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UNITED STATES BANKRUPTCY COURT
MIDDLE DISTRICT OF FLORIDA
Tampa Division

IN RE:

Case No. 8:14-bk-09521-MGW

BAYOU SHORES SNF, LLC,

Chapter 11

Debtor.

PATIENT CARE OMBUDSMAN'S INITIAL WRITTEN REPORT

Robert Rosenthal ("Mr. Rosenthal"), President of Health Care Management Specialist, Inc., the duly appointed Patient Care Ombudsman (the "Ombudsman") in this chapter 11 case, pursuant to 11 U.S.C. §333(b)(2), hereby submits the Ombudsman's Initial Written Report ("Report") as to the status of the quality of patient care being provided by the Debtor Bayou Shores SNF, LLC (the "Debtor"). In support thereof, the Ombudsman states as follows:

I. BACKGROUND

A. Bankruptcy Procedural Summary

On August 15, 2014 (the "Petition Date"), the Debtor filed a voluntary petition for relief under Chapter 11 of the Title 11 United States Code (the "Bankruptcy Code"). The Debtor is a "health care business" pursuant to 11 U.S.C. §101(27)(A).

On or about August 21, 2014, the Assistant U.S. Trustee's office spoke with Mr. Rosenthal about the possibility of Mr. Rosenthal being appointed as the Patient Care Ombudsman in this case. Thereafter, the Ombudsman and his requested counsel had communications with the U.S. Trustee's office and counsel for the Debtor to ensure that the Ombudsman would be ready to proceed upon the Court's entry of an Order directing the appointment of a Patient Care Ombudsman, and the U.S. Trustee's formal appointment.

On September 9, 2014, the Court entered its *Order on Court's Order to Show Cause Directing the United States Trustee to Appoint a Patient Care Ombudsman*. See D.E. 86.

On September 10, 2014, at a Status Conference in this case, the U.S. Trustee advised the Court that the U.S. Trustee's Office would be appointing Robert Rosenthal, President of Health Care Management Specialist, Inc. as the Ombudsman. On the afternoon of September 10, 2014, the United States Trustee appointed Mr. Rosenthal,

President of Health Care Management Specialist, Inc., as the Ombudsman for the Debtor. *See* D.E. 97.

The obligation of the Ombudsman under the Court's order and the applicable section of the Bankruptcy Code is "to monitor the quality of patient care to patients of the debtor." 11 U.S.C. §333(b)(1).

On September 19, 2014, the Court entered an Order authorizing the Ombudsman to hire and retain the services of a registered nurse(s) (an "RN") and a Master of Social Work (an "MSW") in this case to assist him in fulfilling his responsibilities under 11 U.S.C. §333. *See* D.E. 131. In accordance with that Order, the Ombudsman has retained RB Health Partners, Inc. ("RBHP"), which specializes in providing licensed nursing support, or such other registered nurses with comparable qualifications, to assist him.

On September 17, 2014, the Court granted a motion for the Ombudsman to review Confidential Patient Records and related patient care information maintained by the Debtor except that the Ombudsman was not authorized to review any records relating to any patient for whom an objection was submitted by the patient or the patient's guardian. *See* D.E. 125. No objections were received by the Ombudsman, nor was the Ombudsman advised of any objection having been submitted to the Debtor.

Since his appointment, the Ombudsman has fulfilled his obligations and duties under the Bankruptcy Code and the Court's Order directing his appointment. The instant initial Report is being submitted to the Court in accordance with the requirements of 11 U.S.C. §333(b)(2).

B. Ombudsman and Registered Nurse and MSW

The Ombudsman possesses healthcare operational experience over the past 40 years. Specifically, the following summarizes the background of the Ombudsman and the Registered Nurse and MSW, whose retention by the Ombudsman to assist the Ombudsman in the performance of his duties was authorized by the Court.

1. Robert Rosenthal

Robert Rosenthal, N.H.A., has a Bachelor of Arts degree from Michigan State University, and a Masters of Business Administration from Northwestern University. He has been active in the Long Term Care Industry since 1974. Notably, Mr. Rosenthal has been a licensed Nursing Home Administrator since 1974.

In addition, Robert Rosenthal is past President of the Florida Health Care Association ("FHCA"), an association that represents over 700 Skilled Nursing Facilities ("SNF's"), as well as a limited number of Assisted Living Facilities ("ALF's"). He is also a past member of the American Health Care Association's Board of Directors and a current member of its survey and regulatory committee, which represents facilities in all 50 states. Mr. Rosenthal is a past member of the State of Florida, Agency for Health Care Administration's ("AHCA") Nursing Home Advisory Council, current member and

past Chairman of FHCA's Rules and Regulations committee, a past member of the State House of Representatives Elder Affairs and Long Term Committee Workgroup. Mr. Rosenthal has also been appointed by former Florida Governor Charlie Crist to the Board of Nursing Home Administrators which term ended earlier in 2014. Also, Mr. Rosenthal was appointed by former Governor Jeb Bush to the Governor's Gold Seal Panel of Excellence in Long Term Care. As a result of his extensive health care experience and reputation, Mr. Rosenthal has been a Court Appointed Receiver for a number of Skilled Nursing facilities in the State of Florida and has also been a Court Appointed Patient Care Ombudsman.

2. Shirley Hunziker, R.N.

Shirley Hunziker is an RN with RBHP, the Nursing and MSW assistants that the PCO retained to assist him in fulfilling his duties in this case. Ms. Hunziker is a seasoned RN who has over 35 years of healthcare experience. She is also a seasoned Risk Manager and has been a corporate Director of Risk Management for a large healthcare company which managed 27 SNF's and ALF's in Florida, Indiana, and Ohio. In this role, she performed a record review of all potential and current claims of the facilities and management company. Ms. Hunziker tracked and trended event reports, adverse event reports, liability claims, survey outcomes and customer and employee satisfaction surveys. She was also a HIPPA Privacy and Compliance Officer for the management company and responsible for training corporate and facility management. She has also served as a Regional Clinical Consultant, and served as Director of Nursing for three SNF's over an 18 year period. Ms. Hunziker has previously served in the role of assisting a Patient Care Ombudsman.

Ms. Hunziker, who began her career as a registered nurse in an emergency room and then as a nurse on a Hospital Post-Operative Surgical Unit, has a strong clinical foundation. She has a risk management background as she had oversight for the education for all risk managers and management team to ensure all federal and state regulations were being met in her corporate role for the 27 facilities.

3. Tamra Hassler, R.N.

Tamara Hassler is an RN that also assisted the Ombudsman in fulfilling his duties. Ms. Hassler has over 26 years of experience in the health care profession with an expertise in MDS¹ requirements, principles of risk management, and clinical proficiency. Ms. Hassler has been a Director of Nursing, a Nurse Management Trainer and Education Director. Ms. Hassler is also a Health Care Risk Manager.

¹ MDS is the acronym for Minimum Data Sets, which is part of a United States federally mandated process for clinical assessment of all patients in SNF's.

4. **Bonnie Emmes, M.S.W.**

Ms. Emmes is a MSW that assisted the Ombudsman in fulfilling his duties. Ms. Emmes has over 16 years of experience in elder and behavior care services. Her success stems from her eye to detail, and analytical problem solving skills.

Ms. Emmes is also a Certified Activities Consultant. She has an undergraduate degree in Psychology from the State University of Plattsburg, New York, and a Master's Degree in Social Work from Florida International University. Ms. Emmes is a former surveyor and has experience in development of policies and procedures, training program development, and LTC rules, regulations, and compliance.

5. **Robin A. Bleier, RN, HCRM-FADONA**

Ms. Bleier is an RN and a Health Care Risk Manager with over 25 years' experience in health care. Ms. Bleier launched RB Health Partners and has a team of associates that provide clinical risk and operations consulting services to long term care providers. Ms. Bleier Chairs the FHCA Disaster Committee and participates as a consultant to the FHCA Quality Foundation, served on the FADONA Executive Board, earned Fellow status of the National Association of Directors of Nursing in Long Term Care, and participates through membership of the National Association of Professional Case Managers.

C. **Background of the Debtor**

Before describing what the Ombudsman, the RN, and the MSW observed, it is helpful to have some background as to what the Debtor does, and the regulations that govern the Debtor's operations.

As set forth in the Debtor's *Chapter 11 Case Management Summary* (the "Case Summary"), see D.E. 6, the Debtor operates a SNF known as the Rehabilitation Center of St. Petersburg (the "Nursing Home" or the "Facility"), located at 42nd Avenue South, St. Petersburg, Florida 33705. The Debtor's Case Summary provides as follows:

The Nursing Home has a total of 159 licensed beds. Many of the Nursing Homes' residents have Alzheimer's and other dementias, and/or serious psychiatric conditions such as depression, bipolar affective disorder and schizophrenia. The Nursing Home provides valuable services to the St. Petersburg community by caring for high-need patients who are "difficult to place."

Skilled Nursing Facilities (SNF's) and Today's Regulatory Environment

Nursing homes provide long term, sub-acute care, and rehabilitation to persons in need of 24-hour nursing services or significant supportive services. The quality of care and quality of life for residents of nursing homes have been reviewed for decades.

Nursing home residents are generally frail, physically and psycho-socially compromised, heavily dependent upon others for basic care and sustenance. When residents live in an environment where they are totally dependent on others, they are especially vulnerable.

Due to the recognized vulnerability of their residents, today's skilled nursing home facilities operate in a very intensive regulatory environment. Nursing homes must adhere to extensive, detailed federal and state regulations. Starting in the late 1980s, regulatory oversight has been strengthened in response to public comments. Nursing facilities are now obligated to assure the proper health and well-being of a patient/resident is being provided in accordance with written practice standards and enforcement guidelines regarding such matters as residents' health, memory, hobbies, habits and ability to walk, talk, eat, dress, bathe and understand and communicate with other people. Facilities must have individualized plans to maintain and potentially improve each resident's condition. These heightened standards were accompanied by enhanced enforcement with associated penalties for non-compliance.

Florida has a rigorous regulatory environment, overseen by AHCA. CMS is the Federal regulatory body that oversees federal law pertaining to SNF's. Florida and Federal laws and their accompanying regulations (by AHCA and CMS) subject nursing homes to detailed rules that seek to assure that nursing home residents are provided timely quality care and preserve residents' statutory rights and individual dignity. For example, legislation in Florida required nursing homes to implement comprehensive risk management and quality assurance programs, conform to new reporting guidelines, and satisfy increased staffing requirements. *See, e.g.*, §§ 400.147, *Fla. Stat.* (2009) (risk management and quality assurance) and §400.23, *Fla. Stat.* (2009) (staffing requirements).

1. AHCA Surveys/Inspections Background

To ensure compliance with applicable Florida and federal laws and rules, AHCA conducts standard, unannounced surveys every 9-15 months. For facilities with a history of regulatory non-compliance, AHCA surveys every six months or more often. It also conducts separate and regular fire, life and safety inspections as well as complaint investigations upon the filing of a complaint.

Standard surveys generally have four to five surveyors in the building for approximately four or five days, evaluating every aspect of residential life. As appropriate during any survey, inspection or investigation, AHCA personnel review clinical records, policies and procedures, and staffing reports. It also conducts interviews with patients/residents, family members, staff, visitors, and volunteers.

AHCA records the results of its reviews in what is called a "Statement of Deficiencies," which cites the facility for any failure to meet applicable regulations. The nursing home's licensed administrator responds to AHCA's statement of deficiencies by attesting that the deficiencies have been corrected, identifies a plan to systematically fix the problem and then develops a quality assurance plan to make sure

the plan is working. AHCA performs follow up surveys as needed to ensure that the corrective action is working, reporting whether the facility has corrected the deficiencies. All these reports are public records that can be downloaded from AHCA's website.²

To categorize the nature and extent of deficiencies and their impact on residents, AHCA identifies each by a scope (meaning how many residents potentially or actually were affected, ranging from "isolated" to "widespread") and a severity (ranging from no impact and minimal harm to patients, to actual harm and immediate jeopardy, the most severe). See "Scope and Severity Chart" attached hereto as Exhibit "A."

2. Scope and Severity System Chart Summary

Under this system, the least serious "deficiencies" are A, B and C, which describe practices that have the potential for causing no more than minor negative impact on patient care. The most serious are I, J and K, termed "Immediate Jeopardy" ("I.J." in common parlance), which are practices that have caused or are likely to cause serious harm, serious impairment or death, and to reoccur absent immediate corrective action. Deficiency statements also are referred to as "tags" with the preface of "F" or "N" corresponding to a federal or state (respectively) requirement denoted by a number that corresponds with listed kinds of specific deficiencies.

3. AHCA July 2014 Complaint Survey

As indicated in the Debtor's Case Summary (D.E. 6), on July 11, 2014, AHCA concluded a Complaint Survey (the "Complaint Survey") at the Debtor's Nursing Home. AHCA indicated deficiencies related to findings of "immediate jeopardy" concerning three residents in the Nursing Home's secured unit. According to the Debtor, as a result of the AHCA Complaint Survey, on July 22, 2014, CMS sent the Nursing Home a "Notice of Involuntary Termination" stating that it would terminate the Nursing Home's Medicare and Medicaid Provider Agreements effective August 3, 2014, deny payment for new admissions effective July 24, 2014, and impose federal civil monetary payments. See Case Summary, p. 3. The Debtor has indicated that it acted quickly to remedy the alleged deficiencies, including by retaining a third party consultant to assist in taking corrective measures.

4. AHCA July, 2014 Six Month and Recertification Survey

Prior to the July 11, 2014 Complaint Survey, the Facility also had an earlier six month recertification survey on January 28, 2014 with findings of Immediate Jeopardy, and a Complaint Investigation on March 20, 2014 with a finding of Immediate Jeopardy. Each of those findings were later addressed by the Debtor. In addition, simultaneous with the Complaint Survey, in July, 2014, AHCA conducted a further six month recertification survey of the Debtor's entire Facility (the "Recertification Survey"). This

² See <http://www.floridahealthfinder.gov/FacilityLocator/facloc.aspx>

Recertification Survey noted two low level deficiencies. The scope and severity of the deficiencies were one “D and one “E.” The Facility indicated that the Recertification Survey was very comprehensive and covered all areas of the Facility’s operation, as compared to the Complaint Survey which focused solely on a few issues. The Debtor has indicated to the Ombudsman that the Facility corrected the deficiencies that were noted in the Recertification Survey.

II. MONITORING OF THE DEBTOR AND PATIENTS

The Ombudsman’s (and the RN’s and MSW assisting him) initial monitoring, including gathering publicly available data, taking tours of the Debtor’s Facility, meeting with senior management, Facility administrator, department heads, department supervisors and line staff, and interviewing residents/patients. In addition, we observed the general functioning of the Facility with respect to patient care, including but not limited to, weight loss reports, wound reports, restraint screening, antipsychotic medication reviews, activities, meal service, patient chart reviews, pharmacy consultant recommendations, resident council meeting, and interviews with residents, families, and staff. We devoted considerable attention to understanding the functioning, skills, and performance of management, and watching the interaction between representatives of the Debtor and the patients. Initially upon my appointment, we did not have authority to review confidential patient records. Authority to review patient records was granted on September 17, 2014, and patient records were first reviewed beginning on September 30, 2014, after patients and their guardians were first provided an opportunity to object to such review, as required by the Court’s Order. As noted above, no objections were received with respect to such a review.

