 428 (Bankr. D.R.I. 2003), *vacated in part*, 306 B.R. 20 (D.R.I. 2004), *aff'd*, 398 F.3d 98 (1st Cir. 2005); First Am. Health Care of Ga., Inc. v. U.S. Dep't of Health & Human Servs., 208 B.R. 985, 989 (Bankr. S.D. Ga. 1996), *vacated and superseded*, No. 96-2007, 1996 WL 282149 (Bankr. S.D. Ga. Mar. 11, 1996); *In re* Rusnak, 184 B.R. 459, 462–63 (Bankr. E.D. Pa. 1995); *In re* Healthmaster Home Health Care, Inc., No. 95-01031A, 1995 WL 928920, at *1 (Bankr. S.D. Ga. Apr. 13, 1995); *In re* Univ. Med. Ctr., Inc., 973 F.2d 1065, 1072 (3d Cir. 1992); *In re* Town & Country Home Nursing Servs., Inc., 963 F.2d 1146, 1155 (9th Cir. 1991); *In re* Shelby Cty. Healthcare Servs. of Ala., Inc., 80 B.R. 555, 559–60 (Bankr. N.D. Ga. 1987); *In re* Clawson Med., Rehab. & Pain Care Ctr., P.C., 9 B.R. 644, 648 (Bankr. E.D. Mich.), *rev'd*, 12 B.R. 647 (E.D. Mich. 1981).

[59] *E.g.*, *In re* Hodges, 364 B.R. 304, 306 (Bankr. N.D. Ill. 2007) (analyzing in the Social Security context); *In re* House of Mercy, Inc., 353 B.R. 867, 872 (Bankr. W.D. La. 2006); Excel Home Care, Inc. v. U.S. Dep't of Health & Human Servs., 316 B.R. 565, 572 (D. Mass. 2004); U.S. Dep't of Health & Human Servs. v. James, 256 B.R. 479, 481 (W.D. Ky. 2000); *In re* Hosp. Staffing Servs., Inc., 258 B.R. 53, 56 (S.D. Fla. 2000); *In re* Mid-Delta Health Sys., Inc., 251 B.R. 811, 816 (Bankr. N.D. Miss. 1999); *In re* Tri County Home Health Servs., Inc., 230 B.R. 106 (Bankr. W.D. Tenn. 1999); *In re* S. Inst. for Treatment & Evaluation, Inc., 217 B.R. 962, 965 (Bankr. S.D. Fla. 1998); *In re* AHN Homecare, LLC, 222 B.R. 804, 812 (Bankr. N.D. Tex. 1998); *In re* Home Comp Care, Inc., 221 B.R. 202, 206 (N.D. Ill. 1998); *In re* Orthotic Ctr., Inc., 193 B.R. 832, 835 (N.D. Ohio 1996); *In re* St. Johns Home Health Agency, Inc., 173 B.R. 238, 245–46 (Bankr. S.D. Fla. 1994); *In re* Upsher Labs., Inc., 135 B.R. 117, 119 (Bankr. W.D. Mo. 1991); *In re* St. Mary Hosp., 123 B.R. 14, 17 (E.D. Pa. 1991); *In re* Visiting Nurse Ass'n of Tampa Bay, Inc., 121 B.R. 114 (Bankr. M.D. Fla. 1990); *In re* Berger, 16 B.R. 236, 237–38 (Bankr. S.D. Fla. 1981); *Clawson*, 12 B.R. at 653.

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

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

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

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

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

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

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

61 9 B.R. 644.

62 *Id.* at 646.

63 *Id*.

64 *Id*.

65 *Id.* at 649–50, 652.

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

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

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

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

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

[69] *Id*.

[70] *Id.* at 647–48.

[71] *Id.* at 648.

[72] *Id*.

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

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

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

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

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

2. In re St. Johns Home Health Agency

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

[76] *Id.* at 649.

[77] *Id.* at 650–52.

[78] *Id*. at 650.

[79] *Id*.

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

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

[82] *Id*.

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

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

3. In re Healthback

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

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

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

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

[86] 173 B.R. at 242, 243–44.

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

[88] *Id.* at 469–71, 473–74.

[89] *Id.* at 472–73.

[90] *Id.* at 469–70.

[91] *Id*.

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

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

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

92 *Id.* at 470.

93 *Id*.

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

95 *Id.* at 471.

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

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

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

B. The In re Bayou Shores *Decisions*

1. The Facts of Bayou Shores

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

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

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

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

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

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

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

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

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

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

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

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

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

HHS appealed the bankruptcy court's order confirming the debtor's plan to the district court. The appeal of the confirmation order raised the jurisdictional issue of whether § 405(h) precluded the bankruptcy court from taking any action related to the Medicare Provider Agreement. In ruling on the appeals, the district court made several conclusions. First, "the bankruptcy court erred because as a matter of law the jurisdictional bar in Section 405(h) precluded the Bankruptcy Court from delaying or preventing the effect of CMS determination that the provider agreements should be terminated."[114] Second, the bankruptcy court's decision that it had jurisdiction under § 1334 was in error because it ignored the jurisdictional bar provided for in the Medicare Act, and that "[t]he Bankruptcy Court exceeded its subject matter jurisdiction when it interfered with CMS termination of the provider agreements."[115] Third, that "[t]here is no jurisdiction for a court to interpose itself in a provider's termination from the Medicare and Medicaid programs except to provide judicial review under Section 405(g) only after administrative remedies have been exhausted and the Secretary has issued a final agency decision."[116] The district court, therefore, ruled that the bankruptcy court lacked the jurisdiction because of the requirement for exhaustion of administrative remedies included in § 405(h).

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

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

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

[115] *Id.* at 341.

[116] *Id*.

4. Bayou Shores's Appeal

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

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

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

The case is currently pending in the Eleventh Circuit.

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

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

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

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

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

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

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

120 *Id*.

121 *Id.* at 592.

122 *Id.* at 592–93, 594–96.

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

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

125 *Id.* at 595–96.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[132] *Healthback*, 226 B.R. at 469–70.

[133] *Id*.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

V. INTERPRETING MEDICARE'S JURISDICTIONAL BAR

A. Discussion of Plain Language Argument

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

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

The words Congress wrote into law in § 405(h) only bar federal court jurisdiction if the dispute arises under 28 U.S.C. §§ 1331 or 1346; bankruptcy jurisdiction under 28 U.S.C. § 1334 is not referenced. The Supreme Court observed as much in *Heckler v. Ringer*, "The third sentence of 42 U.S.C. § 405(h), made applicable to the Medicare Act by 42 U.S.C. § 1395ii, provides that § 405(g), *to the exclusion of 28 U.S.C. § 1331*, is the sole avenue for judicial review for all "claim[s] arising under" the Medicare Act[,]"[146] and again in *Shalala v. Illinois Council on Long Term Care, Inc.*, "The statute [§ 405(h)] *plainly bars § 1331 review* . . . ."[147] The plain meaning of § 405(h)'s jurisdictional limitations has been adopted by both the Third[148] and Ninth Circuits,[149] as well as by numerous district[150] and bankruptcy courts,[151] and has

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

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

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

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

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

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

[151] *In re* Nurses' Registry & Home Health Corp., 533 B.R. 590, 595 (Bankr. E.D. Ky. 2015); *In re* Bayou Shores SNF, LLC, 525 B.R. 160, 166 (Bankr. M.D. Fla. 2014); *In re* Slater Health Ctr., Inc., 294 B.R. 423, 428 (Bankr. D.R.I. 2003), *vacated in part*, 306 B.R. 20 (D.R.I. 2004), *aff'd*, 398 F.3d 98 (1st Cir. 2005); First Am. Health Care of Ga., Inc. v. U.S. Dep't of Health & Human Servs., 208 B.R. 985, 989 (Bankr. S.D. Ga. 1996), *vacated and superseded*, No. 96-2007, 1996 WL 282149 (Bankr. S.D. Ga. Mar. 11, 1996); *In re* Healthmaster Home Health Care, Inc., No. 95-01031A, 1995 WL 928920, at *1 (Bankr. S.D. Ga. Apr. 13, 1995); *In re* Shelby Cty. Healthcare Servs. of AL, Inc., 80 B.R. 555, 560 (Bankr. N.D. Ga. 1987).

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

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

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

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

153 *Id*.

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

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

156 135 S. Ct. 2480 (2015).

157 *Id.* at 2489.

158 *Id.* at 2492–94.

159 *Id.* at 2490–91.

160 *Id.* at 2492.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[176] *Clawson*, 9 B.R. at 648–49.

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

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

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

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

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

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

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

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

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

B. Discussion of the "Legislative History" Argument

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[187] Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2663(a)(4)(D), 98 Stat. 1162 ("Section 205(h) of such Act is amended by striking out 'section 24 of the Judicial Code of the United States' and inserting in lieu thereof 'section 1331 or 1346 of title 28, United States Code . . . .'"). Changes to a statute by the Law Revision Counsel are not binding absent enactment by Congress.

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

> Except to the extent otherwise specifically provided in this subtitle, the amendments made by section 2663 shall be effective on the date of the enactment of this Act; *but none of such amendments shall be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date*.[188]

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

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

188 *Id.* § 2664(b) (emphasis added).

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

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

191 Deficit Reduction Act § 2664(b).

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

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

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

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

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

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

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

197 *Id.*

198 *Id.* at 393.

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

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

2. Federal Jurisdiction: Claims Against the United States

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

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

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

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

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

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

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

[203] 28 U.S.C. § 2401 (1952).

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

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

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

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

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

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

3. Federal Jurisdiction: Bankruptcy Jurisdiction

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

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

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

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

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

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

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

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

[210] 28 U.S.C. § 41(19) (1934).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

> (a) Except as provided in subsection (b) of this section, the district courts shall have *original and exclusive Jurisdiction of all cases under title 11*.
>
> (b) Notwithstanding any Act of Congress that confers exclusive jurisdiction on a court or courts other than the district courts, the district courts shall have original but not exclusive jurisdiction of all civil proceedings arising under title 11, or arising in or related to cases under title 11.
>
> (c)(1) Nothing in this section prevents a district court in the interest of justice, or in the interest of comity with State courts or respect for

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

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

[218] 458 U.S. at 73.

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

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

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

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

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

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

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

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

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

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

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

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

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

[224] *Id*.

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

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

5. "Before That Date" Language

Section 2664(b) of the "technical" amendments in the DRA states that, "but none of such amendments shall be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) *before that date*."[227] However, the Bankruptcy Reform Act of 1984, which granted bankruptcy courts broad jurisdictional authority over a debtor's estate, was passed eight days before the DRA. As such, § 2664(b) actually preserves the jurisdictional rights granted to bankruptcy courts as they existed *before* the passage of the DRA, which would be based on the

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

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

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

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

6. Courts Lack Power to Correct Technical Errors

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

CONCLUSION

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

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

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

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

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

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

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

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

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

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

INTRODUCTION

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

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

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

3. *See infra* note 29.

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

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

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

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

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

6. 11 U.S.C. § 365 (2012).

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

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

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

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

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

Medicare Provider Agreements

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

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

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

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

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

13. *See* 42 U.S.C. § 1395cc.

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

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

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

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

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

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

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

18. 42 C.F.R. § 489.18 (2016).

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

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

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

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

Government Arguments that Medicare Provider Agreements Are Not Contracts

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

32. 42 U.S.C. § 1395 (2012).

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

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

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

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

37. *Id.* at 200.

38. *Id.*

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

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

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

> Especially is that true when we consider that the whole notion of importing contract doctrines into an area that is a complex statutory and regulatory scheme is problematic. We have, on occasion, stated that providers and others have contracts with the government in this area, but our decisions have turned on the regulatory regime rather than on contract principles. . . . As the Eleventh Circuit Court of Appeals held when hospitals complained of legislative impairment of their contract rights in this area because they had agreements with the Secretary: "Upon joining the Medicare program, however, the hospitals received a statutory entitlement, not a contractual right."[44]

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

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

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

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

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

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

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

Discussion of Section 365 as Applied to the Medicare Provider Agreement

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

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

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

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

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

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

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

52. *See supra* note 5.

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

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

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

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

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

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

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

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

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

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

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

60. RESTATEMENT (SECOND) OF CONTRACTS § 21.

61. *See supra* note 59.

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

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

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

Government Position that Medicare Provider Agreements Are Contracts

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

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

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

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

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

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

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

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

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

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

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

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

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

74. *Id.*

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

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

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

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

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

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

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

78. 2014 Bankr. LEXIS 2752, at *12 (Bankr. D. Conn. June 23, 2014).

79. *Id.* at *12–13.

80. 11 B.R. 1014, 1018 (W.D. Pa. 1981).

81. *See*, *e.g.*, Saint Joseph's Hosp. v. Dep't of Pub. Welfare, 103 B.R. 643, 656 (Bankr. E.D. Pa. 1989) (rejecting a provider's claim for breach of contract in an adversary action relating to certain reimbursement determinations, and noting the Provider Agreement "seems to be merely a form document envisioned to memorialize a hospital's participation in the Medicaid program").

82. No. 98-609-B1, 1998 Bankr. LEXIS 2031, at *16 (Bankr. M.D. Fla. Nov. 16, 1998).

83. No. 91 B 11478, 1995 Bankr. LEXIS 157, at *26 (Bankr. S.D.N.Y. Jan. 26, 1995).

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

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

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

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

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

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

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

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

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

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

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

Why Does It Matter?

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

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

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

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

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

Estoppel

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

113. *Id.*

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

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

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

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

Transfer of Medicare Provider Agreement Under Section 363 or Section 365

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

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

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

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

118. *Id.*

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

120. 11 U.S.C. § 365(a) (2012).

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

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

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

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

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

> (b) (1) The trustee, after notice and a hearing, may use, sell, or lease, other than in the ordinary course of business, property of the estate, . . . (f) The trustee may sell property under subsection (b) or (c) of this section free and clear of any interest in such property of an entity other than the estate, only if—(1) applicable nonbankruptcy law permits sale of such property free and clear of such interest; (2) such entity consents; (3) such interest is a lien and the price at which such property is to be sold is greater than the aggregate value of all liens on such property; (4) such interest is in bona fide dispute; or (5) such entity could be compelled, in a legal or equitable proceeding, to accept a money satisfaction of such interest.[124]

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

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

124. 11 U.S.C. § 363 (2012).

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

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

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

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

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

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

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

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

130. *See* Nobelman v. Am. Sav. Bank, 508 U.S. 324, 329 (1993) ("In the absence of a controlling federal rule, we generally assume that Congress has left the determination of property rights in the assets of a bankrupt's estate to state law."); Butner v. United States, 440 U.S. 48, 55 (1979); *In re* Booth, 266 B.R. 105, 111 (Bankr. N.D. Ohio 2000).

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

132. *Id.* at *2.

133. *Id.* at *1–2.

134. *Id.* at *4.

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

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

Impact on Government's Setoff and Recoupment Rights

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

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

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

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

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

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

138. 11 U.S.C. § 362(a) (2012).

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

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

141. *Id.* at 719.

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

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

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

143. *See supra* note 140.

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

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

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

Impact on Successor Liability

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

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

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

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

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

149. 11 U.S.C. § 363(f) (2012).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

167. *Id.* at 869.

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

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

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

Section 525 Impact

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

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

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

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

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

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

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170. 11 U.S.C. § 525(a) (2012).

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

United States Court of Appeals
for the Seventh Circuit

Nos. 16-3668 and 16-3669

NIGHTINGALE HOME HEALTHCARE, INC.

Appellant,

v.

UNITED STATES, et al.