Upon arrival for most visits to the Facility, the Ombudsman and nurses had an entrance meeting with the Administrator. After the entrance meeting, the Ombudsman and his RN or MSW assistants attend the Stand Up Morning Meeting³ and then the morning Clinical Meeting. Generally, all department heads are in attendance at the Stand Up meeting. The administrator requests particular staff stay to attend the subsequent Clinical Meeting.

The morning meetings have been observed to be comprehensive. In addition, the Clinical Meeting consistently addresses a number of current clinical issues or orders. In addition, an up to date elopement⁴ manual containing a policy and resident photos are reviewed (this was part of their corrective action for the elopement citation on the previous AHCA survey), plus they review any falls and any escalation of behavior of any residents.

³ The “Stand Up Meeting” refers to an early morning meeting generally scheduled for 9 a.m. which is attended by all department heads with each staff member supplying updates and information.

⁴ Elopement refers to a patient leaving the facility without permission and/or as defined by CMS and the facility’s policies and procedures.

Tours of the Facility after the morning Clinical Meeting have noted that staffing assignments were posted on each unit, residents were noted to be appropriately groomed and dressed, resident rooms and public areas were noted to be clean and well organized. Other general observations during the Ombudsman's initial 60 day period were as follows:

- Each floor has a "Code Team" and on each staffing board, the code team is listed with the staff member's name and responsibility. Responsibilities listed include, Code Team Leader, who is always a nurse; Transcriber, who is also always a nurse; and Crash Cart and 911 Caller.
- There is a Hydration Cart on each floor. Fluids as well as snacks were observed being offered to the residents on all three floors. Facility staff members offer fluids and snacks to patients three times daily.
- On the 2nd floor, which is the secured floor, there were staff members sitting outside the two different elevators on the unit. According to Facility staff, this practice continues 24 hours a day, seven days a week. This new practice is part of their updated elopement policy. This was observed on all three shifts.
- Also on the second floor, there is a private room that may be utilized as an isolation room because it has its own bathroom with a shower as well as an entry area with cabinets for personal protective equipment and a sink for hand washing. Staff members reported to the Ombudsman that this private room has also been utilized for hospice patients who are nearing the end of their lives in order to allow a more intimate and private setting for the resident and their family.
- There is usually an active activities program ongoing during our tours. One such example on the 2nd floor was an entertainer playing music. The residents were noted to be actively engaged in the activity clapping their hands along with the rhythm, bobbing their heads to the beat, and some were, in fact, singing along. The Activity staff member was also observed to be encouraging other residents to actively join the others.
- There were several wheel chairs observed in the hallway. The staff member reported that they encourage the residents to transfer into a standard chair (*i.e.* not a wheelchair) while at meals and activities and that there is a Walk-to-Dine program. There were several residents noted to be sitting in standard chairs during the music activity.

MEAL OBSERVATION:

On most visits, the lunch meal was observed. On other visits, the breakfast and dinner meals were observed. The following was noted:

- There was generally one staff member passing trays to nine residents during the lunch meal. Breakfast and dinner had less staff present, but the number present was considered satisfactory.
- Hand washing practices were consistently followed.
- All residents sitting at the same table were served together.
- All residents were offered fluids at the beginning of the meal.
- Adaptive eating equipment (eating utensils that make eating easier for special needs residents) was being used by several of the residents.

CLINICAL RISK OBSERVATION:

On several visits the RN/MSW and/or the Ombudsman attended the clinical risk meeting that was held. These meetings generally last about one hour, at which as many as twelve staff members were present. Care plans were noted to be brought to the meeting. There was an attendance sign-in sheet passed around for all attendees to sign. The following risk areas were discussed to be reviewed, which included a discussion of the resident, the risk area, status of risk area, current, past and new interventions:

- Wounds – the wound care nurse reviewed all wounds which included, pressure ulcers, vascular ulcers, skin tears, and shearing and reported on those residents who have resolved wounds. At the meetings attended, all wounds were noted to be improving.
- Elopement – all equipment was reported to be in place and functioning properly. Elopement books are in place on all floors as well as the receptionist desk. The 24/7 attendant has been in place. The 24/7 attendant who is stationed by the elevators (in addition to their elopement books and other measures to identify those residents as elopement risks) was in response to the Immediate Jeopardy Finding on the July 11, 2014 Complaint and Recertification Survey by AHCA.
- Weights – all residents with weight gain, weight loss and receiving enteral feedings were discussed.
- Restraints – At these meetings, they discussed a limited number of residents with restraints. On October 10, 2014, there were two residents with restraints that were discussed. The Ombudsman's RN has noted that 22 of 25 resident reviews did not indicate restraint usage. Of the 3 restraints of the 25 reviews physician orders were present, consent for restraint was missing in 1 of the 3, and 1 of 3 was

missing documentation on the treatment record. The Ombudsman's RN followed up on this and it was corrected.

- Contractures – all residents with contractures were discussed
- Falls – falls from the previous week were reviewed and all incidents reports were reviewed and interventions documented.
- Other Accident/Incident Reports – At each risk meeting, all other accident/incident reports that occurred since the last meeting were reviewed and interventions documented.
- On October 10, 2014, there was a new Restorative form reviewed by the clinical risk team and the Director of Nursing recommended that they use the form as a Quality Assurance item. On other dates, other new forms, if any, would be reviewed.
- On October 10, 2014, there was a discussion about a Performance Improvement Plan with stated improvement in the identified area, which related to falls on the 11 P.M. – 7 A.M. shift with on one fall this month on that shift. Since October 10, 2014, the Ombudsman's RN interviewed the Director of Nursing who stated progress has been made because of their new plan and as a result they have had a decline in falls.

OTHER OBSERVATIONS:

We also noted the following general observations:

- Multiple staff and resident interactions;
- Staff smiling and friendly;
- Residents smiling and friendly;
- No odors noted.

A. Administration

On our initial visit, the Ombudsman and his medical assistants met with Ms. T. Johnson, Administrator, M. Bokor, Management, and J. Kestler Corporate Administrator. The welcome was cordial and an introduction was given as to the purpose of the Ombudsman. An agreed upon plan was developed as to the Ombudsman's duties and how the Facility administration and staff would help assist the Ombudsman and his team in accomplishing their Court ordered duties. On subsequent visits, the team members would initiate their visit with an entrance conference with Ms. Johnson. On September

29, 2014, due to the resignation of Ms. Johnson, there was a change in administration and Mr. T. Martin became the licensed nursing home administrator. On subsequent visits, the Ombudsman and his team members would continue to meet with Mr. Martin and he was most helpful in assisting the Team accomplish their duties.

Most recently, on October 9, 2014, A. Pankhurst became the Nursing Home Administrator. Ms. Pankhurst told the Ombudsman that she is willing to become the permanent administrator. However, this is obviously dependent on the current status of the facility, and on the final outcome of the Decertification Action taken by CMS and AHCA and the Debtor's bankruptcy case. In the brief time Ms. Pankhurst has been at the facility, she has been helpful in enabling the Ombudsman and his RN and MSW Assistants to accomplish the Ombudsman's duties.

B. Pharmacy Consultant Recommendations

The Pharmacy Consultant that the Debtor has hired in the ordinary course of business focused in his recent reports to the Debtor on resident behaviors with monitoring and determined documentation was not consistent in September. The Facility is looking at a better way to document and observe behaviors without using the BMF forms sent by the pharmacy. The Pharmacy Consultant's October review indicated documentation was improving.

Some of the issues noted included documentation omissions on MAR's (medication administration records) and PRN effectiveness. There were no med errors noted. It was noted that some residents were without a diagnosis for medications. This was noted and corrected within 24 hours. Findings have been placed under the Initial Findings section at the end of this report.

C. Building and Fire Safety

The entire Facility is equipped with a fire sprinkler system as well as fire alarms activated / protected by detectors, and which can also be set off manually. There is an emergency generator for this facility.

An interview with the Director of Plant Operations provided the following information: major areas of safety are monitored daily, weekly and monthly as required including pest control, elevator safety, grease trap evacuation, water temperatures, smoking receptacles, exit doors, wander guard system, pull stations, fire extinguishers, generator function, air conditioner functioning, battery power lighting, kitchen hood, and laundry. The last building inspection at the Facility was completed on July 9, 2014 by Life Safety and the Facility received 4 tags consisting of K-038- exit doors, K-051- fire alarm system, K-062- sprinkler system, and K-076- oxygen storage. A plan of correction was submitted and all areas have been corrected, and are monitored at least weekly. The Facility conducts fire drills on all 3 shifts as required, as well as an annual internal and external disaster drill. The Facility's fire and disaster plan has been submitted to Pinellas County and is awaiting approval.

D. Human Resources

The Director of Human Resources was interviewed and 4 records were reviewed of new hires to ensure compliance. All employee records reviewed contained an application, reference checks, background screening, as well as abuse, neglect, and elder crime reporting in servicing on hire. Agency usage was discussed and Agency hour usage was presented for the last 60 days that show a continuous reduction in usage from September 1, 2014 to current date. Director of Nursing indicates that several staff have been hired and other staff members are offering to work extra hours if needed. Employee resignations have declined and the staff is stabilizing.

E. Social Services

The Social Service Director is new to the field of long-term care and has a background in working for hospice. She has been provided some training and support by a social worker from a sister facility. She will develop into a good department head but is in significant need of additional training to the requirements and regulations for SNF's.

F. Dietary

The meals and food at the facility get a good review by residents, family, and staff. Dietary appears to be one of the strongest departments at the Facility. The general appearance of the dietary department is clean and well cared for.

G. MDS/Care Plan

Upon the admission of any nursing home patient, federally mandated minimum data sets ("MDS") must be filled out and a plan of care completed. Of the 30 charts reviewed, the Facility developed a complete plan of within seven (7) days of admission. We reviewed a sample of assessments for accuracy and that they were conducted by an RN and done and signed by the appropriate director.

S. Hunziker, RN reviewed clinical practice and quality assurance programs. Specifically, she reviewed the following:

- Chart review of selected charts
- Clinical Review (checking systems supporting significant weight loss, skin integrity, medication dissemination and control, and various clinical practices).
- Sentinel Events reportable incidents)
- Weight Loss reports

- Decubitus Ulcer reports
- Pharmacy Consultant Recommendations and follow through.

H. RN and MSW Reviews

1. Quality Rounds with Director of Nursing

Facility Quality Rounds on all areas were conducted by the Ombudsman and the RN. A minimum of three (3) times during each visit, a facility quality round was done focusing on different times of the day. As part of the rounds the following meetings were attended: departmental stand-up, clinical stand-up, quality assurance, and risk management. Visits were conducted on all three shifts, as well as during a weekend shift. The following overall observations were noted during the 60-day period of this initial report:

- a. Overall residents are out of bed dressed and groomed appropriately by mid morning in time for activities.
- b. Residents are clean and odor free.
- c. Staffing is posted daily and noted staff interactions with residents on a continuous basis.
- d. Medications are passed timely and resident interviews indicate no concerns with pain control.
- e. Rooms are coded with dot system to indicate type of fluids residents can accommodate if any.
- f. Meals are served at bedside or in the dining rooms located on each floor.
- g. Menus are posted and followed. Alternatives are offered, and meals are served timely, and staff members are present in the dining areas to assist residents as needed. One floor offers a steam table and meals are served buffet style.
- h. Residents interviewed are happy with food and have no concerns.
- i. Activities are posted on each floor and conducted throughout the day in activity rooms and outside on the patio.
- j. Linen is abundant and in good condition.
- k. Equipment is clean and in good condition.

- l. Smoking area is equipped with smoking aprons, extinguishers, fire blankets, and an announcement system to alert others of a fire. Staff members are always available during smoking times for residents.
- m. Additional Observations Noted:
 - Trash and linen was noted on the floor on some wings during morning rounds. This was corrected after it was mentioned to Administration.
 - Incontinence odors were noted on the 3rd floor at times, but seemed to be resolved by late morning.

2. Selected Chart Review

A total of 10 resident records were reviewed through the week of October 6th visits (October 6th and 10th). A total of 25 charts were reviewed as of October 23, 2014. A total of 30 charts have been reviewed as of November 1, 2014. The Ombudsman and his RN and MSW assistants will continue to review charts during the next 60 day period.

Records selected were based on observation, request from administration, and random selection. Resident records were satisfactory. There are findings which are listed under initial findings at the conclusion of this report.

3. Clinical Review

a. Restraints - As of October 10, 2014, 10 of 10 resident reviews do not indicate restraint usage. As of October 23rd 22 of 25 residents do not indicate restraint usage. As of November 1, 2014, no additional restraint usage was found.

b. Facility management indicate 3 resident with restraints. Will continue to review during upcoming visits.

c. Elopements - 30 of 30 resident records have elopement screens and wander guards are in place and monitored every shift. There have been no elopements during the 60 days of this report period.

d. Smoking- 17 of 30 records indicate resident is a smoker. Assessment completed timely and care planned. Facility notes there are 38 residents who smoke.

e. Falls- 1 of 10 resident reviews had a fall requiring transfer to the ER for evaluation and return as of October 10th. Fall risk completed and Care Plan updated. As this was continued to be monitored, as of November 1, 2014, there were 3 of 30 residents had a fall requiring a transfer to hospital emergency room. Fall risk was completed and a care plan updated. There has been an improvement with a decrease in the number of falls from July thru October. In

July, 2014 there were 19 falls with 9 falls on the 11 p.m. - 7a.m. shift. In August the total number of falls decreased to 10 with 4 on the 11-7 shift. The trend continued through October with total falls declining to 9 with 0 on the 11-7 shift.

f. Psychoactive medications/Behaviors – Reviewed psychoactive med usage and behaviors for all 30 residents reviewed.

g. On October 10, 2014, behaviors monitored each shift and patients' behavior appeared stable.

h. Dosages of doctor prescribed medications for behavior have been lowered to the lowest effective dosage at this time (this is called titration). Behaviors and meds are care planned, psychiatric services are available and provided if resident agrees. As of November 1, 2014, 30 residents were monitored and medical records appeared satisfactory.

4. Reportable Events

There has been one (1) reportable event called into the Department of Health. This report pertained to an allegation of verbal abuse by a staff member to a resident. DCF was notified and refused to accept the call based on the facts given to the DCF hot line staff member. The Facility staff member was suspended pending the outcome of the investigation. The Federal immediate and 5-day required reports were submitted timely. An investigation determined that the allegation was not substantiated.