Appellees

On Appeal from the United States District Court for
the Southern District of Indiana

BRIEF OF AMICUS CURIAE PROFESSOR JOHN A. E. POTTOW IN SUPPORT OF APPELLANT

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STATEMENT OF INTEREST OF AMICUS CURIAE

Putative amicus curiae, Professor John A. E. Pottow (Amicus), is the John Philip Dawson Collegiate Professor of Law at the University of Michigan Law School. He co-authors one of the leading textbooks on bankruptcy law, *The Law of Debtors and Creditors* (7th ed. 2014), and has special expertise in the area of bankruptcy court jurisdiction. He has briefed cases to many appellate courts as amicus, and has briefed and argued cases before the Supreme Court as counsel of record on matters of bankruptcy jurisdiction, most recently in *Wellness International Network Ltd. v. Sharif*, 135 S. Ct. 1932 (2015). He submits this brief as part of his ongoing pro bono service to the federal courts in matters of his scholarly expertise, such as this appeal's complex and novel jurisdictional question regarding the interaction between section 1334 of the Judicial Code and section 205(h) of the Social Security Act. Amicus states that no party's counsel authored this brief in whole or in part, and that no party or other person contributed money to fund this brief's submission. Both parties have consented to the filing of this brief for purposes of Fed. R. App. P. 29(a)(3).

SUMMARY OF ARGUMENT

This appeal concerns whether 42 U.S.C. § 405(h), which on its face bars claims from being brought under "section 1331 or 1346 of Title 28 to recover on any claim arising under" the Medicare Act, also bars claims from being brought under 28 U.S.C. § 1334, the district courts' grant of bankruptcy jurisdiction, to recover on claims arising under the Medicare Act. The answer to that question may seem obvious, but a precedent of this Court, *Bodimetric Health Services, Inc. v. Aetna Life & Casualty*, 903 F.2d 480 (7th Cir. 1990), arguably compels a different result. In *Bodimetric*, this Court held that § 405(h) bars Medicare claims from being brought under diversity jurisdiction—a jurisdictional ground, like § 1334, that is not cross-referenced in § 405(h)'s text—reasoning that when Congress amended § 405(h) in 1984 to restrict its old cross-reference from essentially all grants of district-court jurisdiction to exclusively §§ 1331 and 1346, it committed scrivener's error. In reaching that conclusion, *Bodimetric* relied on a proviso to a list of 220 technical amendments to the Social Security and Medicare Acts, among them the § 405(h) amendment, providing that those amendments should not "be construed" to change or affect any previously existing rights, liabilities, statuses, or interpretations.

While *Bodimetric* can be distinguished, the better course is to overrule it outright, because it corrected a kind of error (assuming, arguendo, there was error)

that this Court's precedents hold cannot be judicially corrected. Congress's choice to bar only §§ 1331 and 1346 jurisdiction over Medicare claims was neither absurd, nor linguistically incoherent, nor an accident. In barring §§ 1331 and 1346, Congress deliberately targeted the two jurisdictional grounds most relevant to Medicare disputes: federal-question, actions against the United States. Congress may have mistakenly believed that barring §§ 1331 and 1346 would do the work of the old global jurisdictional bar, overlooking the potential for Medicare disputes to enter federal court via bankruptcy jurisdiction. But even if such an oversight occurred, it was an incorrectible substantive mistake of policy judgment, not an accidental misuse of words.

As to the proviso, it is best read to instruct courts on how to "construe" ambiguous amendments, not to instruct them to disregard unambiguous amendments that plainly change substantive law. This reading avoids both contradiction between the proviso and the § 405(h) amendment, as well as constitutional concerns that would arise were Congress to instruct courts to disregard the plain meaning of statutes. To the extent, however, the proviso inescapably contradicts the § 405(h) amendment, the amendment's operative provision of law must supersede the proviso's interpretive guidance. At most, the proviso sheds light on Congress' misunderstanding of the amendment's practical consequences; that misunderstanding

cannot displace what Congress actually wrote. *Bodimetric* should be overruled and the judgment of the District Court reversed.

ARGUMENT

I. The Court Should Overrule *Bodimetric*.

The District Court below held that the Bankruptcy Court's jurisdiction under 28 U.S.C. § 1334 to entertain Appellant's request for a preliminary injunction enforcing the Bankruptcy Code's automatic stay was stripped by 42 U.S.C. § 405(h), a section of the Social Security Act that provides, in material part, that "[n]o action against the United States, the [Secretary of HHS, *see* 42 U.S.C. § 1395ii] or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under [the Medicare Act]." 42 U.S.C. § 405(h) (emphasis added).

The District Court concluded that this result was compelled by two opinions: the Eleventh Circuit's recent decision in *Florida Agency of Health Care Administration v. Bayou Shores SNF, LLC (In re Bayou Shores SNF, LLC)*, 828 F.3d 1297 (11th Cir. 2016), which held that the quoted sentence of § 405(h) bars bankruptcy jurisdiction under § 1334 in addition to §§ 1331 and 1346), and this Court's similarly-reasoned decision, *Bodimetric Health Services, Inc. v. Aetna Life & Casualty*, 903 F.2d 480 (7th Cir. 1990), which held that the same sentence of § 405(h) bars diversity jurisdiction under 28 U.S.C. § 1332 in addition to §§ 1331 and 1346.

See Appellant's Short App. at 17–18. The Court should overrule its decision in *Bodimetric,* on which the Eleventh Circuit's decision in *Bayou Shores* rests.

In *Bodimetric*, this Court reasoned that when Congress amended § 405(h) thirty-two years ago to narrow its jurisdiction-stripping cross reference to §§ 1331 and 1346, it "clearly expressed its intent not to alter the substantive scope of section 405(h)," *Bodimetric*, 903 F.2d at 489, which prior to the amendment had extended to essentially "*all* of . . . title[] [28's] grants of jurisdiction to United States district courts." *Weinberger v. Salfi*, 422 U.S. 749, 756 n.3 (1975) (emphasis added). That reasoning is the wellspring of the Eleventh Circuit's conclusion in *Bayou Shores* that "Congress enacted [an] error" in amending § 405(h) to remove bankruptcy jurisdiction from its jurisdictional bar, *Bayou Shores*, 828 F.3d at 1319, and of the various lower-court decisions that have read that bar to apply to § 1334, notwithstanding its omission from § 405(h)'s cross-reference. *See, e.g.*, *In re St. Johns Home Health Agency*, 173 B.R. 238, 244–45 (Bankr. S.D. Fla. 1994); *Sullivan v. Hiser (In re St. Mary Hosp.)*, 123 B.R. 14, 16–18 (E.D. Pa. 1991).

Bodimetric's exegesis of § 405(h)'s convoluted history is generally accurate, and given a certain set of then-prevailing interpretive premises on the scope of the scrivener's error and absurdity rules and, more generally, the relative weight of congressional purpose and intent in the face of contrary statutory language, it was defensibly decided. But intervening precedent of the Supreme Court and this

Court have rejected those premises. This Court should accept Appellant's invitation to overrule *Bodimetric* and hold that § 405(h) only bars federal jurisdiction under the statutes it says it does—§§ 1331 and 1346.

Bodimetric held that a sentence of § 405(h) that bars Medicare-related "action[s] against the United States, the [Secretary of HHS], or any officer or employee thereof . . . [from being] brought under section 1331 or 1346 of Title 28," 42 U.S.C. § 405(h), bars Medicare-related diversity actions against private fiscal intermediaries of the Medicare program from being brought under § 1332. In reaching that holding, *Bodimetric* encountered two textual obstacles. The first and less relevant to this case was that, by its terms, § 405(h) only bars actions against the United States, the HHS Secretary, and "officer[s] or employee[s] thereof."[1] In holding that § 405(h)'s bar of actions against United States officers and employees also barred actions against private fiscal intermediaries, *Bodimetric* rested its conclusion on two considerations. First, it cited legislative history that generally indicated "Congress intended for . . . fiscal intermediaries . . . to play a 'considerable role' in the Medicare reimbursement program," even though that history did not specifically address whether § 405(h)'s bar protected fiscal intermediaries. *Bodimetric*, 903 F.2d at 487 (quoting S. Rep. No. 89-404, *reprinted in* 1965

[1] This Court recently held that identical "officers and employees" language in another statute did *not* embrace Medicare's fiscal intermediaries, specifically rejecting a request to extend *Bodimetric*'s gloss. *See United States ex rel. Garbe v. Kmart Corp.*, 824 F.3d 632, 642 (7th Cir. 2016).

U.S.C.C.A.N. 1943, 1992). Second, it made a purposive argument that if "dissatisfied claimants" could avoid § 405(h)'s bar of actions against the Secretary "by simply bringing suit against the fiscal intermediary instead of the Secretary, the Medicare Act's goals of efficiency and finality would be substantially undermined." *Id.* at 487–88.

The Court reached this result despite the fact that Congress has never acted to expand § 405(h)'s protections to cover Medicare's fiscal intermediaries, even as it enacted legislation applying § 405(h) (which was originally enacted in the Social Security Act of 1939) to Medicare, *see* 42 U.S.C. § 1395ii, and then amended that legislation to clarify the minor detail that in applying § 405(h) to Medicare, references in § 405(h) to the Commissioner of Social Security are considered references to the Secretary of HHS. *See* Pub. L. No. 103-926, § 108(c)(4), 108 Stat. 1464, 1485 (1994), *codified at* 42 U.S.C. § 1395ii. Three circuits have followed *Bodimetric* on this point (one doing so in an opinion authored by the author of *Bodimetric* sitting by designation), but none has offered any additional reasons beyond those offered in *Bodimetric*. *See Nichole Med. Equip. & Supply, Inc. v. TriCenturion, Inc.*, 694 F.3d 340 (3d Cir. 2012); *Kaiser v. Blue Cross of Cal.*, 347 F.3d 1107 (9th Cir. 2003) (Cudahy, J.); *Midland Psychiatric Assocs., Inc. v. United States*, 145 F.3d 1000 (8th Cir. 1998).

The second textual hurdle that *Bodimetric* had to clear in holding that § 405(h)'s jurisdictional bar reaches diversity actions is that the bar does not refer to diversity jurisdiction. Here, *Bodimetric* offered a somewhat more elaborate rationale. When § 405(h) was enacted in 1939, it originally barred jurisdiction under "section 24 of the Judicial Code [codified at 28 U.S.C. § 41]." Social Security Act Amendments of 1939, Pub. L. No. 379, § 205(h), 53 Stat. 1360, 1371 (1939). Section 41 at the time was an omnibus statute that contained essentially all the grants of jurisdiction to the federal district courts. In 1948, however, Congress recodified title 28 and separated § 41's numerous subsections into the various jurisdictional sections of title 28 we know today. *See Bayou Shores*, 828 F.3d at 1305; *Bodimetric*, 903 F.2d at 488–89 (enumerating the thirty-two sections of title 28 formerly housed in § 41). Section 405(h)'s cross-reference, however, continued to look anachronistically to the dismembered § 41 for over a quarter of a century, until in 1976 the Office of Law Revision Counsel (a legislative office that publishes the U.S. Code) decided with little explanation to revise the U.S. Code's version of § 405(h) by substituting its cross-reference to § 41 with a cross-reference to §§ 1331 and 1346 only—even as it acknowledged that there were thirty other "[j]urisdictional provisions previously covered by section 41" its revision did not include. *Id.* at 488 (quoting 42 U.S.C.A. § 405 (West 1982) (codification note)). The original language in the Statutes at Large continued to control, *see id.* at 489,

but in 1984, Congress enacted the codifiers' revision as one of a list of 220 "Technical Corrections in the Social Security Act." *See* Deficit Reduction Act of 1984 ("DRA"), Pub. L. No. 98-369, §§ 2663, 2663(a)(4)(D), 98 Stat. 494, 1160–71, 1162 (1984). As to this particular list of technical amendments, which was only one of six lists of technical amendments to the Social Security and Medicare Acts in the DRA, *see* DRA §§ 2315, 2354, 2373, 2661–63, Congress added a proviso, instructing that "none of such amendments shall be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before [their effective] date." DRA § 2664(b), 98 Stat. 1171–72.

On the basis of this proviso and § 405(h)'s history, *Bodimetric* reasoned as follows. The old § 405(h) had stripped diversity jurisdiction over Medicare-related actions. Therefore, interpreting the DRA amendment to § 405(h) according to its literal text to remove that bar "would contravene" the proviso "by 'changing or affecting [a] right, liability, status, or interpretation' of section 405(h) that existed before" the amendment. *Bodimetric*, 903 F.2d at 489. The court concluded that a "literal application of [§ 405(h) would] produce a result demonstrably at odds with the intentions of its drafters" and had to be rejected in favor of an interpretation that read § 1332, and presumably the twenty-nine other jurisdictional grants § 405(h) no longer cross-referenced, back into § 405(h). *Id.* (quoting *Griffin v.*

Oceanic Contractors, Inc., 458 U.S. 564, 571 (1982)). Or as the Eleventh Circuit more starkly put the point in applying *Bodimetric*'s interpretation of § 405(h) to bankruptcy jurisdiction, "Congress enacted [an] error into positive law when it passed the DRA." *Bayou Shores*, 828 F.3d at 1319.

Whatever the accuracy of *Bodimetric*'s conjectures on Congress' intent in amending § 405(h), the theory of drafting error on which *Bodimetric* and its successors rely is a theory that this Court and the Supreme Court have emphatically rejected since *Bodimetric* was decided. No one would suggest that § 405(h)'s explicitly restricted bar of Medicare-related actions to those brought under §§ 1331 or 1346 fails to "parse[] without the assistance of a red pencil," *Jaskolski v. Daniels*, 427 F.3d 456, 464 (7th Cir. 2005), or that it is a "linguistic garble." *United States v. Logan*, 453 F.3d 804, 806 (7th Cir. 2006). Equally, no one would suggest that "it would have been . . . so bizarre that Congress could not have intended," *United States v. Head*, 552 F.3d 640, 643 (7th Cir. 2009) (quoting *Robbins v. Chronister*, 435 F.2d 1238, 1241 (10th Cir. 2006) (en banc)), to except bankruptcy claims against Medicare from § 405(h)'s jurisdictional bar, subject to the demanding albeit excusable exhaustion requirements that separately inhere in § 405(h)'s second sentence. *See Bayou Shores*, 828 F.3d at 1326–27. And certainly no one would suggest that it was an accident, much less bizarre, that first the Office of Law Revision Counsel and then Congress targeted federal-question jurisdiction

and jurisdiction over suits against the United States—obviously the most germane jurisdictional grants to Medicare actions against the United States, the Secretary, and officers and employees thereof—when they belatedly revised § 405(h) to account for title 28's recodification.

Rather, the error *Bodimetric* and its progeny postulate is much more substantive in nature (and much less absurd). They suppose that in 1976, the Office of Law Revision Counsel reasoned that a bar of §§ 1331 and 1346 jurisdiction alone would functionally do just the same job as the old bar of jurisdiction under thirty-two grants including §§ 1331 and 1346, perhaps forgetting that Medicare claims might occasionally wend their way to federal court by other means, such as diversity or bankruptcy jurisdiction. (Of course, the Office could hardly be blamed for not prophesying that omitting diversity jurisdiction would work any substantive change in the bar's coverage, given that the bar facially only protected defendants—the United States, the Secretary, and her employees and officers—that could not be sued in diversity.) They then suppose that Congress, even after being advised by the Office that the old § 405(h) "previously covered . . . sections 1331 to 1348, 1350 to 1357, 1359, 1397, 2361, 2401, and 2402 of Title 28," 42 U.S.C.A. § 405 (West 1982) (codification note), made the same mistake. As one bankruptcy court has recently more precisely described the argument, the DRA amendment to § 405(h) "was clearly no drafting error, but at most a considered mistake in judg-

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

This Court, in a series of post-*Bodimetric* decisions that build on Supreme Court precedent, has made it exquisitely clear that courts cannot correct Congress' mistakes in judgment, even when those mistakes result from a cross-referencing snafu. In the first of this line of cases, *Jaskolski*, the Court, relying on an exhaustive survey of recent Supreme Court application of the absurdity and scrivener's error rules, concluded that "[t]oday the anti-absurdity canon is linguistic rather than substantive" and "deals with texts that don't scan as written and need repair work, rather than with statutes that seem poor fits for the task at hand." *Jaskolski*, 427 F.3d at 462. Next, in *Logan*, the Court, observing that "[t]he Supreme Court insists that statutes be enforced as written even when they seem mistaken or pointless," held that courts may not "correct a legislature's mistakes and oversights," and that statutes may only be corrected where they do not "parse[]" on account of a "linguistic garble." *Logan*, 453 F.3d at 806.