There were no further reports submitted during the Ombudsman's initial 60-day period after his appointment.

5. Weight Loss Records

Weight loss report indicate four (4) patients with significant weight losses. Weights are documented consistently and have documentation to support the reasons for the weight loss, and indicate that each of them was unavoidable (*i.e.* beyond the control of anyone at the Facility). RD documentation is present and care plans updated. RN continued to follow up as well as significant weight changes are reviewed weekly in the facility Clinical Risk Meeting

6. Wound Reports

There are currently six (6) In House Acquired Wounds (*i.e.* wounds developed while a resident was in the facility) that have developed in late August to September, 2014. All have unavailability statements by the MD.⁵ Three (3) record reviews indicate

⁵ This information was obtained from CMS QI/QM Report.

Braden scores⁶ current, wound documentation weekly and MD notes (wound care MD), weekly skin checks, and care plans present. Unavoidability documentation is in place and signed by the MD.

The RN followed up and as of November 1, 2014, 5 of the 6 wounds have shown significant improvement. The one remaining wound resident identified is awaiting surgical debridement by the wound physician and is then expected to improve afterward.

7. Quality Indicator Report

CMS has a report called the MDS Quality Indicator (“QI’s”) Report which summarizes 24 quality indicators for nursing home residents. Quality Indicators are not definitive measures of the quality of care, but are “pointers” that indicate a potential problem area that may need further review for investigation. This tool can be used by the facility as a tool to rate its performance compared to the state and to target areas of care for improvement.

The Ombudsman and/or the RN reviewed the QI /QM for September, 2014. These indexes which the government posts are not yet available for October, 2014.

a. Hi Risk Pressure Ulser 81%: This indicator shows 81% of the residents in the facility are at high risk for pressure ulcer formation. This is due to diagnosis, age, mobility, nutritional status, and skin concerns.

Follow up: The Director of Nursing has identified the risk, and the Facility has implemented the following measures to avoid any negative outcomes related to pressure ulcer development:

- Early identification of any skin concerns is completed every shift by nursing assistants and weekly observation of skin by licensed staff,
- Braden scores completed on admission and quarterly to assess risk for pressure ulcer formation,
- Full time wound care nurse who assesses and treats wounds daily,
- Certified Wound Care MD who visits weekly and assesses, measures, and gives treatment orders,
- Pressure reduction mattresses on all beds (in process of replacing all), and low air loss mattresses and roho cushions for residents with skin breakdown requiring enhanced pressure reduction,
- RD visits weekly to review and assess nutritional needs to encourage healing, and
- Clinical risk review weekly to review all skin and wound concerns.

b. Physical Restraints 92%: This indicator shows that 92% of the Facility residents were restrained.

⁶ Braden scores refers to a nationally recognized assessment score.

Follow up: The Director of Nursing investigated these numbers and determined that only 3 residents were currently restrained. This indicates the Facility conducted a full facility assessment and re-evaluated all those residents restrained during this report time frame and discontinued restraints with respect to those for whom restraints were no longer needed, as well as recoded data correctly. This should show a decrease in percentages at the next review. All restraints are monitored by therapy at least monthly, and reviewed at Clinical Risk weekly for any side effects of restraint usage.

c. Antipsychotic medications short term - 82%, Antipsychotic medications long term - 91%, and Behaviors affecting others - 81%

Antipsychotic medication and behaviors affecting others indicators show the percentages of residents who take antipsychotic medications or who have behaviors that affect other residents.

Follow up: Review by the Director of Nursing indicated that these numbers are to be expected due to the type of residents that reside at the Facility which includes psychiatric diagnosis, behaviors affecting others, and end stage dementia. The Facility has four (4) psychiatrists/psychologists and MSW who visit the Facility at least 3-4 days a week to evaluate and treat any residents with psychiatric diagnosis, psychoactive medication usage, and inappropriate behaviors. Services that these groups provide at the Facility include focus treatment of high psychotic younger residents, treatment for Dementia / Alzheimer's Disease, behavior management, holistic approaches to treatment, medication management, titration and monitoring, drug and alcohol therapy, and group therapy. The licensed staff conduct quarterly evaluations to evaluate any movement disorders that have developed due to psychoactive medication usage, monitoring of targeted behaviors every shift to warrant medication usage, and weekly clinical risk meetings to ensure that proper diagnosis, lowest effective dosage, and behavior monitoring are all in compliance.

Note: It was noted on October 30, 2014 that the Facility received a fax letter from AHCA dated October 22, 2014 advising that the Facility was receiving recognition by the AHCA Quality Initiative Recognition Program for safe reduction of antipsychotics.

d. Increased ADL Help. 75%. : This indicator shows that 75% of residents in the Facility require increased help with activities of daily living than previously reported.

Follow up: The Director of Nursing has investigated and determined this is an educational issue with the staff who document help with activities of daily living in their electronic record called CareTracker. This data is retrieved by the MDS Coordinator and implemented in the assessment record. The Facility has determined that there have been no declines in resident activity needs and have re-educated staff on proper documentation from observation. The Director of Nursing will monitor this area, as well as therapy, and review next month's indicators for improvement.

I. Patient and Family Interviews

Residents and/or families have been interviewed on each floor of the Facility. Residents and families stated their care was good or satisfactory with food noted as the highest rated department. Most concerns have been addressed to the residents' or families' satisfaction. The Ombudsman has indicated to the Administrator and the Director of Nursing several further opportunities to alleviate the concerns of several residents or family members. For example, an obese resident expressed concerns as to how staff would transfer her from her bed to a wheelchair. Administration has responded to each of these instances. A follow up with the resident in question indicated that the resident's concerns had been resolved. The Director of Nursing has provided a video to staff regarding educating them on the proper technique for Hoyer Lift transfers

J. Resident Council

The Resident Counsel is a meeting of any and all residents who want to participate, with a president (the Resident Counsel President) who is elected by the residents. The Resident Council President was interviewed by the Ombudsman's MSW assistant and the resident said she had a hard life. She attributes the Facility as being responsible for saving her life. Approximately 20-25 residents attend the monthly meetings. The President stated concerns by residents are taken seriously and are acted upon by Facility staff. The residents are overall pleased with each department.

The Ombudsman's RN attended a Resident Council meeting which lasted for 30 minutes on October 21, 2014. Twenty residents were in attendance. The meeting is run completely by the residents. Many of the residents expressed no concerns and were pleased with the care and things were happening for the good. There were two residents that had minor concerns about the noise level at night time, a resident questioned about snack machines, and another queried about call lights at night. The Ombudsman and RN followed up with Facility administration on these points and the Administrator stated the concerns were investigated and resolved. The Ombudsman's RN also investigated these concerns and could not substantiate these concerns.

K. Admissions

There have been no new resident admissions in the 60 days since the Ombudsman was appointed on September 10, 2014. The Facility chose to limit admissions to only those residents who required hospitalization and then were ready to return to the nursing home.

L. Current Staffing

Staffing schedules were reviewed and staffing meets State Regulations. If the Facility has call-ins for sickness and is unable to replace staff with their own, then they make use of agency personnel.

III. AHCA & OTHER SURVEYS

During the sixty days since the Ombudsman's appointment, there have been not been any further surveys by AHCA or CMS. The only survey or review was the Annual Florida Long-Term Care Ombudsman Program Inspection which occurred on September 6, 2014. This is an administrative assessment or resident visitation and has nothing to do with the Ombudsman appointed in this case. The identified problems were:

- A. Residents had concerns about Facility closing, process for placement, cold food, missing laundry, and medication changes without explanation.
- B. The Ombudsman observed all the problems were corrected by staff. In addition, the Facility had a Psychologist, L. Henderson, Psy. D., meet with 25 residents on October 29, 2014 to address anxiety secondary to recent correspondence the residents received from outside parties regarding finances and support for their stay at this SNF. The Psychologist answered all questions and offered reasonable assurance that all possible steps to keep them safe and secure were being taken. The Psychologist said the residents asked good questions and their concerns were calmed over the course of the session. Other resources were encouraged if necessary.

IV. INITIAL FINDINGS

- A. Loss of key staff from resignations. Loss of staff has included T. Johnson, Administrator, and T. Martin interim administrator from a sister facility. In addition, the social service director recently left and was replaced with an MSW who is most capable but requires training for SNF requirements. The MSW's previous position was with Hospice.
- B. The R.N. noted the following observations for Facility Q.A. and follow up for opportunities for improvement which must be addressed are:

1. The Facility has not been timely in their resident quarterly assessments.
2. There is a need for staff to review monthly the physicians' orders to ensure old discontinued meds have been deleted from the physician orders.
3. Care Plans need to be more specific, especially concerning activities for residents off the grounds when unsupervised and non-compliant behaviors and the care plans need to be more specific for wounds or weight loss.

C. The Consultant Pharmacist focused his findings on:

1. The documentation for the behavior monitoring of residents was not consistent in September as compared with the observable and documented current behaviors.
2. There were issues with documentation omissions on Medication Records and Medication effectiveness documentation.

V. INITIAL RECOMMENDATIONS

With the resignation of key staff such as the Administrator and the laying off of staff as census decreased monitoring over the next 60 days is necessary to ensure patient care and quality of care remains satisfactory. At the present time, the Ombudsman has made recommendations to the Debtor and its Management that they should or can do to improve upon the services and care being provided. Among these are the following:

- A. With respect to Clinical Review and Quality Assurance and Improvement, it is noted that on the Facility's secured/locked second floor, clarification would be beneficial to distinguish between secured policies from that of a locked unit policy.
- B. AIM's testing does not appear to be timely completed on a consistent basis. Update policies to ensure testing timely
- C. Issues with documentation omissions on Medication Records and Medication effectiveness documentation. Re-education of licensed staff by Director of Nursing on medication documentation with improvement was noted.
- D. We noted some residents without a diagnosis for medications. Thereafter, re-education was conducted by the Director of Nursing as to the need to include diagnosis on all medications given. These areas identified by the

Pharmacy consultant were noted as corrected. Continue to provide additional education in this area to assure continued compliance.

- E. The Ombudsman and his RN and MSW assistants will continue to monitor the care being provided to patients during the upcoming 60 day period until his next required report, and the implementation of the suggestions the Ombudsman has made to the Debtor and Management.

VI. CONCLUSION

This report is the initial report of the Ombudsman and is a summarization based upon numerous visits, interviews, meetings and document reviews conducted with management at all levels, staff and patients and/or guardians and family members to date. Those interviewed or spoken with have been cooperative in providing information to the Ombudsman, the RN and MSW, producing data and reports, and appear to have responded to questions in an honest and open fashion. The Ombudsman assumes that the Debtor and others have provided all information requested and have not hidden or withheld anything from the Ombudsman, the RN, and the MSW. The Ombudsman has made a best effort, within the time constraints, to conduct a comprehensive review and assessment of the quality of care at the Debtor's Facility as set forth in this Report.

Based upon the information reviewed to date, and the observations during this initial 60-day period since his appointment, the Ombudsman believes that the health and welfare of the patients at the Debtor's Facility are being satisfactorily and adequately provided.

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Dated: November , 2014

By: 
Robert Rosenthal, President of Health Care
Management Specialist, Inc., as Patient Care
Ombudsman

SCOPE AND SEVERITY CHART

SCOPE →→→→ SEVERITY/HARM ↓	ISOLATED (One or a very limited number of residents affected and/or one or a very limited number of staff involved, and/or the involved, and/or the situation several locations and/or occasionally or in a very limited number of locations.)	PATTERN (More than a limited number of residents affected, and/or more than a limited number of staff failure that affected a large situation, occurred only the same resident(s) have been affected by repeated occurrences of the same practice.)	WIDESPREAD (Situation was pervasive throughout the facility or represented a systematic occurred in portion or all of the facility's residents.)
(4) Immediate jeopardy to resident health or safety (Deficiencies practice caused or is likely to cause serious injury, serious harm, serious impairment or death AND there is a reasonable degree of predictability of a similar situation occurring in the future, Immediate corrective action is need.)	J Immediate Jeopardy	K Immediate Jeopardy	L Immediate Jeopardy
(3) Actual harm that is not immediate jeopardy (Deficiencies practice has led to a negative outcome that has compromised the resident's ability to maintain and/or reach his/her highest practicable physical, mental, and/or psychosocial well-being.)	G	H Substandard Quality of Care	I Substandard Quality of Care
(2) No actual harm with potential for more than minimal harm that is not immediate jeopardy (Deficiencies practice has led to minimal physical, mental, and/or a psychosocial discomfort to the resident and/or a yet unrealized potential for compromising the resident's ability to maintain and/or reach his/her highest practicable level of physical, mental, and/or psychosocial well-being.)	D	E	F Substandard Quality of Care (tags 221-226, 240-258, & 309-333)
(1) No actual harm with potential for more than minimal harm (Deficiencies practice has the potential for causing no more than minor negative impact on residents.)	A Substantial Compliance	B Substantial Compliance	C Substantial Compliance

Exhibit “A”

2015 WL 6502704

Only the Westlaw citation is currently available.
United States District Court,
M.D. Florida,
Tampa Division.

In re: Bayou Shores SNF, LLC, Debtor.
Florida Agency for Health Administration and the
United States of America, on Behalf of the
Secretary of the United States Department of
Health and Human Services, Appellants,
v.
Bayou Shores SNF, LLC, Appellee.

CASE NOS: 8:14-bk-9521-MGW,
8:14-cv-02816-T-30, 8:14-cv-02617-T-30,
8:15-cv-00103-T-30, 8:15-cv-00128-T-30

|
Signed 10/27/2015

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ORDER

[JAMES S. MOODY, JR.](#), UNITED STATES DISTRICT JUDGE

*1 THIS CAUSE comes before the Court upon Bayou Shores SNF, LLC's ("Bayou Shores") Emergency Renewed Motion for Further Stay Pending Appeal (Dkt.89) and the Responses (Dkts.93, 94) filed in opposition thereto. On October 26, 2015, the Court held an evidentiary hearing on Bayou Shores' motion. At the conclusion of the hearing, the Court granted the motion and stated its reasons for doing so. This Order explains that ruling in

PROCEDURAL BACKGROUND

On July 20, 2015, the Court entered its order (Dkt.83), partially granting a motion for stay pending appeal filed by Bayou Shores and authorizing a ninety day stay; the Court noted in its order that Bayou Shores "may seek an additional stay directly from the Eleventh Circuit if it so chooses." Subsequently, Bayous Shores requested an additional stay from the Eleventh Circuit—the motion was denied. Bayous Shores then filed a motion for reconsideration before the Eleventh Circuit. On October 16, 2015, the Eleventh Circuit granted the request to the extent that the stay was extended until 5:00 p.m., on Monday, October 26, 2015. The Eleventh Circuit also stated that Bayou Shores was permitted to present a renewed motion for a stay before this Court, in light of what Bayou Shores characterized as "new evidence." The Eleventh Circuit "underscore[d]" that this Court was the appropriate fact-finder "(1) for considering, in the first instance, any alleged new evidence proffered [sic] by the parties and (2) for making any findings of fact for [the Eleventh Circuit] to review."