Finally, in a pair of recent cases, this Court held that even where a statute falls into substantive error because of a failure to update a cross-reference to maintain its original meaning, the error may not be corrected absent linguistic incoherence or substantive bizarreness. In *Head*, this Court confronted a supervisory-release statute that, as originally enacted, sensibly provided by way of cross-

reference that district courts could impose confinement in a halfway house as a term of supervisory release, but could not impose intermittent confinement in a *federal prison* as a term of supervisory release. *See Head*, 552 F.3d at 642. After the subsections of the cross-referred statute were renumbered, the supervisory-release statute (which Congress failed to concurrently amend) provided that district courts *could* impose intermittent confinement in a federal prison as a term of supervisory release, but *could not* impose confinement in a halfway house as a term of same. *See id.* This result was "odd," *id.* at 648, and as "discussed at length in *Head* . . . almost certainly accidental . . . ." *United States v. Anderson*, 583 F.3d 504, 510 (7th Cir. 2009). But the Court declined to correct it for two reasons. First, "there was nothing unclear or incoherent about" the statute. *Head*, 552 F.3d at 643. Second, while Congress's failure to update the cross-reference may have been "a bad substantive choice," it was not "so bizarre or shocking" as to fall into the rare category of correctible substantive error. *Id.* at 643–44.

In a subsequent decision, this Court reaffirmed *Head*, again holding that a "bollixed" cross-reference cannot be corrected unless the bollixing results in textual "hash." *Owner-Operator Indep. Drivers Ass'n, Inc. v. Mayflower Transit, LLC*, 615 F.3d 790, 792 (7th Cir. 2010). The case followed essentially the same pattern as *Head*; a statute of limitations, as originally enacted, referred to a civil cause of action, not a related administrative proceeding. *See id.* Renumbering caused the

cross-reference in the statute of limitations to control the administrative proceeding rather than the civil cause of action. *See id.* This led the district court to conclude Congress committed a scrivener's error by neglecting to update the cross-reference. *Id.* This Court reversed, holding that after *Head*, "a legislative blunder in adjusting cross-references when amending a statute does not justify invoking the doctrine of scrivener's error, unless the text as enacted is hash," or unless the blunder results in true substantive absurdity. *Id.*

Head and *Owner-Operator* on the one hand, and *Bodimetric* on the other, cannot both be the law of this Circuit. *Bodimetric* reasoned that Congress committed "a legislative blunder in adjusting cross-references when amending a statute," namely § 405(h). *Owner-Operator*, 615 F.3d at 792. That blunder (assuming that it *was* a blunder), however, did not render § 405(h) "hash." *Id.* Therefore, it does not "justify invoking the doctrine of scrivener's error." *Id.* In fact, the *Head*/*Owner-Operator* principle applies much more forcefully to *Bodimetric* than to *Head* and *Owner-Operator* themselves. In *Head* and *Owner-Operator*, Congress enacted cross-references in a statute that originally meant X and that, due to a later renumbering in the cross-referenced statute of which Congress neglected to take account, came to mean Y. While those changes may not have transformed what Congress originally wrote into "hash," Congress's failure to update the cross-references could at least plausibly be described as an inadvertent drafting error of

passivity, or, as this Court later described the error in *Head* itself, a "glitch." *Anderson*, 583 F.3d at 510. The "error" in *Bodimetric* is quite different. Thirty-six years after the cross-referenced statute in § 405(h) was rearranged, and eight years after Congress's codification office proposed a revision to § 405(h)'s cross-reference that it candidly described as narrowing § 405(h)'s scope, Congress affirmatively turned its mind to the matter and *acted* to update § 405(h)'s cross-reference. In doing so, it deliberately targeted the two jurisdictional statutes that were most germane to Social Security and Medicare disputes. Congress's overlooking the potential for Medicare disputes to occasionally enter bankruptcy court via § 1334, or district court via § 1332, is the *ne plus ultra* of the sort of "bad substantive choice," *Head*, 552 F.3d at 643, or "substantive problem[]," *Owner-Operator*, 615 F.3d at 792, that this Court has repeatedly held it cannot fix.

But what of the proviso to the § 405(h) amendment that seems to say Congress didn't intend to change anything substantive? Recall that DRA § 2664(b), which was also enacted by Congress, provides that the amendment to § 405(h) shall not "be construed as changing or affecting any right, liability, status, or interpretation which existed" under § 405(h) before its enactment. The amendment, however, plainly did alter § 405(h)'s "substantive scope." *Bodimetric*, 903 F.2d at 489. Given the apparent conflict between these two provisions of the DRA, is the DRA not the sort of "linguistically incoherent" statute the scrivener's error doc-

trine gives the Court license to fix? *See Head*, 552 F.3d at 643 ("A statute might be absurd because it's linguistically incoherent; that's something we can fix.").

No. First, it is arguable whether the proviso even applies. Assuming that enforcing § 405(h) as amended would "chang[e] or affect[] any right, liability, status, or interpretation which existed" under pre-amendment § 405(h),[2] applying § 405(h)'s plain language would not "*construe[]* [DRA's amendment to § 405(h)] as changing or affecting any right, liability, status, or interpretation which existed" under pre-amendment § 405(h). DRA § 2664(b) (emphasis added). "Construc-

[2] This assumption is itself doubtful. Enforcing the amendment to § 405(h) as written would plainly not affect any "status." It would also not affect any "liability"; fiscal-intermediary suits aside, which even pre-amendment § 405(h) did not cover, narrowing the scope of § 405(h)'s jurisdictional bar would not affect liability, but only the jurisdictional means by which the government could be held liable. *See* 42 U.S.C. § 405(g) (creating a review channel for Social Security and Medicare actions). Jurisdiction is usually not thought of in terms of "rights," and former § 405 preserved the right to sue Medicare after satisfying an excusable exhaustion requirement, *see id.*, whereas the same requirement applies under § 405(h)'s second sentence even to unbarred jurisdictional grants. *See Bayou Shores*, 828 F.3d at 1326–27.

That leaves only "interpretation." An "interpretation which existed" before the amendment seems to be the only thing the § 405(h) amendment could have upset, but where and when did an interpretation of pre-amendment § 405(h) barring bankruptcy and diversity claims "exist"? In *Salfi*, a case decided in 1975, the Supreme Court glossed § 405(h)'s cross-reference to the former § 41 to apply to "s 1331 et seq.," noting that § 41 formerly contained "all of . . . title[] [28's] grants of jurisdiction to United States district courts." *Salfi*, 422 U.S. at 756 n.3 and accompanying text. But *Salfi* only *applied* § 405(h) to bar § 1331 jurisdiction; it did not hold it barred anything else. In fact, as far as can be told, no court ever held that pre-amendment § 405(h) barred diversity jurisdiction, while only one district court held that pre-amendment § 405(h) barred bankruptcy jurisdiction, and did so only by reasoning that bankruptcy jurisdiction's omission from the post-1976 recodified § 405(h) ought not "catapult" bankruptcy jurisdiction over Medicare actions above its own jurisdiction. *Andrews v. Blue Cross & Blue Shield of Mich. (In re Clawson Med., Rehab., & Pain Ctr., P.C.)*, 12 B.R. 647, 652 (E.D. Mich. 1981). And after § 405(h)'s 1976 recodification, some courts held that it *didn't* bar bankruptcy or diversity jurisdiction. *See Bodimetric*, 903 F.2d at 489 n.8 (noting decisions by the Eighth Circuit and other courts permitting Medicare diversity actions); *Andrews v. Blue Cross & Blue Shield of Mich. (In re Clawson Med., Rehab. & Pain Ctr.)*, 9 B.R. 644 (Bankr. E.D. Mich. 1981) (holding § 405(h) did not bar bankruptcy jurisdiction).

tion" is something courts do with *ambiguous* texts. *Unambiguous* texts do not require "construction"; they are simply "applied" as written. *See United States v. Fisher*, 6 U.S. (2 Cranch) 358, 386 (1805) (Marshall, C.J.) (where a statute "is plain, nothing is left to construction"); *see also Wehrle v. Cincinnati Ins. Co.*, 719 F.3d 840, 843 (7th Cir. 2013) (quoting *United States Fire Ins. Co. v. Schnackenberg*, 429 N.E.2d 1203, 1205 (Ill. 1981)) (where an insurance policy is "clear and unambiguous there is no need for construction"); *S.C. Produce Ass'n v. Comm'r*, 50 F.2d 742, 744 (4th Cir. 1931) ("where there is no ambiguity [in a statute], there is no need for . . . construction."). Reading a statute that says it bars jurisdiction under "section 1331 or 1346 of Title 28" to bar jurisdictions under those statutes and not others unmentioned is not construction, but mere mechanical application of plain language. To be sure, legislatively enacted rules of construction, like legislatively enacted statements of purpose, are not mere legislative history; they may and must be looked to in cases of plausible ambiguity. *See Rubin v. Islamic Republic of Iran*, 830 F.3d 470, 479–80 (7th Cir. 2016); *United States v. Holcomb*, 657 F.3d 445, 448 (7th Cir. 2011) (Easterbrook, C.J., statement respecting the denial of rehearing en banc). But like a legislative statement of purpose, they cannot "provide[] statutory meaning independent of the operative statutory text." *Rubin*, 830 F.3d at 480 n.3. Interpreting legislatively enacted rules of construction that tell courts how to "construe" statutes to mandate "turn[ing] a clear text on its head,"

Spivey v. Vertrue, Inc., 528 F.3d 982, 985 (7th Cir. 2008), would raise constitutional concerns sounding both in separation of powers and fair notice that can easily be avoided by giving "construe" its ordinary legal meaning. *See generally* Linda D. Jellum, *"Which Is to Be Master," the Judiciary or the Legislature? When Statutory Directives Violate Separation of Powers*, 56 UCLA L. REV. 837 (2009); *cf.* Larry Alexander & Saikrishna Prakash, *Mother May I? Imposing Mandatory Prospective Rules of Statutory Interpretation*, 20 CONST. COMMENT. 97, 97 (2003) ("Artificial rules of interpretation laid down in advance that do not reflect subsequent usages or intentions should not be allowed to trump the actual meaning of statutes.").

Second, even granting that "construe" might encompass the enforcement of plain text, the Court should read it in a way that harmonizes the arguably divergent commands of DRA §§ 2663(a)(4)(D) and 2664(b). "[W]henever possible, statutes are to be construed so that no clause, sentence, or word is rendered void or contradictory." *Ill. v. Consol. Rail Corp.*, 589 F.2d 1327, 1331 (7th Cir. 1978). The best way to do that would be to read "construe" in DRA § 2664(b) as "construe ambiguities." Indeed, as discussed below, it is the only way to reasonably address several of the § 2663 amendments. It preserves the amendment to § 405(h) while leaving § 2664(b) with plenty of work to do regarding the hundreds of potentially ambiguous technical amendments in § 2663. By contrast, reading "construe" to mean

"construe ambiguities and plain text" creates a contradiction between § 2664(b) and the § 405(h) amendment that requires the Court to choose which one to honor and which to treat as void.

Third, even if § 2664(b) and the § 405(h) amendment were irreconcilable—unable to be saved by any interpretation of "construe"—that would not end the matter, but merely advance the enquiry to the harder question of which one to treat as error. Under a principle whereby courts that are forced to correct a statutory error should strive to do the "least violence to the text" possible, *Green v. Bock Laundry & Machine Co.*, 490 U.S. 504, 529 (1989) (Scalia, J., concurring in the judgment), the provision that must fall victim to the judicial blue pencil is clearly § 2664(b). Locating error in the § 405(h) amendment, as *Bodimetric* did, renders the amendment a nullity, because the theory of *Bodimetric* is that § 405(h) must be read as if it still cross-referenced § 41 and its thirty-two scattered descendants, just as it did pre-amendment. Locating error in the application of the § 2664(b) proviso to the amendment renders it only 1/220th of a nullity, as it still would control the interpretation of 219 other contemporaneous amendments (less two, discussed below, that appear to have been misplaced in § 2663).

Fourth, continuing to assume an irreconcilable textual conflict, when a court is faced with a choice between altering an interpretative provision to yield to an operative one or altering an operative provision to yield to an interpretative one,

the operative provision should prevail. Courts follow that order of priority in choosing between inconsistent operative provisions and definitions, which are analogous to statutory rules of construction. A definition, like a statutory rule of construction, is a "type of interpretive statute." Nicholas Quinn Rosenkranz, *Federal Rules of Statutory Interpretation*, 115 HARV. L. REV. 2085, 2103 (2002). When "reading [a] statutory definition mechanically into" a particular statute would "render [it] ineffective," *Philko Aviation, Inc. v. Shacket*, 462 U.S. 406, 412 (1983), or "nullify the . . . provision," *Puerto Rico v. Franklin California Tax-Free Trust*, 136 S. Ct. 1938, 1949 (2016), the Supreme Court has held courts should not read the definition in. Indeed, the Court finds this interpretive move so unremarkable that it does not even describe its refusals to apply incompatible definitions as exercises in correcting scrivener's error, although technically the Court is correcting the language that would otherwise mandate application of the incompatible global definition to the provision at hand. Likewise, when courts encounter statutory rules of construction that would nullify some of the statutes they cover, as § 2664(b) would nullify the amendment to § 405(h), or that simply don't make sense as applied to certain statutes, they decline to apply that rule of construction to those statutes. *See, e.g.*, *River Road Hotel Partners, LLC v. Amalgamated Bank*, 651 F.3d 642, 649 n.5 (7th Cir. 2011), *aff'd*, *RadLAX Gateway Hotel, LLC v. Amalgamated Bank*, 132 S. Ct. 2065 (2012) (noting that in practice, there are "sev-

eral exceptions" to 11 U.S.C. § 102(5)'s dictate that "or" in the Bankruptcy Code must be read conjunctively, not disjunctively). Ultimately, statutory rules of construction, like titles, headings, preambles, findings, and legislative statements of purpose, must give way to operative provisions when those provisions are clear. *See, e.g.*, *Hawaii v. Office of Hawaiian Affairs*, 556 U.S. 163, 175 (2009) (privileging "the operative words of the law" over "whereas" clauses); *City of Joliet, Ill. v. New W., L.P.*, 562 F.3d 830, 837 (7th Cir. 2009) ("purpose clauses" must give way to "the concrete rules the political branches have selected to achieve the stated ends").

That prioritizing the substantive amendments of DRA § 2663 over what § 2664(b) says about how to interpret them is the only way to handle conflicts between the two is perhaps best illustrated by some of the other cases where Congress plainly changed the law in § 2663. Section 2663 amendments made it a crime to impersonate a divorced husband or divorced parent of a Social Security beneficiary, whereas previously it had only been a crime to impersonate a Social Security beneficiary's divorced wife, *see Nurses' Registry*, 533 B.R. at 596, and narrowed a benefits deduction that applied to all spouses of Social Security retirement beneficiaries to spouses of beneficiaries under the age of seventy. *See* DRA § 2663(a)(3)(B), 98 Stat. 1162 (amending 42 U.S.C. § 403(d)(2)). In the other list of DRA technical amendments graced by a proviso like § 2664(b)'s, Congress

moved the eligibility age for certain Medicare benefits up by a month. *See Nurses' Registry*, 533 B.R. at 596 n.11. There can be no question that these amendments affected persons' "rights" and "liabilities."