On October 26, 2015, this Court held an evidentiary hearing on Bayou Shores' renewed motion. The evidence relied upon in support of Bayou Shores' motion was admitted. The Court heard testimony from witnesses. And the evidence relied upon in support of the responses in opposition was admitted. After considering all of this evidence, the Court granted the stay during the pendency of the appeal.

LEGAL STANDARD

The grant of an emergency motion to stay a district court's order pending appeal is "an exceptional response granted only upon a showing of four factors: 1) that the movant is likely to prevail on the merits on appeal; 2) that absent a stay the movant will suffer irreparable damage; 3) that the adverse party will suffer no substantial harm from the issuance of the stay; and 4) that the public interest will be served by issuing the stay." *Garcia-Mir v. Meese*, 781 F.2d 1450, 1453 (11th Cir.1986) (citing *Jean v. Nelson*, 683 F.2d 1311, 1312 (11th Cir.1982)). Although the first factor is typically the most important, it is less crucial when "the balance of the equities [identified in factors 2, 3, and 4] weighs heavily in favor of granting the stay." *Id.* (quoting *Ruiz v. Estelle*, 650 F.2d 555, 565 (5th Cir.1981)).

DISCUSSION

As the Court stated on the record at the October 26, 2015 hearing, it believes that its order, reversing the Bankruptcy Court for lack of jurisdiction, will be affirmed. However, whether 42 U.S.C. § 405(h) proscribes bankruptcy jurisdiction under 28 U.S.C. § 1334 is an issue of first impression for the Eleventh Circuit and upon which this Court and the Bankruptcy Court disagree. There is also disagreement on this issue among other circuit courts and lower courts.

*2 In its renewed motion, Bayou Shores relies heavily on a recent case, *In re Nurses Registry and Home Health Corp.*, 533 B.R. 590 (Bankr.E.D.Ky.2015). There, the court suggested that this Court went against the plain language of the statute with respect to the jurisdictional issue. Essentially, the court applied the same analysis that Bayou Shores has advocated in this appeal. For the same reasons discussed in the Court's reversal order, it does not agree with the court's holding in *In re Nurses Registry and Home Health Corp.*; however, the Court must acknowledge the debate and that reasonable people could disagree. This is especially so since there is no binding authority on this issue. As such, whether Bayou Shores is likely to prevail on its appeal is not dispositive on the issue of whether a stay is appropriate, especially in light of the remaining factors, which weigh heavily in favor of a stay. The Court now turns to those factors and its findings of fact based on the evidence.

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.

The Court heard testimony from Andrea Pankhurst, Bayou Shores' administrator. Pankhurst's duties include daily interaction with the patients. She is also responsible for initiating the transfer of any patient. During the initial ninety-day stay, Pankhurst called other facilities in order to determine alternative residences. If Bayou Shores ceases operations as a result of the stay being lifted, Pankhurst is responsible for signing a notice of transfer for each patient that specifies the effective date of the transfer and the location to which the resident is being discharged or transferred. She testified that about thirty-seven of Bayou Shores' patients require a limited access unit in connection with their care; these patients exhibit active psychiatric behaviors and can be violent to themselves and others. Pankhurst identified only two facilities in the area that were appropriate for these patients—one facility had six open beds and the other had

two open beds. The facilities required an admission process. This was inadequate to house these nearly thirty-seven patients that would need alternative residences in a facility with a limited access unit if Bayou Shores shut down as a result of the stay being lifted. The Court finds that, absent a stay, these high risk patients would be irreparably harmed because they require a skilled facility that can accommodate their needs. They also need stability and a daily routine that does not change.

The Court also finds that, as of this date, it is un rebutted that Bayou Shores is operating in substantial compliance with all applicable regulatory requirements. Its patients are receiving adequate care and do not want to leave the facility. Pankhurst testified that many of the patients' family members and/or guardians refused to transfer their loved ones despite the uncertainty of Bayou Shores' future because they are happy with Bayou Shores' care.

Finally, the Court finds that the Florida Agency for Health Care Administration ("AHCA") and the United States Department of Health and Human Services ("HHS") will suffer no harm, much less substantial harm, from a stay pending appeal. 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.

CONCLUSION

Bayou Shores' appeal boils down to a jurisdictional issue—one that the Eleventh Circuit has not addressed to date. During the pendency of that appeal, Bayou Shores is faced with closing its operations and displacing its staff and patients if the Court does not grant its request for a stay. After considering the evidence, the Court finds that Bayou Shores has met its burden to establish a stay. There is certainly substantial evidence of irreparable harm—to Bayou Shores, its patients, the patients' family and guardians, and the public. In contrast, an additional stay will not harm AHCA or HHS.

*3 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.

It is therefore **ORDERED AND ADJUDGED** that:

1. Bayou Shores SNF, LLC's ("Bayou Shores") Emergency Renewed Motion for Further Stay Pending Appeal (Dkt.89) is granted to the extent stated herein.
2. The Court's Reversal Order (Dkt.# 72) is STAYED (with no bond required) until the Eleventh Circuit rules upon the merits of the issues on appeal.

3. As stated on the record, Bayou Shores is hereby barred from accepting any new Medicare and/or Medicaid patients during the stay.

DONE and ORDERED.

All Citations

Not Reported in F.Supp.3d, 2015 WL 6502704

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136 S.Ct. 1938
Supreme Court of the United States

Commonwealth Of **PUERTO RICO**, et al.,
Petitioners

v.
FRANKLIN CALIFORNIA TAX-FREE TRUST, et
al.

Nos. 15–233, 15–255.

Argued March 22, 2016.

Decided June 13, 2016.

Synopsis

Background: Investors commenced actions against Commonwealth of **Puerto Rico**, its Governor, its Secretary of Justice, and the Government Development Bank to challenge validity of **Puerto Rico** Public Corporation Debt Enforcement and Recovery Act, which was **Puerto Rico's** own municipal **bankruptcy** law, and enjoin its implementation. The United States District Court for the District of **Puerto Rico**, **Francisco A. Besosa**, J., 2015 WL 522183, consolidated actions and permanently enjoined enforcement of the Recovery Act on ground that it was preempted. Defendants appealed. The Court of Appeals for the First Circuit, **Sandra Lea Lynch**, Circuit Judge, 805 F.3d 322, affirmed. Certiorari was granted.

[Holding:] The Supreme Court, Justice **Thomas**, held that although **Puerto Rico** is not a “State” for purposes of the federal **Bankruptcy** Code’s “gateway” provision governing who may be a debtor, and so cannot authorize its municipalities to seek relief under Chapter 9 of the Code, it is a “State” for other purposes related to Chapter 9, including that chapter’s preemption provision, such that the Code preempts **Puerto Rico's** Recovery Act.

Affirmed.

Justice **Sotomayor** filed a dissenting opinion, in which Justice **Ginsburg** joined.

Justice **Alito** took no part in the consideration or decision of the cases.

West Headnotes (14)

[1]

Bankruptcy

Adjustment of Debts of a Municipality

Federal **Bankruptcy** Code preempts state **bankruptcy** laws that enable insolvent municipalities to restructure their debts over the objections of creditors and, instead, requires municipalities to restructure such debts under Chapter 9 of the Code. 11 U.S.C.A. § 903(1).

1 Cases that cite this headnote

[2]

Bankruptcy

Adjustment of Debts of a Municipality

Congress has tailored the federal municipal **bankruptcy** laws to preserve the States’ reserved powers over their municipalities.

2 Cases that cite this headnote

[3]

Bankruptcy

Municipalities

“Gateway” provision of the **Bankruptcy** Code, defining who may be a debtor under Chapter 9, requires the States to authorize their municipalities to seek relief under Chapter 9 before the municipalities may file a Chapter 9 petition. 11 U.S.C.A. § 109(c).

2 Cases that cite this headnote

[4]

Bankruptcy

Adjustment of Debts of a Municipality

Pursuant to the express preemption provision of Chapter 9 of the **Bankruptcy** Code, the States may not enact their own municipal **bankruptcy** schemes. 11 U.S.C.A. § 903(1).

1 Cases that cite this headnote

[5]

Bankruptcy

☛ **Municipalities**

Bankruptcy

☛ **Adjustment of Debts of a Municipality**

Although, under the federal **Bankruptcy** Code's amended definition of "State," **Puerto Rico** is not a "State" for purposes of the Code's "gateway" provision governing who may be a debtor under Chapter 9 of the Code, and so cannot authorize its municipalities to seek relief under Chapter 9, it is a "State" for other purposes related to Chapter 9, including that chapter's preemption provision, such that the Code preempts **Puerto Rico's** Public Corporation Debt Enforcement and Recovery Act, legislation enabling the Commonwealth's public utilities to implement a recovery or restructuring plan for their debt. 11 U.S.C.A. §§ 101(52), 109(c)(2), 903(1).

3 Cases that cite this headnote

[6]

Statutes

☛ **Plain Language; Plain, Ordinary, or Common Meaning**

Where a statute's language is plain, resolution of disputed issue begins with the language of the statute, and that is also where the inquiry should end.

1 Cases that cite this headnote

[7]

States

☛ **Congressional intent**

Where a federal statute contains an express preemption clause, courts do not invoke any presumption against preemption but, instead, focus on the plain wording of the clause, which necessarily contains the best evidence of Congress' preemptive intent.

2 Cases that cite this headnote

[8]

Bankruptcy

☛ **Municipalities**

Because, under the **Bankruptcy** Code's amended definition of "State," **Puerto Rico** is not a "State" for purposes of the Code's "gateway" provision governing who may be a debtor, and so cannot authorize its municipalities to seek Chapter 9 relief, **Puerto Rico's** municipalities cannot satisfy the requirements of Chapter 9's gateway provision until Congress intervenes. 11 U.S.C.A. §§ 101(52), 109(c)(2).

2 Cases that cite this headnote

[9]

Bankruptcy

☛ **Municipalities**

To "define," as used in the section of the **Bankruptcy** Code specifying that **Puerto Rico** is not a "State" for the purpose of defining who may be a debtor under Chapter 9, is to decide upon, to settle, or to establish or prescribe authoritatively. 11 U.S.C.A. § 101(52).

Cases that cite this headnote

[10]

Bankruptcy

☛ **Who May Be a Debtor**

Section of the **Bankruptcy** Code governing who may be a debtor serves an important gatekeeping role, specifying who qualifies and who does not qualify as a debtor under the various chapters of the Code. 11 U.S.C.A. § 109.

Cases that cite this headnote

[11]

Bankruptcy

 Municipalities

States do not “pass through” the **Bankruptcy** Code’s “gateway” provision governing who may be a debtor; the gateway provision is instead directed at the debtors themselves. 11 U.S.C.A. § 109.

Cases that cite this headnote

[12] **Bankruptcy**
 Municipalities

Municipality that cannot secure state authorization to file a Chapter 9 petition is excluded from Chapter 9 entirely. 11 U.S.C.A. § 109(c).

Cases that cite this headnote

[13] **Bankruptcy**
 Municipalities

In the case of Chapter 9 **bankruptcy**, a State’s only role under the **Bankruptcy** Code’s “gateway” provision governing who may be a debtor is to provide authorization for a municipality to file a Chapter 9 petition. 11 U.S.C.A. § 109(c).

Cases that cite this headnote

[14] **Constitutional Law**
 Judicial rewriting or revision

Nation’s constitutional structure does not permit the Supreme Court to rewrite the statute that Congress has enacted.

1 Cases that cite this headnote

1940 Syllabus

In response to an ongoing fiscal crisis, petitioner **Puerto Rico** enacted the **Puerto Rico** Public Corporation Debt Enforcement and Recovery Act. Portions of the Recovery Act mirror Chapters 9 and 11 of the Federal **Bankruptcy** Code and enable **Puerto Rico’s** public utility corporations to restructure their climbing debt. Respondents, a group of investment funds and utility bondholders, sought to enjoin the Act. They contended, among other things, that a **Bankruptcy** Code provision explicitly pre-empts the Recovery Act, see 11 U.S.C. § 903(1). The District Court enjoined the Act’s enforcement, and the First Circuit affirmed, concluding that the **Bankruptcy** Code’s definition of “State” to include **Puerto Rico**, except for purposes of defining who may be a debtor under Chapter 9, § 101(52), did not remove **Puerto Rico** from the scope of the pre-emption provision.

Held : Section 903(1) of the **Bankruptcy** Code pre-empts **Puerto Rico’s** Recovery Act. Pp. 1944 – 1949.

(a) Three federal municipal **bankruptcy** provisions are relevant here. First, the “gateway” provision, § 109(c), requires a Chapter 9 debtor to be an insolvent municipality that is “specifically authorized” by a State “to be a debtor.” Second, the pre-emption provision, § 903(1), expressly bars States from enacting municipal **bankruptcy** laws. Third, the definition of “State,” § 101(52), as amended in 1984, “includes ... **Puerto Rico**, except for the purpose of defining who may be a debtor under chapter 9.” P. 1945.

(b) If petitioners are correct that the amended definition of “State” excludes **Puerto Rico** altogether from Chapter 9, then the pre-emption provision does not apply. But if respondents’ narrower reading is correct and the definition only precludes **Puerto Rico** from authorizing its municipalities to seek Chapter 9 relief, **1941* then **Puerto Rico** is barred from implementing its Recovery Act. Pp. 1945 – 1949.

(1) The **Bankruptcy** Code’s plain text supports respondents’ reading. The unambiguous language of the pre-emption provision “contains an express pre-emption clause,” the plain wording of which “necessarily contains the best evidence of Congress’ pre-emptive intent.” *Chamber of Commerce of United States of America v. Whiting*, 563 U.S. 582, 594, 131 S.Ct. 1968, 179 L.Ed.2d 1031. The definition provision excludes **Puerto Rico** for the single purpose of defining who may be a Chapter 9 debtor, an unmistakable reference to the § 109 gateway provision. This conclusion is reinforced by the definition’s use of the phrase “defining who may be a debtor under chapter 9,” § 101(52), which is tantamount

Puerto Rico v. Franklin California Tax-Free Trust, 136 S.Ct. 1938 (2016)

195 L.Ed.2d 298, 84 USLW 4393, 75 Collier Bankr.Cas.2d 1318, 62 Bankr.Ct.Dec. 185...

to barring **Puerto Rico** from “specifically authorizing” which municipalities may file Chapter 9 petitions under the gateway provision, § 903(1). The text of the exclusion thus extends no further. Had Congress intended to exclude **Puerto Rico** from Chapter 9 altogether, including Chapter 9’s pre-emption provision, Congress would have said so. Pp. 1946 – 1947.