These amendments create doubt that Congress pristinely maintained the boundary between proviso-governed DRA technical amendments that were not intended to substantively affect the law and proviso-free ones that were. But they also illustrate the unworkability of using § 2664(b) to override plain meaning. Under *Bodimetric*'s approach, courts must simply disregard these patently substantive amendments, categorically (and inexplicably) elevating the proviso to supremacy over Congress' equally valid statutory pronouncements. The Eleventh Circuit, recognizing this tension, tried a workaround that is equally unavailing. In *Bayou Shores*, it suggested that substantive amendments, like the amendment to § 405(h), could be honored notwithstanding coverage by the proviso, but only if Congress writes specific legislative history about them to quasi-corroborate the statutory text. *See Bayou Shores*, 828 F.3d at 1321 n.39 (allowing that the fraud amendment should be enforced because a committee report avowed a "clear intent" to eliminate sexist distinctions in Social Security fraud law). Requiring Congress to produce legislative history to confirm it means what it says contravenes the Supreme Court's admonition that courts may not "require Congress to state in committee reports . . . that which is obvious on the face of the statute." *Harrison v. PPG Indus.,*

Inc., 446 U.S. 578, 592 (1980). This is unsound. The only logical method of handling conflicts between patently substantive amendments that are labeled "technical" and provisos that disclaim any substantive intent to those amendments is to give the former legal effect, while restricting the provisos to amendments that are ambiguous and thereby in need of judicial construction.

Finally, even assuming that § 2664(b) provides courts with reliable information on Congress's understanding of the § 405(h) amendment's import, that information is ultimately not actionable. If Congress thought that pruning a jurisdictional bar of thirty-two grants down to two would not meaningfully "chang[e] or affect[]" the law, DRA § 2664(b), that can only be because Congress failed to apprehend the relevance of the omitted thirty grants to Social Security and Medicare, thereby misunderstanding its handiwork as merely technical. Unlike a situation where § 2664(b) might fortify doubts that Congress' choice of words was intentional, taking § 2664(b) at its word about the § 405(h) amendment can only prove that Congress was mistaken about the practical consequences of its intentional choice of words. Unless Congress can constitutionally mandate courts to fix *that* sort of mistake, and unless § 2664(b) does mandate courts to fix that sort of mistake, this Court is required to give effect to § 405(h)'s plain meaning notwithstanding § 2664(b)'s hypothesized interpretive guidance. The Court should overrule

Bodimetric and hold that § 405(h) does not bar Medicare claims brought under §§ 1332 or 1334.[3]

II. *Bodimetric* Can and Should Be Distinguished If It Is Not Overruled.

In overruling *Bodimetric*, this Court would create a circuit split on § 405(h) and diversity with the three circuits that have followed *Bodimetric*. But deepening a circuit split cannot be avoided in this case, because the Ninth Circuit, which has held in an opinion by *Bodimetric*'s author that § 405(h) bars diversity actions, *see Kaiser v. Blue Cross of Cal.*, 347 F.3d 1107 (9th Cir. 2003) (Cudahy, J.), previously held in an opinion not mentioned in *Kaiser* that § 405(h) does not bar bankruptcy jurisdiction under § 1334. *See Sullivan v. Town & Country Home Nursing Servs. (In re Town & Country Home Nursing Servs.)*, 963 F.2d 1146, 1155 (9th Cir. 1991) (holding that § 405(h) "only bars actions under 28 U.S.C. §§ 1331 and 1346; it in no way prohibits an assertion of jurisdiction under section 1334.") The Eleventh Circuit acknowledged in *Bayou Shores* that it was creating a split with the Ninth Circuit, *see Bayou Shores*, 828 F.3d at 1322 ("[T]his Court is constrained to disagree with the Ninth Circuit's *In re Town & Country* opinion . . . ."), and the Ninth Circuit has acknowledged the tension between its treatment of bankruptcy and diversity under § 405(h). *See Do Sung Uhm v. Humana, Inc.*, 620 F.3d 1134, 1141 n.11 (9th Cir. 2010).

[3] Of course, claimants must still exhaust administrative remedies or be excused therefrom.

In reaffirming *both Kaiser* and *Town & Country* in *Humana*, the Ninth Circuit explained that *Town & Country* "relie[d] almost exclusively on the special status of § 1334's 'broad jurisdictional grant over all matters conceivably having an effect on the bankruptcy estate.'" *Id.* (quoting *Town & Country*, 963 F.2d at 1155) (alteration omitted). While Amicus thinks this characterization of "almost exclusive" reliance is overstatement that shortchanges *Town & Country*'s reliance on a plain-language interpretation of § 405(h), it is a defensible distinction that underscores the unique nature of the grant of bankruptcy jurisdiction under § 1334, which is an in rem fount of jurisdiction.

Without defending *Bodimetric*, it is, in fairness, somewhat difficult to understand why Congress would want to leave the § 405(h) bar open to routine evasion by allowing providers to sue fiscal intermediaries for underpayment in diversity. *See Bodimetric*, 903 F.2d at 487–88.[4] On the other hand, it is eminently plausible that Congress would affirmatively want to exempt bankruptcy causes of action from § 405(h)'s jurisdictional bar, subject to an exhaustion requirement (which is excusable under appropriate circumstances). A bankruptcy system in which bankruptcy courts cannot fully police the automatic stay or resolve disputes between chapter 11 medical-services debtors and what will often be, in Medicare, their largest creditor or debtor is not, as to those debtors, a bankruptcy system at all. *See*

[4] Moreover, *Bodimetric*'s result, if not its reasoning, can be defended as an application of the artful pleading doctrine.

Town & Country, 963 F.2d at 1155 (rejecting application of § 405(h) to § 1334 in part because of the need for "efficient and expeditious resolution of all matters connected to the bankruptcy estate."). Moreover, it is entirely unclear how channeling bankruptcy claims (as opposed to claims for underpayment) into administrative review is supposed to work; Medicare ALJs or the Medicare Appeals Council are likely ill-suited to decide whether Medicare is violating the automatic stay. Whereas *Bodimetric*, at least, found it all but unthinkable that Congress would save diversity suits against fiscal intermediaries from § 405(h)'s bar, it is eminently thinkable that Congress would save bankruptcy claims from that bar. Thus, this Court if inclined can decline to apply *Bodimetric*'s reasoning to bankruptcy jurisdiction without overruling *Bodimetric* outright.

III. *Bayou Shores*'s Additional "Recodification Canon" Rationale for Reading § 1334 into the § 405(h) Bar Is Unpersuasive.

The *Bayou Shores* court, while building heavily on *Bodimetric* in substance, innovated on *Bodimetric*'s reasoning in one respect. Rather than justifying its holding in terms of scrivener's error or absurdity, which it acknowledged were inapposite, *see Bayou Shores*, 828 F.3d at 1314, it claimed its holding was compelled by the so-called recodification canon, which provides "that when legislatures codify the law, courts should presume that no substantive change was intended absent a clear indication otherwise." *Id.*

Bracketing that the DRA was not a recodification project, but rather a substantive deficit-reduction bill that, with respect to one among its thousands of provisions, *responded* to a recodification of title 28 that took place thirty-six years prior, the glaring hole in the *Bayou Shores* argument from the recodification canon is that the "clear indication" needed to rebut the canon's presumption is the § 405(h) amendment itself. What could be clearer than replacing a cross-reference that had been recently interpreted by the Supreme Court and Office of Law Revision Counsel to capture essentially every grant of jurisdiction to the district courts with a cross-reference that explicitly singled out just two of those grants? *Bayou Shores*' only answer, and one completely foreclosed by Supreme Court and circuit precedent, is that if Congress really wanted to clearly indicate its intention to remove § 1334 from § 405(h)'s bar, it should have said so in legislative history. *See id.* at 1319 ("One would expect that" if the removal were intentional, "it would merit *some* mention."); *id.* ("[O]ne would expect to find some indication in the . . . legislative history stating as much."); *id.* at 1321 n.39 ("The House report indicates the 'clear intent' behind [the Social Security fraud amendment], whereas nothing in the legislative history indicates a 'clear intent' to change the jurisdiction of bankruptcy courts with the amendment. Thus, the [fraud] amendment . . . is not analogous to the amendment to § 405(h)."). As a rule of statutory interpretation, reading silence in legislative history to negate clear text is impermissible. "In as-

certaining the meaning of a statute, a court cannot, in the manner of Sherlock Holmes, pursue the theory of the dog that did not bark." *Harrison*, 446 U.S. at 592; *see also Logan*, 453 F.3d at 805 ("Statutes do not depend, for their force, on some statement in the legislative history along the lines of: 'We really mean it!'").