(2) The amended definition of “State” does not exclude **Puerto Rico** from all of Chapter 9’s provisions. First, **Puerto Rico’s** exclusion as a “State” for purposes of the gateway provision does not also remove **Puerto Rico** from Chapter 9’s separate pre-emption provision. A State that chooses under the gateway provision not to authorize a municipality to file is still bound by the pre-emption provision. Likewise, **Puerto Rico** is bound by the pre-emption provision, even though Congress has removed its authority under the gateway provision to authorize its municipalities to seek Chapter 9 relief. Second, because **Puerto Rico** was not “by definition” excluded from Chapter 9, both § 903’s introductory clause and its proviso, the pre-emption provision, continue to apply in **Puerto Rico**. Finally, the argument that the Recovery Act is not a “State law” that can be pre-empted is based on technical amendments to the terms “creditor” and “debtor” that are too “subtle” to support such a “[f]undamental chang[e] in the scope” of Chapter 9’s pre-emption provision. *Kellogg Brown & Root Services, Inc. v. United States ex rel. Carter*, 575 U.S. —, —, 135 S.Ct. 1970, 1977, 191 L.Ed.2d 899. Pp. 1947 – 1949.

805 F.3d 322, affirmed.

THOMAS, J., delivered the opinion of the Court, in which ROBERTS, C.J., and KENNEDY, BREYER, and KAGAN, JJ., joined. SOTOMAYOR, J., filed a dissenting opinion, in which GINSBURG, J., joined. ALITO, J., took no part in the consideration or decision of these cases.

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Opinion

Justice THOMAS delivered the opinion of the Court.

[1] The Federal **Bankruptcy** Code pre-empts state **bankruptcy** laws that enable insolvent municipalities to restructure their debts over the objections of creditors and instead requires municipalities to restructure such debts under Chapter 9 of the Code. 11 U.S.C. § 903(1). We must decide whether **Puerto Rico** is a “State” for purposes of this pre-emption provision. We hold that it is.

The **Bankruptcy** Code has long included **Puerto Rico** as a “State,” but in 1984 Congress amended the definition of “State” to exclude **Puerto Rico** “for the purpose of defining who may be a debtor under chapter 9.” **Bankruptcy** Amendments and Federal Judgeship Act, § 421(j)(6), 98 Stat. 368, now codified at 11 U.S.C. § 101(52). **Puerto Rico** interprets this amended definition to mean that Chapter 9 no longer applies to it, so it is no longer a “State” for purposes of Chapter 9’s pre-emption provision. We hold that Congress’ exclusion of **Puerto Rico** from the definition of a “State” in the amended definition does not sweep so broadly. By excluding **Puerto Rico** “for the purpose of defining who may be a debtor under chapter 9,” § 101(52) (emphasis added), the Code prevents **Puerto Rico** from authorizing its municipalities to seek Chapter 9 relief. Without that authorization, **Puerto Rico’s** municipalities cannot qualify as Chapter 9 debtors. § 109(c)(2). But **Puerto Rico** remains a “State” for other purposes related to Chapter 9, including that chapter’s pre-emption provision. That provision bars **Puerto Rico** from enacting its own municipal **bankruptcy** scheme to restructure the debt of its insolvent public utilities companies.

I

A

Puerto Rico and its instrumentalities are in the midst of a fiscal crisis. More than \$20 billion of **Puerto Rico's** climbing debt is shared by three government-owned public utilities companies: the **Puerto Rico** Electric Power Authority, the **Puerto Rico** Aqueduct and Sewer Authority, and the **Puerto Rico** Highways and Transportation Authority. For the fiscal year ending in 2013, the three public utilities operated with a combined deficit of \$800 million. The Government Development Bank for **Puerto Rico** (Bank)—the Commonwealth's government-owned bank and fiscal agent—has previously provided financing to enable the utilities to continue operating without defaulting on their debt obligations. But the Bank now faces a fiscal crisis of its own. As of fiscal year 2013, it had loaned nearly half of its assets to **Puerto Rico** and its public utilities. **Puerto Rico's** access to capital markets has also been severely compromised since ratings agencies downgraded Puerto Rican bonds, including the utilities', to noninvestment grade in 2014.

Puerto Rico responded to the fiscal crisis by enacting the **Puerto Rico** Corporation *1943 Debt Enforcement and Recovery Act (Recovery Act) in 2014, which enables the Commonwealth's public utilities to implement a recovery or restructuring plan for their debt. 2014 Laws P.R. p. 371. See generally McGowen, **Puerto Rico** Adopts A Debt Recovery Act For Its Public Corporations, 10 Pratt's J. Bkrty. Law 453 (2014). Chapter 2 of the Recovery Act creates a "consensual" debt modification procedure that permits the public utilities to propose changes to the terms of the outstanding debt instruments, for example, changing the interest rate or the maturity date of the debt. 2014 Laws P. R., at 428–429. In conjunction with the debt modification, the public utility must also propose a Bank-approved recovery plan to bring it back to financial self-sufficiency. *Ibid.* The debt modification binds all creditors so long as those holding at least 50% of affected debt participate in (or consent to) a vote regarding the modifications, and the participating creditors holding at least 75% of affected debt approve the modifications. *Id.*, at 430. Chapter 3 of the Recovery Act, on the other hand, mirrors Chapters 9 and 11 of the Federal **Bankruptcy** Code by creating a court-supervised restructuring process intended to offer the best solution for the broadest group of creditors. See *id.*, at 448–449. Creditors holding two-thirds of an affected class of debt must participate in the vote to approve the restructuring plan, and half of those participants must agree to the plan. *Id.*, at 449.

B

A group of investment funds, including the Franklin California Tax-Free Trust, and BlueMountain Capital Management, LLC, brought separate suits against **Puerto Rico** and various government officials, including agents of the Bank, to enjoin the enforcement of the Recovery Act. Collectively, the plaintiffs hold nearly \$2 billion in bonds issued by the Electric Power Authority, one of the distressed utilities. The complaints alleged, among other claims, that the Federal **Bankruptcy** Code prohibited **Puerto Rico** from implementing its own municipal **bankruptcy** scheme.

The District Court consolidated the suits and ruled in the plaintiffs' favor on their pre-emption claim. 85 F.Supp.3d 577 (P R 2015). The court concluded that the pre-emption provision in Chapter 9 of the Federal **Bankruptcy** Code, 11 U.S.C. § 903(1), precluded **Puerto Rico** from implementing the Recovery Act and enjoined its enforcement. 85 F.Supp.3d, at 601, 614.

The First Circuit affirmed. 805 F.3d 322 (2015). The court examined the 1984 amendment to the definition of "State" in the Federal **Bankruptcy** Code, which includes **Puerto Rico** as a "State" for purposes of the Code "except for the purpose of defining who may be a debtor under chapter 9." *Id.*, at 330–331 (quoting § 101(52); emphasis added). The court concluded that the amendment did not remove **Puerto Rico** from the scope of the pre-emption provision and held that the pre-emption provision barred the Recovery Act. *Id.*, at 336–337. The court opined that it was up to Congress, not **Puerto Rico**, to decide when the government-owned companies could seek **bankruptcy** relief. *Id.*, at 345.

We granted the Commonwealth's petitions for writs of certiorari. 577 U.S. —, 136 S.Ct. 582, 193 L.Ed.2d 465 (2015).*

*1944 II

These cases require us to parse three provisions of the **Bankruptcy** Code: the "who may be a debtor" provision requiring States to authorize municipalities to seek Chapter 9 relief, § 109(c), the pre-emption provision barring States from enacting their own municipal **bankruptcy** schemes, § 903(1), and the definition of "State," § 101(52). We first explain the text and history of these provisions. We then conclude that **Puerto Rico** is

still a “State” for purposes of the pre-emption provision and hold that this provision pre-empts the Recovery Act.

A

The Constitution empowers Congress to establish “uniform Laws on the subject of **Bankruptcies** throughout the United States.” Art. I, § 8, cl. 4. Congress first exercised that power by enacting a series of temporary **bankruptcy** Acts beginning in 1800, which gave way to a permanent federal **bankruptcy** scheme in 1898. See An Act To Establish a Uniform System of **Bankruptcy** Throughout the United States, 30 Stat. 544; *Hanover Nat. Bank v. Moyses*, 186 U.S. 181, 184, 22 S.Ct. 857, 46 L.Ed. 1113 (1902). But Congress did not enter the field of municipal **bankruptcy** until 1933 when it enacted the precursor to Chapter 9, a chapter of the Code enabling an insolvent “municipality,” meaning a “political subdivision or public agency or instrumentality of a State,” 11 U.S.C. § 101(40), to restructure municipal debts. See McConnell & Picker, *When Cities Go Broke: A Conceptual Introduction to Municipal Bankruptcy*, 60 U. Chi. L.Rev. 425, 427, 450–451 (1993).

^[2] Congress has tailored the federal municipal **bankruptcy** laws to preserve the States’ reserved powers over their municipalities. This Court struck down Congress’ first attempt to enable the States’ political subdivisions to file for federal **bankruptcy** relief after concluding that it infringed the States’ powers “to manage their own affairs.” *Ashton v. Cameron County Water Improvement Dist. No. One*, 298 U.S. 513, 531, 56 S.Ct. 892, 80 L.Ed. 1309 (1936). Congress tried anew in 1937, and the Court upheld the amended statute as an appropriate balance of federal and state power. See *United States v. Bekins*, 304 U.S. 27, 49–53, 58 S.Ct. 811, 82 L.Ed. 1137 (1938). Critical to the Court’s constitutional analysis was that the State had first authorized its instrumentality to seek relief under the federal **bankruptcy** laws. See *id.*, at 47–49, 53–54, 58 S.Ct. 811.

^[3] Still today, the provision of the **Bankruptcy** Code defining who may be a debtor under Chapter 9, which we refer to here as the “gateway” provision, requires the States to authorize their municipalities to seek relief under Chapter 9 before the municipalities may file a Chapter 9 petition:

“§ 109. Who may be a debtor

.....

“(c) An entity may be a debtor under chapter 9 of this title if and only if such entity—

“(1) is a municipality;

“(2) is specifically authorized, in its capacity as a municipality or by name, to be a debtor under such chapter by State law, or by a governmental officer or organization empowered by State law to authorize such entity to be a debtor under such chapter....”

The States’ powers are not unlimited, however. The federal **bankruptcy** laws changed again in 1946 to bar the States *1945 from enacting their own municipal **bankruptcy** schemes. The amendment overturned this Court’s holding in *Faitoute Iron & Steel Co. v. Asbury Park*, 316 U.S. 502, 507–509, 62 S.Ct. 1129, 86 L.Ed. 1629 (1942) (rejecting contention that Congress occupied the field of municipal **bankruptcy** law). In *Faitoute*, the Court held that federal **bankruptcy** laws did not pre-empt New Jersey’s municipal **bankruptcy** scheme, which required municipalities to seek relief under state law before resorting to the federal municipal **bankruptcy** scheme. *Ibid.* To override *Faitoute*, Congress enacted a provision expressly pre-empting state municipal **bankruptcy** laws. Act of July 1, 1946, 60 Stat. 415.

^[4] The express pre-emption provision, central to these cases, is now codified with some stylistic changes in § 903(1):

“§ 903. Reservation of State power to control municipalities

“This chapter does not limit or impair the power of a State to control, by legislation or otherwise, a municipality of or in such State in the exercise of the political or governmental powers of such municipality, including expenditures for such exercise, but—

“(1) a State law prescribing a method of composition of indebtedness of such municipality may not bind any creditor that does not consent to such composition; and

“(2) a judgment entered under such a law may not bind a creditor that does not consent to such composition.”

The third provision of the **Bankruptcy** Code at issue is the definition of “State,” which has included **Puerto Rico** since it became a Territory of the United States in 1898. The first Federal **Bankruptcy** Act, also enacted in 1898, defined “States” to include “the Territories, the Indian Territory, Alaska, and the District of Columbia.” 30 Stat. 545. When Congress recodified the **bankruptcy** laws to form the Federal **Bankruptcy** Code in 1978, the definition of “State” dropped out of the definitional

section. See generally **Bankruptcy** Reform Act, 92 Stat. 2549–2554. Congress then amended the Code to reincorporate the definition of “State” in 1984. § 421, 98 Stat. 368–369, now codified at § 101(52). The amended definition includes **Puerto Rico** as a State for purposes of the Code with one exception:

“§ 101. Definitions

.....

“(52) The term ‘State’ includes the District of Columbia and **Puerto Rico**, except for the purpose of defining who may be a debtor under chapter 9 of this title.”

B

^[5] It is our task to determine the effect of the amended definition of “State” on the Code’s other provisions governing Chapter 9 proceedings. We must decide whether, in light of the amended definition, **Puerto Rico** is no longer a “State” only for purposes of the gateway provision, which requires States to authorize their municipalities to seek Chapter 9 relief, or whether **Puerto Rico** is also no longer a “State” for purposes of the pre-emption provision.

The parties do not dispute that, before 1984, **Puerto Rico** was a “State” for purposes of Chapter 9’s pre-emption provision. Accordingly, before 1984, federal law would have pre-empted the Recovery Act because it is a “State law prescribing a method of composition of indebtedness” for **Puerto Rico’s** instrumentalities that would bind nonconsenting creditors, § 903(1).

The parties part ways, however, in deciphering how the 1984 amendment to the definition of “State” affected the pre-emption *1946 provision. Petitioners interpret the amended definition of “State” to exclude **Puerto Rico** altogether from Chapter 9. If petitioners are correct, then the pre-emption provision does not apply to them. **Puerto Rico**, in other words, may enact its own municipal **bankruptcy** scheme without running afoul of the Code. Respondents, on the other hand, read the amended definition narrowly. They contend that the definition precludes **Puerto Rico** from “specifically authoriz[ing]” its municipalities to seek relief, as required by the gateway provision, § 109(c)(2), but that **Puerto Rico** is no less a “State” for purposes of the pre-emption provision than the other “State[s],” as that term is defined in the Code. If respondents are correct, then the pre-emption provision applies to **Puerto Rico** and bars it

from enacting the Recovery Act.

Respondents have the better reading. We hold that **Puerto Rico** is still a “State” for purposes of the pre-emption provision. The 1984 amendment precludes **Puerto Rico** from authorizing its municipalities to seek relief under Chapter 9, but it does not remove **Puerto Rico** from the reach of Chapter 9’s pre-emption provision.

1

^[6] ^[7] The plain text of the **Bankruptcy** Code begins and ends our analysis. Resolving whether **Puerto Rico** is a “State” for purposes of the pre-emption provision begins “with the language of the statute itself,” and that “is also where the inquiry should end,” for “the statute’s language is plain.” *United States v. Ron Pair Enterprises, Inc.*, 489 U.S. 235, 241, 109 S.Ct. 1026, 103 L.Ed.2d 290 (1989). And because the statute “contains an express pre-emption clause,” we do not invoke any presumption against pre-emption but instead “focus on the plain wording of the clause, which necessarily contains the best evidence of Congress’ pre-emptive intent.” *Chamber of Commerce of United States of America v. Whiting*, 563 U.S. 582, 594, 131 S.Ct. 1968, 179 L.Ed.2d 1031 (2011) (internal quotation marks omitted); see also *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. —, —, 136 S.Ct. 936, 946, 194 L.Ed.2d 20 (2016).