IV. Whether Appellant's Failure to Exhaust May Be Waived Is a Question for Remand.

The District Court held that the Bankruptcy Court lacked § 1334 jurisdiction because Appellant did not exhaust its administrative remedies. *See* Appellant's Short App. at 17–18. As Appellant explains, this holding was confused. *See* Appellant's Br. at 38–39. Section 405(h)'s third sentence either bars § 1334 jurisdiction or not, full-stop. Separately, § 405 imposes a "waivable" "requirement of exhaustion" that must be satisfied or excused even if jurisdiction beyond § 405(g) is not barred, or even where a party pursues review under § 405(g)'s grant of jurisdiction to review Medicare agency decisions and satisfies its truly jurisdictional prerequisites, i.e., *presentment* of claims to the agency. *Martin v. Shalala*, 63 F.3d 497, 504 (7th Cir. 1995). That exhaustion requirement "may be waived if it would be futile, that is, if there is no reasonable prospect that the applicant could obtain any relief by pursuing [its administrative remedies],'" *id*. (quoting *Health Equity Res., Urbana, Inc. v. Sullivan*, 927 F.2d 963, 965 (7th Cir. 1991)); it is also particularly subject to judicial waiver in cases of "futility plus hardship." *Health Equity Res.*, 927 F.2d at 966. Given these well-established bases for waiver of exhaus-

tion, which have obvious potential bearing here but have not yet been litigated, *see* Appellant's Br. at 39–40, Amicus agrees with Appellant that whether exhaustion is excusable in the particular circumstances of Appellant's case can only be decided in the first instance by way of remand to the Bankruptcy Court. *See id.* at 41.

CONCLUSION

The judgment below should be reversed and the matter remanded to the Bankruptcy Court to decide whether Appellant's failure to exhaust should be excused.

Dated: January 4, 2016

Respectfully submitted,

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The Top 10 Issues to Be Aware of when Buying a Healthcare Business*

*and how to plan for the inevitable surprise

Hosted by: The ABI Asset Sales and Healthcare Committees

4:00 p.m., April 22, 2017

Healthcare Industry Stressors

- **Declining revenues**
  - Declining Census and Occupancy
    - Changes in care setting
    - Decreased hospital spending
    - Pressure from payors to reduce length of stay
  - Billing Issues
    - Lack of negotiating power with insurers
    - Improper coding by diagnosis
  - Overall Operational Issues
    - Poor cash management
    - Reimbursement very complicated
    - Collection efforts often poorly managed

Healthcare Industry Stressors

- **Increasing Costs**
  - Nursing Challenges
  - Doctor Challenges
  - Capital Demands
  - Drugs & Medical Supplies
  - Litigation
  - Insurance Costs
  - Regulatory environment
  - Provider taxes

What are you buying?

1

Are you buying the operating entity? Just the lease? The Medicare and Medicaid provider agreements? Other contracts for goods and services? The licenses? What licenses do you need?

Defining the scope of the acquisition can be key, and creates or eliminates issues for each category.

Issues surrounding bankruptcy

2

Do you buy the business through bankruptcy or try to do the acquisition outside of bankruptcy?

What are the advantages and disadvantages of proceeding in those ways, especially with regard to:

- transfer of the provider agreements
- dealing with Collective Bargaining Agreement (CBAs)
- PTO
- leases with anti-assignment provisions, etc.?

Issues surrounding bankruptcy

- How does your decision affect cost?
- How does your decision affect timing?
- How do you handle the risk of overbids?

Are you buying a not-for-profit?

- What regulatory hoops do you and the seller have to jump through?
- Do these requirements change in a bankruptcy?

Healthcare Receivership

4

A unique remedy for lenders or landlords attempting to preserve the value of collateral

- **Court Order Specifies Duties of Receiver**
  - Receiver can take over operations, stabilizing and improving business before transition to new operator or new owner
  - Manage business & property until foreclosure is resolved via new lease or sale to a third party
  - Authorizes interim management agreement
  - Insulates Lender/Landlord from risks associated with operating a healthcare business

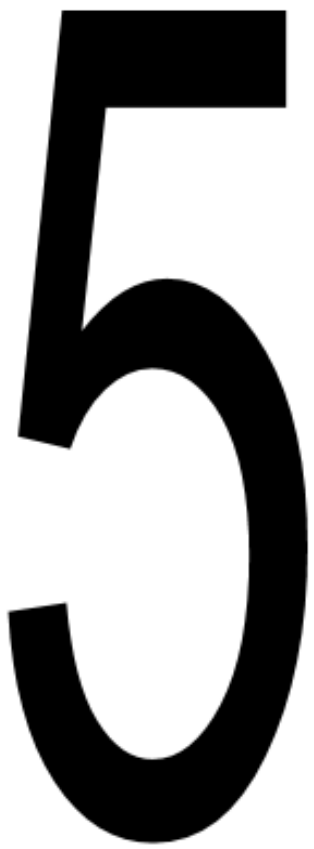
Healthcare Receivership

4

Receivership is often a better option than bankruptcy:

- **Cost Effective**
  - Establishes Receivership Estate, alleviating need to service pre-receivership debts.
  - All assets to be preserved for benefit of all creditors.
- **Allows for Orderly Transition to New Operator or to Tee Up Sale**
  - Without displacing residents
  - Without disrupting patient care
  - Without jeopardizing licenses
- **Allows a new operator time to obtain licenses**

False Claims Act Liability

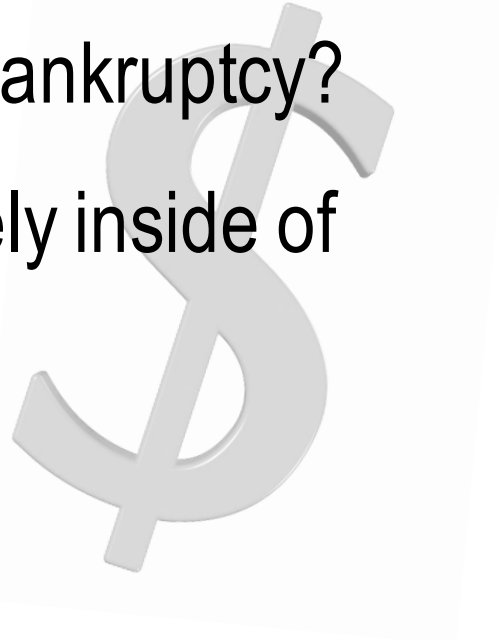


- How do you deal with potential false claims act liability being acquired with the assets?
- Is this a real problem?
- What impact does it have?
- Can you deal with it outside of bankruptcy? Inside of bankruptcy?

Providing Funding

6

- If you are buying a failing healthcare entity, do you provide funding to keep it operating while you close the sale?
- Can you do this outside of bankruptcy?
- How do you do this effectively inside of bankruptcy?



Issues surrounding HIPAA

7

- How does HIPAA affect your ability to do your due diligence?
- How can HIPAA affect your ability to close the sale?
- If you are in bankruptcy, do you need a consumer privacy ombudsman?

Government Ownership

8

- Are you buying a healthcare business owned by a governmental entity or a quasi-governmental entity?
- Does it matter?
- How, if at all, does it change your options and procedures?

Expect the unexpected

9

- **What steps can you take to insulate yourself from the unpredictability of the industry?**
  - Illinois State funding example

What all this means to you

10

Audience Questions?