^[8] The amended definition of “State” excludes **Puerto Rico** for the single “purpose of defining who may be a debtor under chapter 9 of this title.” § 101(52) (emphasis added). That exception unmistakably refers to the gateway provision in § 109, titled “who may be a debtor.” Section 109(c) begins, “An entity may be a debtor under chapter 9 of this title if and only if” § 109(c). We interpret Congress’ use of the “who may be a debtor” language in the amended definition of “State” to mean that Congress intended to exclude **Puerto Rico** from this gateway provision delineating who may be a debtor under Chapter 9. See, e.g., *Sullivan v. Stroop*, 496 U.S. 478, 484, 110 S.Ct. 2499, 110 L.Ed.2d 438 (1990) (reading same term used in different parts of the same Act to have the same meaning); see also *Northcross v. Board of Ed. of Memphis City Schools*, 412 U.S. 427, 428, 93 S.Ct. 2201, 37 L.Ed.2d 48 (1973) (*per curiam*) (“[S]imilarity of language ... is ... a strong indication that the two statutes should be interpreted *pari passu*”). **Puerto Rico**, therefore, is not a “State” for purposes of the gateway provision, so it cannot perform the single function of the “State[s]” under that provision: to “specifically authoriz[e]” municipalities to seek Chapter 9 relief. §

Puerto Rico v. Franklin California Tax-Free Trust, 136 S.Ct. 1938 (2016)

195 L.Ed.2d 298, 84 USLW 4393, 75 Collier Bankr.Cas.2d 1318, 62 Bankr.Ct.Dec. 185...

109(c). As a result, **Puerto Rico's** municipalities cannot satisfy the requirements of Chapter 9's gateway provision until Congress intervenes.

^[9] The amended definition's use of the term "defining" also confirms our conclusion that the amended definition excludes *1947 **Puerto Rico** as a "State" for purposes of the gateway provision. The definition specifies that **Puerto Rico** is not a "State ... for the purpose of defining who may be a debtor under Chapter 9." § 101(52) (emphasis added). To "define" is "to decide upon," 4 Oxford English Dictionary 383 (2d ed. 1989), or "to settle" or "to establish or prescribe authoritatively," Black's Law Dictionary 380 (5th ed.1979). As discussed, a State's role under the gateway provision is to do just that: The State must define (or "decide upon") which entities may seek Chapter 9 relief. Barring **Puerto Rico** from "defining who may be a debtor under chapter 9" is tantamount to barring **Puerto Rico** from "specifically authorizing" which municipalities may file Chapter 9 petitions under the gateway provision. The amended definition of "State" unequivocally excludes **Puerto Rico** as a "State" for purposes of the gateway provision.

The text of the definition extends no further. The exception excludes **Puerto Rico** only for purposes of the gateway provision. **Puerto Rico** is no less a "State" for purposes of the pre-emption provision than it was before Congress amended the definition. The Code's pre-emption provision has prohibited States and Territories defined as "States" from enacting their own municipal **bankruptcy** schemes for 70 years. See 60 Stat. 415 (overturning *Faitoute*, 316 U.S., at 507–509, 62 S.Ct. 1129). Had Congress intended to "alter th[is] fundamental detail[]" of municipal **bankruptcy**, we would expect the text of the amended definition to say so. *Whitman v. American Trucking Assns., Inc.*, 531 U.S. 457, 468, 121 S.Ct. 903, 149 L.Ed.2d 1 (2001). Congress "does not, one might say, hide elephants in mouseholes." *Ibid*.

2

The dissent, adopting many of petitioners' arguments, reads the amended definition to say what it does not—that "for the purpose of ... chapter 9," **Puerto Rico** is not a State. The arguments in support of that capacious reading are unavailing.

^[10] First, the dissent agrees with petitioners' view that the exclusion of **Puerto Rico** as a "State" for purposes of the gateway provision effectively removed **Puerto Rico** from all of Chapter 9. See *post*, at 1952 – 1953 (opinion of

SOTOMAYOR, J.). To be sure, § 109(c) and the surrounding subsections serve an important gatekeeping role. Those provisions "specify who qualifies—and who does not qualify—as a debtor under the various chapters of the Code." *Toibb v. Radloff*, 501 U.S. 157, 161, 111 S.Ct. 2197, 115 L.Ed.2d 145 (1991). For instance, a railroad must file under Chapter 11, not Chapter 7, §§ 109(b)(1), (d), whereas only "family farmer[s] or family fisherm[e]n" may file under Chapter 12. The provision delineating who may be a debtor under Chapter 9 is no exception. Only municipalities may file under Chapter 9, and only if the State has "specifically authorized" the municipality to do so. §§ 109(c)(1)–(2); see also McConnell & Picker, 60 Chi. L. Rev., at 455–461 (discussing the gatekeeping requirements for Chapter 9).

^[11] ^[12] ^[13] That **Puerto Rico** is not a "State" for purposes of the gateway provision, however, says nothing about whether **Puerto Rico** is a "State" for the other provisions of Chapter 9 involving the States. The States do not "pass through" the gateway provision. *Post*, at 1953. The gateway provision is instead directed at the debtors themselves—the municipalities, in the case of Chapter 9 **bankruptcy**. A *municipality* that cannot secure state authorization to file a Chapter 9 petition is excluded from Chapter 9 entirely. But the same cannot be said about the *State* in which that municipality is located. A *1948 State's only role under the gateway provision is to provide that "authoriz[ation]" to file. § 109(c)(2). The pre-emption provision then imposes an additional requirement: The States may not enact their own municipal **bankruptcy** schemes. A State that chooses not to authorize its municipalities to seek Chapter 9 relief under the gateway provision is no less bound by that pre-emption provision. Here too, **Puerto Rico** is no less bound by the pre-emption provision even though Congress has removed its authority to provide authorization for its municipalities to file Chapter 9 petitions. Again, if it were Congress' intent to also exclude **Puerto Rico** as a "State" for purposes of that pre-emption provision, it would have said so.

Second, both petitioners and the dissent place great weight on the introductory clause of § 903. *Post*, at 1952. The pre-emption provision cannot apply to **Puerto Rico**, so goes the argument, because it is a proviso to § 903's introductory clause, which they posit is inapplicable to **Puerto Rico**. The introductory clause affirms that Chapter 9 "does not limit or impair the power of a State to control" its "municipalit[ies]." § 903. The dissent surmises that this clause "is irrelevant" and "meaningless" in **Puerto Rico**. *Post*, at 1952. Because **Puerto Rico's** municipalities are ineligible for Chapter 9 relief, Chapter 9 cannot "affect[t] **Puerto Rico's** control over its municipalities," according to the dissent. *Ibid*. In other

words, “there is no power” for the introductory clause to “reserve” for **Puerto Rico’s** use. *Ibid.* Petitioners likewise contend that “it would be nonsensical for Congress to provide **Puerto Rico** with a shield against intrusion by a Chapter that, by definition, can have no effect on **Puerto Rico**.” Brief for Petitioner **Commonwealth of Puerto Rico et al.** in No. 15–233, p. 25. So “it follows” that the pre-emption provision, the proviso to that clause, cannot apply either. *Ibid.*

This reading rests on the faulty assumption that **Puerto Rico** is, “by definition,” excluded from Chapter 9. *Ibid.* For all of the reasons already explained, see Part II–B–1, *supra*, it is not. The amended definition of “State” precludes **Puerto Rico** from authorizing its municipalities to seek Chapter 9 relief. But **Puerto Rico** is no less a “State” for purposes of § 903’s introductory clause and its proviso. Both continue to apply in **Puerto Rico**. They are neither “irrelevant” nor “meaningless.” *Post*, at 1952. If, for example, Congress created a path for the Puerto Rican municipalities to restructure their debts under Chapter 9, then § 903 would assure **Puerto Rico**, no less a “State” for purposes of this section, of its continued power to “control, by legislation or otherwise, [its] municipalit[ies] ... in the exercise of the political or governmental powers of such municipalit[ies].”

Third, the Government Development Bank contends that the Recovery Act does not run afoul of the pre-emption provision because the Recovery Act does not bind nonconsenting “creditors,” as the **Bankruptcy** Code now defines that term. In 1978, Congress redefined “creditor” to mean an “entity that has a claim against the debtor” 92 Stat. 2550, now codified at § 101(10) (emphasis added). A “debtor,” in turn, is a “person or municipality concerning which a case under this title has been commenced.” *Id.*, at 2551, now codified at § 101(13) (emphasis added). In light of these definitions, the Bank contends that the Puerto Rican municipalities are not “debtor[s]” as the Code defines the term because they cannot “commenc[e]” an action under Chapter 9 without authorization from **Puerto Rico**. Brief for Petitioner Acosta-Febo et al. 31–33. And because respondents cannot be “creditors” of a nonexistent “debtor,” the Recovery Act is not a “State law” that *1949 binds “any creditor.” § 903(1). *Id.*, at 31–33.

Tellingly, the dissent does not adopt this reading. The Bank’s interpretation would nullify the pre-emption provision. Applying the Bank’s logic, a municipality that fails to meet any one of the requirements of Chapter 9’s gatekeeping provision is not a “debtor” and would have no “creditors.” So a State could refuse to “specifically authoriz[e]” its municipalities to seek relief under Chapter 9, § 109(c)(2), required to commence a case under that

chapter. That State would be free to enact its own municipal **bankruptcy** scheme because its municipalities would have no “creditors” under federal law. The technical amendments to the definitions of “creditor” and “debtor” are too “subtle a move” to support such a “[f]undamental chang[e] in the scope” of Chapter 9’s pre-emption provision. *Kellogg Brown & Root Services, Inc. v. United States ex rel. Carter*, 575 U.S. —, —, 135 S.Ct. 1970, 1977, 191 L.Ed.2d 899 (2015).

¹¹⁴¹ The dissent concludes that “the government and people of **Puerto Rico** should not have to wait for possible congressional action to avert the consequences” of the Commonwealth’s fiscal crisis. *Post*, at 1953 – 1954. But our constitutional structure does not permit this Court to “rewrite the statute that Congress has enacted.” *Dodd v. United States*, 545 U.S. 353, 359, 125 S.Ct. 2478, 162 L.Ed.2d 343 (2005); see also *Electric Storage Battery Co. v. Shimadzu*, 307 U.S. 5, 14, 59 S.Ct. 675, 83 L.Ed. 1071 (1939). That statute precludes **Puerto Rico** from authorizing its municipalities to seek relief under Chapter 9. But it does not remove **Puerto Rico** from the scope of Chapter 9’s pre-emption provision. Federal law, therefore, pre-empts the Recovery Act. The judgment of the Court of Appeals for the First Circuit is affirmed.

It is so ordered.

Justice ALITO took no part in the consideration or decision of these cases.

Justice SOTOMAYOR, with whom Justice GINSBURG joins, dissenting.

Chapter 9 of the Federal **Bankruptcy** Code allows States’ “municipalities”—cities, utilities, levee boards, and the like—to file for federal **bankruptcy** with their State’s authorization. But the Code excludes Puerto Rican municipalities from accessing federal **bankruptcy**. 11 U.S.C. §§ 101(52), 109(c)(2). Because of this bar, **Puerto Rico** enacted its own law in 2014—the Recovery Act—to allow its utilities to restructure their significant debts outside the federal **bankruptcy** process.

The Court today holds that **Puerto Rico’s** Recovery Act is barred by § 903(1) of Chapter 9 of the **Bankruptcy Code**, which prohibits States from creating their own **bankruptcy** processes for their insolvent municipalities. § 903(1). Because Puerto Rican municipalities cannot

access Chapter 9's federal **bankruptcy** process, however, a nonfederal **bankruptcy** solution is not merely a parallel option; it is the only existing legal option for **Puerto Rico** to restructure debts that could cripple its citizens. The structure of the Code and the language and purpose of § 903 demonstrate that **Puerto Rico's** municipal debt restructuring law should not be read to be prohibited by Chapter 9.

I respectfully dissent.

I

The Commonwealth of **Puerto Rico** and its municipalities are in the middle of a fiscal crisis. *Ante*, at 1942. The combined debt of **Puerto Rico's** three main public utilities exceeds \$20 billion. These utilities *1950 provide power, water, sewer, and transportation to residents of the island. With rising interest rates and limited access to capital markets, their debts are proving unserviceable. Soon, **Puerto Rico** and the utilities contend, they will be unable to pay for things like fuel to generate electricity, which will lead to rolling blackouts. Other vital public services will be imperiled, including the utilities' ability to provide safe drinking water, maintain roads, and operate public transportation.

When debtors face untenable debt loads, **bankruptcy** is the primary tool the law uses to forge workable long-term solutions. By requiring a debtor and creditors to negotiate together and forcing both sides to make concessions within the limits set by law, **bankruptcy** gives the debtor a "fresh start," discourages creditors from racing each other to sue the debtor, prohibits a small number of holdout creditors from blocking a compromise, protects important creditor rights such as the prioritization of debts, and allows all parties to find equitable and efficient solutions to fiscal problems. See *Marrama v. Citizens Bank of Mass.*, 549 U.S. 365, 367, 127 S.Ct. 1105, 166 L.Ed.2d 956 (2007); *Young v. Higbee Co.*, 324 U.S. 204, 210, 65 S.Ct. 594, 89 L.Ed. 890 (1945).

These concerns are starkly presented in the context of municipal entities like public utilities. While a business corporation can use **bankruptcy** to reorganize, and, if that fails, fold up shop and liquidate all of its assets, governments cannot shut down power plants, water, hospitals, sewers, and trains and leave citizens to fend for themselves. A "fresh start" can help not only the unfortunate individual debtor but also—and perhaps especially—the unfortunate municipality and its people. See *United States v. Bekins*, 304 U.S. 27, 53–54, 58 S.Ct.

811, 82 L.Ed. 1137 (1938).

Congress has excluded the municipalities of **Puerto Rico** and the District of Columbia from the federal municipal **bankruptcy** scheme in Chapter 9 of the **Bankruptcy Code**. See 11 U.S.C. §§ 101(52), 109(c). So, in 2014, the Puerto Rican Government enacted the **Puerto Rico** Public Corporation Debt Enforcement and Recovery Act (Recovery Act or Act). 2014 Laws P.R. p. 371. The Act authorizes **Puerto Rico's** public utilities to restructure their debts while continuing to provide essential public services like electricity and water. Portions of the Act mirror Chapter 9 of the **Bankruptcy Code** and allow **Puerto Rico's** utilities to renegotiate their debts with their creditors. See *ante*, at 1942 – 1943. Like a restructuring plan filed under Chapter 9, a restructuring plan under the Recovery Act that is approved by at least a majority of creditors and a court would be binding on all creditors, including objecting holdouts.

After the Recovery Act was signed into law, mutual funds and hedge funds holding bonds of the **Puerto Rico** Electric Power Authority filed two lawsuits seeking to enjoin **Puerto Rico's** enforcement of the Act. The District Court held that the Recovery Act could not be enforced because, *inter alia*, it was prohibited by § 903(1) of the **Bankruptcy Code**. The First Circuit agreed that § 903(1) pre-empted the Act, and did not address whether some provisions of the Act might be unlawful for other reasons. This Court now affirms.

II

Bankruptcy is not a one-size-fits-all process. The Federal **Bankruptcy Code** sets out specific procedures and governing law for each type of entity that seeks **bankruptcy** protection. To see how this approach works, consider the structure of the Code in more depth.

*1951 Chapter 1 is the starting point. It sets out how to read the Code. See 11 U.S.C. § 101 *et seq.* For example, § 101 sets out general definitions, and § 102 provides rules of construction. Now skip ahead to § 109, titled, "Who may be a debtor." That section tells would-be debtors and the interested parties in their **bankruptcy** which specific **bankruptcy** laws apply to them. For example, § 109 tells an ordinary person seeking to restructure her debts to do so using the rules outlined in Chapter 7, § 109(b), or those enumerated in Chapter 13, § 109(e). It tells a family farm or fisherman to use the rules outlined in Chapter 12, § 109(f). Certain corporations can use Chapter 7, § 109(b), or Chapter 11, § 109(d). And a

municipality's **bankruptcy** is governed by the rules in Chapter 9. § 109(c)(1).

Because § 109 tells different kinds of debtors which bodies of **bankruptcy** law apply to them, the Court has described that section as a “gateway” provision. *Ante*, at 1944 – 1945. Once an entity meets the eligibility requirements for a specific “gateway” set out in § 109 and elects to pass through that gateway, it becomes subject to the relevant chapter of the Code—7, 9, 11, 12, or 13. The debtor, its creditors, and any other interested parties are governed only by that chapter and the chapters of the **Bankruptcy** Code—like Chapter 1—that apply to all cases. See § 103; 1 Collier Pamphlet Edition, **Bankruptcy** Code 2015, p. 59 (“[A]s a general rule, the provisions of the particular chapter apply only in that chapter”).

Interpreting statutory provisions in the context of the operative chapters in the **Bankruptcy** Code in which they appear is not unusual—it is how the Code is designed to work. For example, both Chapter 9 and Chapter 13 require the debtor to “file a plan” proposing how the court should reorganize its debts. Compare §§ 941–946 (“The Plan” under Chapter 9) with §§ 1321–1330 (“The Plan” under Chapter 13). But no **bankruptcy** court or practitioner would suggest that a Chapter 9 “plan” also has to satisfy the requirements of Chapter 13. The Code is read in context.

These cases concern § 109’s “gateway” for municipalities. That provision says that a municipality may file for **bankruptcy** under Chapter 9 if and only if it meets five eligibility criteria. The debtor must (1) be “a municipality,” § 109(c)(1); (2) be “specifically authorized ... by State law” to seek **bankruptcy** restructuring, § 109(c)(2); (3) be “insolvent,” § 109(c)(3); (4) have a “desir[e] to effect a plan to adjust” its debts, § 109(c)(4); and (5) have attempted to negotiate with its creditors, with some exceptions, § 109(c)(5).

The second eligibility requirement is relevant here. Only a municipality “authorized ... by State law” may pass through the “gateway” and file for **bankruptcy** under Chapter 9’s provisions. But Chapter 1’s definitional provision, which applies throughout the Code, provides that the “term ‘State’ includes the District of Columbia and **Puerto Rico**, except for the purpose of defining who may be a debtor under chapter 9 of this title.” § 101(52). It is undisputed that the “except for the purpose of defining who may be a debtor under chapter 9” clause is referring to the second eligibility prerequisite in § 109’s gateway provision. *Ante*, at 1945 – 1946. So, in short, **Puerto Rico** cannot “specifically authoriz[e]” any of its municipalities to apply for Chapter 9 **bankruptcy**. No

Puerto Rican municipality will thus satisfy the state authorization requirement of § 109’s gateway for municipalities, and so no Puerto Rican municipality can access Chapter 9.¹

*1952 The question in these cases is whether § 903(1), a pre-emption provision in Chapter 9, still applies to **Puerto Rico** even though its municipalities are not eligible to pass through the “gateway” into Chapter 9. It should not. Section 903 by its terms presupposes that Chapter 9 applies only to States who have the power to authorize their municipalities to invoke its protection.

Section 903 delineates the balance of power between the States that can authorize their municipalities to access Chapter 9 protection and the **bankruptcy** court that would preside over any municipal **bankruptcy** commenced under Chapter 9. To understand that interplay, and why § 903(1) does not pre-empt the Recovery Act, it is important to consider that statutory provision in context.

Section 903, titled “Reservation of State power to control municipalities,” reads in full:

“This chapter [Chapter 9] does not limit or impair the power of a State to control, by legislation or otherwise, a municipality of or in such State in the exercise of the political or governmental powers of such municipality, including expenditures for such exercise, but—

“(1) a State law prescribing a method of composition of indebtedness of such municipality may not bind any creditor that does not consent to such composition; and

“(2) a judgment entered under such a law may not bind a creditor that does not consent to such composition.”

This “reservation” of power to the States was added to the Code in response to this Court’s earlier recognition that States possess plenary control over their municipalities, particularly in fiscal matters. *Faitoute Iron & Steel Co. v. Asbury Park*, 316 U.S. 502, 509, 62 S.Ct. 1129, 86 L.Ed. 1629 (1942), overruled in part by Act of July 1, 1946, 60 Stat. 415. Section 903 says that States continue to possess those powers not implicated by the **bankruptcy** itself by noting that “[t]his chapter,” *i.e.*, Chapter 9, “does not limit or impair the power of a State to control” its municipalities. § 903. For example, even if a municipality is in Chapter 9 **bankruptcy**, a State could still revoke its charter.

Section 903, however, also subjects that broad reservation to an exception articulated in the pre-emption provision that the Court now says bars **Puerto Rico’s** Recovery

Puerto Rico v. Franklin California Tax-Free Trust, 136 S.Ct. 1938 (2016)

195 L.Ed.2d 298, 84 USLW 4393, 75 Collier Bankr.Cas.2d 1318, 62 Bankr.Ct.Dec. 185...

Act. States may control their municipalities, but they may not “prescrib[e] a method of composition of indebtedness of [a] municipality” that “bind[s] any creditor that does not consent to such composition.” § 903(1).

But this distribution of power between the State and the bankruptcy court is irrelevant to **Puerto Rico**. Because **Puerto Rico’s** municipalities cannot pass through the § 109(c) gateway to Chapter 9, nothing in the operation of a Chapter 9 case affects **Puerto Rico’s** control over its municipalities. The “reservation” preamble is therefore meaningless to **Puerto Rico**—there is no power to reserve from Chapter 9’s operation. And if this preamble does not and cannot apply to **Puerto Rico**, it follows that § 903(1)’s proviso qualifying that reservation of power to the States does not apply to **Puerto Rico** either. See, e.g., *United States v. Morrow*, 266 U.S. 531, 534–535, 45 S.Ct. 173, 69 L.Ed. 425 (1925).

This understanding of § 903 is fundamentally confirmed by the careful gateway *1953 structure the Code sets out for understanding how its chapters work together. See *Utility Air Regulatory Group v. EPA*, 573 U.S. —, —, 134 S.Ct. 2427, 2441, 189 L.Ed.2d 372 (2014) (“ ‘[W]ords of a statute must be read in their context and with a view to their place in the overall statutory scheme’ ” (quoting *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133, 120 S.Ct. 1291, 146 L.Ed.2d 121 (2000))). Chapter 1’s definitions section prevents **Puerto Rico** from defining “who may be a debtor under chapter 9” under § 109(c)’s gateway. Because of the structure of the Code, that change to Chapter 1’s definition has ripple effects. By amending the definition of State to exclude **Puerto Rico**, the District of Columbia, and their municipalities from § 109(c)’s gateway, Congress excluded **Puerto Rico** from Chapter 9 for all purposes—it shut the gate and barred it tight. And because Chapter 9’s process and rules by their terms can only affect municipalities and States eligible to pass through the gateway in § 109(c), that must mean that none of Chapter 9’s provisions—including § 903’s pre-emption provision—apply to **Puerto Rico** and its municipalities.

III

The Court rejects contextual analysis in favor of a syllogism. According to the Court, § 903(1) pre-empts all “State” composition laws like **Puerto Rico’s** that bind nonconsenting municipal creditors. “State” includes **Puerto Rico**, “except for the purpose of defining who may be a debtor under chapter 9 of this title,” § 101(52), which is a reference to § 109(c). Thus, according to the

Court, while the definition of “State” prevents **Puerto Rico** from authorizing its municipalities to seek Chapter 9 protection under § 109(c), it has no effect on the pre-emption clause in § 903(1).

The majority’s plain meaning syllogism is not without force. But it ignores this Court’s repeated exhortations to read statutes in context of the overall statutory scheme. *Utility Air*, 573 U.S., at —, 134 S.Ct., at 2441–2442. In context, for the reasons discussed, § 903 is directed to States that can approve their municipalities for Chapter 9 bankruptcy. Moreover, in an attempt to buttress its syllogism, the majority’s analysis makes an additional critical misstep.

The majority argues that, in light of the longstanding nature of the § 903(1)’s pre-emption provision to preclude state municipal bankruptcy laws, “[h]ad Congress intended to ‘alter this fundamental detail’ of municipal bankruptcy” to not apply to **Puerto Rico**, “we would expect the text of the amended definition to say so. Congress ‘does not, one might say, hide elephants in mouseholes.’ ” *Ante*, at 1947 (quoting *Whitman v. American Trucking Assns., Inc.*, 531 U.S. 457, 468, 121 S.Ct. 903, 149 L.Ed.2d 1 (2001); citation and brackets omitted). But the Court ignores that Congress already altered the fundamental details of municipal bankruptcy when it amended the definition of “State” to exclude **Puerto Rico** from authorizing its municipalities to take advantage of Chapter 9. Nobody has presented a compelling reason for why Congress would have done so, and the legislative history of the amendment is unhelpful.² Under either interpretation the scheme has been fundamentally *1954 altered by Congress. And, in context, the proper understanding of that alteration is that **Puerto Rico** and its municipalities have been removed entirely from Chapter 9—both from the benefits it provides and from the burden of the pre-emption clause in § 903(1).

Pre-emption cases may seem like abstract discussions of the appropriate balance between state and federal power. But they have real-world consequences. Finding pre-emption here means that a government is left powerless and with no legal process to help its 3.5 million citizens.

Congress could step in to resolve **Puerto Rico’s** crisis. But, in the interim, the government and people of **Puerto Rico** should not have to wait for possible congressional action to avert the consequences of unreliable electricity, transportation, and safe water—consequences that members of the Executive and Legislature have described as a looming “humanitarian crisis.” The White House, Addressing **Puerto Rico’s** Economic and Fiscal Crisis

Puerto Rico v. Franklin California Tax-Free Trust, 136 S.Ct. 1938 (2016)

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and Creating a Path to Recovery, p. 1 (Oct. 26, 2015) (italics deleted); Letter from Sen. Richard Blumenthal et al. to Charles Grassley, Chair, Senate Committee on the Judiciary (Sept. 30, 2015). Statutes should not easily be read as removing the power of a government to protect its citizens.

* * *

For the foregoing reasons, I would hold that § 903(1) of the Bankruptcy Code does not pre-empt Puerto Rico's Recovery Act. I respectfully dissent.

Footnotes

- * The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States v. Detroit Timber & Lumber Co.*, 200 U.S. 321, 337, 26 S.Ct. 282, 50 L.Ed. 499.
- * After the parties briefed and argued these cases, Members of Congress introduced a bill in the House of Representatives to establish an oversight board to assist Puerto Rico and its instrumentalities. See H. 5278, 114th Cong., 2d Sess. (2016). The bill does not amend the Federal Bankruptcy Code; it instead proposes adding a chapter to Title 48, governing the Territories. *Id.*, § 6.
- ¹ Puerto Rico was initially included in the scope of Chapter 9. § 1(29), 52 Stat. 842. But in 1984, Congress amended the Bankruptcy Code, without comment, to bar Puerto Rico and the District of Columbia from authorizing their municipalities to access Chapter 9. § 421(j)(6), 98 Stat. 368, codified at 11 U.S.C. § 101(52).
- ² The only comment on excluding Puerto Rico from Chapter 9 came from Professor Frank Kennedy, former Executive Director of the Commission on Bankruptcy Laws, who said: "I do not understand why the municipal corporations of Puerto Rico are denied by the proposed definition of 'State' of the right to seek relief under Chapter 9." Bankruptcy Improvements Act, Hearing on S. 333 et al. before the Senate Committee on the Judiciary, 98th Cong., 1st Sess., 326 (1983).

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UNITED STATES BANKRUPTCY COURT
MIDDLE DISTRICT OF FLORIDA
Tampa Division

IN RE: Case No. 8:14-bk-09521-MGW
BAYOU SHORES SNF, LLC, Chapter 11
Debtor.
_____ /

PATIENT CARE OMBUDSMAN'S NOTICE OF FILING SECOND REPORT

Robert Rosenthal, President of Health Care Management Specialist, Inc., the duly appointed Patient Care Ombudsman (the "Ombudsman") in this case filed by the Debtor Bayou Shores SNF, LLC, pursuant to 11 U.S.C. §333(b)(2), hereby gives Notice that on December 18, 2014, the Ombudsman is filing the Ombudsman's Second Written Report with the Court that is attached hereto as Exhibit "1."

Dated: December 18, 2014

SHAWDE & EATON, P.L.
Attorneys for Patient Care Ombudsman
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Weston, Florida 33326
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By: /s/ John D. Eaton
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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on December 18, 2014, the foregoing Notice of Filing and attached exhibit were served via CM/ECF transmission on all parties currently registered to receive e-mail notice/service for this case as set forth below.

By: /s/John D. Eaton
John D. Eaton

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4811-7606-8897, v. 1

EXHIBIT “1”

**UNITED STATES BANKRUPTCY COURT
MIDDLE DISTRICT OF FLORIDA
Tampa Division**

IN RE: Case No. 8:14-bk-09521-MGW
BAYOU SHORES SNF, LLC, Chapter 11
Debtor.
_____ /

PATIENT CARE OMBUDSMAN’S SECOND WRITTEN REPORT

Robert Rosenthal (“Mr. Rosenthal”), President of Health Care Management Specialist, Inc., the duly appointed Patient Care Ombudsman (the “Ombudsman”) in this chapter 11 case, pursuant to 11 U.S.C. §333(b)(2), hereby submits the Ombudsman’s Second Written Report (“Report”) as to the status of the quality of patient care being provided by the Debtor Bayou Shores SNF, LLC (the “Debtor”). In support thereof, the Ombudsman states as follows:

I. BACKGROUND

In the *Patient Care Ombudsman’s Initial Written Report* (the “Initial Report”)(D.E. 178-1), the Ombudsman set forth a summary of the procedural history that led to the filing of the Initial Report, as well as discussion of the background of the Ombudsman and the Registered Nurse and MSW, whose retention by the Ombudsman to assist the Ombudsman in the performance of his duties was authorized by the Court. In addition, the Initial Report contained a discussion as to the background as to what the Debtor does, and the regulations that govern the Debtor’s operations. The Ombudsman would direct the Court to the detailed discussion of these areas in the Initial Report, and which are incorporated herein by reference.

On November 20, 2014, the Debtor filed its *First Amended Disclosure Statement* (D.E. 185) and *First Amended Plan of Reorganization* (D.E. 186). The Ombudsman understands that a combined Disclosure Statement and Confirmation Hearing is scheduled for December 22, 2014 at 9:30 a.m.

Since the filing of the Initial Report, the Ombudsman has continued to fulfill his obligations and duties under the Bankruptcy Code and the Court’s Order directing his appointment. This Second Report is being submitted to the Court in accordance with the requirements of 11 U.S.C. §333(b)(2), and in light of the December 22, 2014 hearing date, is being filed a few weeks before the outside 60-day period requirement imposed by §333(b)(2) for subsequent reports.¹

¹ Pursuant to 11 U.S.C. §333(b)(2), the Ombudsman is required to report to the Court within 60 days of his appointment as to the quality of health care being provided to patients, and “not less frequently than at 60-day intervals thereafter.”

II. MONITORING OF THE DEBTOR AND PATIENTS

The Ombudsman (and the RN's and MSW assisting him) have continued with their monitoring of the care being provided to the patients, including gathering publicly available data, taking tours of the Debtor's Facility, meeting with senior management, Facility administrator, department heads, department supervisors and line staff, and interviewing residents/patients. In addition, we observed the general functioning of the Facility with respect to patient care, including but not limited to, weight loss reports, wound reports, restraint screening, antipsychotic medication reviews, activities, meal service, patient chart reviews, pharmacy consultant recommendations, resident council meeting, and interviews with residents, families, and staff. Like we did during the initial 60 day period covered by the Initial Report, we again observed the functioning, skills, and performance of management, and watching the interaction between representatives of the Debtor and the patients. In addition, we have continued with our review of patient records.

Upon arrival at the Facility for the Ombudsman's visits during this reporting period, the Ombudsman and nurses had an entrance meeting with the Administrator. After the entrance meeting, the Ombudsman and his RN or MSW assistants attend the Stand Up Morning Meeting² and then the morning Clinical Meeting. Generally, all department heads are in attendance at the Stand Up meeting. The administrator requests particular staff stay to attend the subsequent Clinical Meeting.

The morning meetings have continued to be comprehensive. In addition, the Clinical Meetings have continued to consistently address a number of current clinical issues or orders. In addition, an up to date elopement³ manual containing a policy and resident photos are reviewed (this was part of their corrective action for the elopement citation on the previous AHCA survey), plus they review any falls and any escalation of behavior of any residents has continued to be in place and used appropriately.

The tours of the Facility after the morning Clinical Meeting have continued to note that staffing assignments were posted on each unit, residents were noted to be appropriately groomed and dressed, resident rooms and public areas were noted to be clean and well organized. Other general observations during the current period covered by this Second Report and the Initial Report continue to be observed as follows:

- Each floor has a "Code Team" and on each staffing board, the code team is listed with the staff member's name and responsibility. Responsibilities listed include, Code Team Leader,

² The "Stand Up Meeting" refers to an early morning meeting generally scheduled for 9 a.m. which is attended by all department heads with each staff member supplying updates and information.

³ Elopement refers to a patient leaving the Facility without permission and/or as defined by CMS and the Facility's policies and procedures.

who is always a nurse; Transcriber, who is also always a nurse; and Crash Cart and 911 Caller.

- There is a Hydration Cart on each floor. Fluids as well as snacks were observed being offered to the residents on all three floors. Facility staff members offer fluids and snacks to patients three times daily.
- On the 2nd floor, which is the secured floor, there were staff members sitting outside the two different elevators on the unit. According to Facility staff, this practice continues 24 hours a day, seven days a week. This new practice is part of the updated elopement policy. This was observed on all three shifts.
- Also on the second floor, there is a private room that may be utilized as an isolation room because it has its own bathroom with a shower as well as an entry area with cabinets for personal protective equipment and a sink for hand washing. Staff members reported to the Ombudsman that this private room has also been utilized for hospice patients who are nearing the end of their lives in order to allow a more intimate and private setting for the resident and their family.
- There continues to be an active activities program ongoing during our tours.

MEAL OBSERVATION:

During this reporting period, on most visits, the Ombudsman and/or the RN continued to observe the lunch meal. On other visits, the breakfast and dinner meals were observed. The following was continued to be noted:

- There was generally one staff member passing trays to nine residents during the lunch meal. Breakfast and dinner had less staff present, but the number present was considered satisfactory.
- Hand washing practices were consistently followed.
- All residents sitting at the same table were served together.
- All residents were offered fluids at the beginning of the meal.
- Adaptive eating equipment (eating utensils that make eating easier for special needs residents) was being used by several of the residents.

CLINICAL RISK OBSERVATION:

On the continued visits during this reporting period, the RN/MSW and/or the Ombudsman continued to attend the clinical risk meetings that were held. These meetings generally last about one hour, at which as many as twelve staff members were present. Care plans were noted to be brought to the meeting. There was an attendance sign-in sheet passed around for all attendees to sign. As in the Initial Report, the following risk areas were discussed to be reviewed, which

included a discussion of the resident, the risk area, status of risk area, current, past and new interventions:

- Wounds – the wound care nurse reviewed all wounds which included, pressure ulcers, vascular ulcers, skin tears, and shearing and reported on those residents who have resolved wounds. At the meetings attended, all wounds were noted to be improving.
- Elopement – all equipment was reported to be in place and functioning properly. Elopement books are in place on all floors as well as the receptionist desk. The 24/7 attendant has been in place. The 24/7 attendant who is stationed by the elevators (in addition to their elopement books and other measures to identify those residents as elopement risks) was in response to the Immediate Jeopardy Finding on the July 11, 2014 Complaint and Recertification Survey by AHCA.
- Weights – all residents with weight gain, weight loss and receiving enteral feedings were discussed.
- Restraints – At these meetings, they discussed a limited number of residents with restraints. As of December 3, 2014, there were three residents that continue to require physical restraints. Record reviews by the RN indicate areas are in compliance.
- Contractures – all residents with contractures were continued to be discussed
- Falls – falls from the previous weeks were reviewed and all incidents reports were reviewed and interventions documented.
- Other Accident/Incident Reports – At each risk meeting, all other accident/incident reports that occurred since the last meeting were reviewed and interventions documented.
- On November 26, 2014, there was a new Restorative form reviewed by the clinical risk team and the Director of Nursing recommended that they use the form as a Quality Assurance item. On other dates, other new forms, if any, would be reviewed.
- On October 10, 2014, there was a discussion about a Performance Improvement Plan with stated improvement in the identified area, which related to falls on the 11 P.M. – 7 A.M. shift with on one fall this month on that shift. Since October 10, 2014, the Ombudsman's RN has reviewed reported falls since the last report and noted that there continues to be a further reduction in falls during the month of November from ten (10) falls in October to four (4) falls in November. The 11-7 shift has reported no falls for the month of November.

OTHER OBSERVATIONS:

We have continued to note the following general observations during this reporting period:

- Multiple staff and resident interactions;
- Staff smiling and friendly;
- Residents smiling and friendly;
- No odors noted.

a. Administration

As reported in the Initial Report, on our initial visit, the Ombudsman and his medical assistants met with Ms. T. Johnson, Administrator, M. Bokor, Management, and J. Kestler Corporate Administrator. The welcome was cordial and an introduction was given as to the purpose of the Ombudsman. An agreed upon plan was developed as to the Ombudsman's duties and how the Facility administration and staff would help assist the Ombudsman and his team in accomplishing their Court ordered duties. On subsequent visits, the team members would initiate their visit with an entrance conference with Ms. Johnson. On September 29, 2014, due to the resignation of Ms. Johnson, there was a change in administration and Mr. T. Martin became the licensed nursing home administrator. On subsequent visits, the Ombudsman and his team members would continue to meet with Mr. Martin and he was most helpful in assisting the Team accomplish their duties.

Most recently, on October 9, 2014, A. Pankhurst became the Nursing Home Administrator. Ms. Pankhurst told the Ombudsman that she is willing to become the permanent administrator. However, this is obviously dependent on the current status of the facility, and on the final outcome of the Decertification Action taken by CMS and AHCA and the Debtor's bankruptcy case. In the brief time Ms. Pankhurst had been at the facility, she has been helpful in enabling the Ombudsman and his RN and MSW Assistants to accomplish the Ombudsman's duties. During this reporting period Ms. Pankhurst continued to enable the Ombudsman and his RN and MSW Assistants to accomplish their duties and she continued to be both responsive and timely in our requests.

b. Pharmacy Consultant Recommendations

The Pharmacy Consultant that the Debtor has hired in the ordinary course of business focused in his recent reports to the Debtor on resident behaviors with monitoring and determined documentation was not consistent in September. The Facility's medication administration documentation has continued to improve with less omissions and there was improved and consistent monitoring of residents with behaviors. There were no medication errors noted for the months of November or December through the date of this report. The Facility continues to investigate alternate ways to document behaviors in the medical record.

c. Building and Fire Safety

As reported in the Initial report, the entire Facility is equipped with a fire sprinkler system as well as fire alarms activated / protected by detectors, and which can also be set off manually. There is an emergency generator for this facility.

During the current report period, the Ombudsman continued to find the following information accurate as provided in the Initial Report: An interview with the Director of Plant Operations provided the following information: major areas of safety are monitored daily, weekly and monthly as required including pest control, elevator safety, grease trap evacuation, water temperatures, smoking receptacles, exit doors, wander guard system, pull stations, fire extinguishers, generator function, air conditioner functioning, battery power lighting, kitchen hood, and laundry. The last building inspection at the Facility was completed on July 9, 2014 by Life Safety and the Facility received 4 tags consisting of K-038- exit doors, K-051- fire alarm system, K-062- sprinkler system, and K-076- oxygen storage. A plan of correction was submitted and all areas have been corrected, and are monitored at least weekly. The Facility conducts fire drills on all 3 shifts as required, as well as an annual internal and external disaster drill. The Facility's fire and disaster plan has been submitted to Pinellas County and is still awaiting approval.

d. Human Resources

The Director of Human Resources was interviewed and 4 records were reviewed of new hires to ensure compliance. All employee records reviewed contained an application, reference checks, background screening, as well as abuse, neglect, and elder crime reporting in servicing on hire. Agency usage continued to decline during this reporting period with additional nursing staff being hired and oriented. The MDS/Care Plan Coordinator was replaced with a nurse with certifications in MDS under the guidance of the facility's D.O.N. and facility's corporate R.N. which should improve the MDS and Care Plan documentation. The Facility staffing schedules for the upcoming holidays has been completed with no concerns noted with additional needs.

e. Social Services

The Social Service Director is new to the field of long-term care and has a background in working for hospice. She has been provided some training and support by a social worker from a sister facility. She will develop into a good department head but is in significant need of additional training to the requirements and regulations for SNF's. As of December 8, 2014, additional training had not taken place but the Administrator stated that the Social Worker from a sister facility was scheduled to continue the training in the next several weeks. A. Pankhurst, administrator, told the Ombudsman that the Social Worker (F. Blanton) received her first additional training on-site on December 10, 2014 and reviewed the role and responsibilities of the position of a social worker in a skilled nursing facility and specifically reviewed the job requirements. The Ombudsman understands that in the next thirty (30) days, F. Blanton is scheduled to visit a sister facility in order to observe the Social Worker's practice at that facility and to be mentored by that person. He further understands that a social worker consultant is available for follow-up visits with F. Blanton as needed.

f. Dietary

The meals and food at the Facility continue to get good reviews by residents, family, and staff. Dietary continues to be one of the strongest departments at the Facility. The general appearance of the dietary department is clean and well cared for. The attitude of the dietary personnel demonstrates good customer service training.

g. MDS/Care Plan

Upon the admission of any nursing home patient, federally mandated minimum data sets (“MDS”) must be filled out and a plan of care completed. Of the 30 charts reviewed, the Facility developed a complete plan of within seven (7) days of admission. We reviewed a sample of assessments for accuracy and that they were conducted by an RN and done and signed by the appropriate director. The MDS/Care Plan Coordinator was replaced with a nurse with certifications in MDS under the guidance of the Facility D.O.N. and facility corporate R.N. which should continue to improve the MDS and Care Plan documentation. Ombudsman and his R.N.’s will continue to monitor.

S. Hunziker, RN continued to review clinical practice and quality assurance programs. Specifically, she reviewed the following:

- Chart review of selected charts
- Clinical Review (checking systems supporting significant weight loss, skin integrity, medication dissemination and control, and various clinical practices).
- Sentinel Events reportable incidents)
- Weight Loss reports
- Decubitus Ulcer reports
- Pharmacy Consultant Recommendations and follow through.

h. RN and MSW Reviews

i. Quality Rounds with Director of Nursing

Facility Quality Rounds were continued to be conducted in all areas by the Ombudsman and the RN. A minimum of three (3) times during each visit, a facility quality round was done focusing on different times of the day. As part of the rounds the following meetings were attended: departmental stand-up, clinical stand-up, quality assurance, and risk management. Visits were conducted on all three shifts, as well as during a weekend shift. The following overall observations continued to be noted during the period of this report:

- a. Overall residents are out of bed dressed and groomed appropriately by mid morning in time for activities.
- b. Residents are clean and odor free.
- c. Staffing is posted daily and noted staff interactions with residents on a continuous basis.
- d. Medications are passed timely and resident interviews indicate no

concerns with pain control.

- e. Rooms are coded with dot system to indicate type of fluids residents can accommodate if any.
- f. Meals are served at bedside or in the dining rooms located on each floor.
- g. Menus are posted and followed. Alternatives are offered, and meals are served timely, and staff members are present in the dining areas to assist residents as needed. One floor offers a steam table and meals are served buffet style.
- h. Residents interviewed are happy with food and have no concerns.
- i. Activities are posted on each floor and conducted throughout the day in activity rooms and outside on the patio.
- j. Linen is abundant and in good condition.
- k. Equipment is clean and in good condition.
- l. Smoking area is equipped with smoking aprons, extinguishers, fire blankets, and an announcement system to alert others of a fire. Staff members are always available during smoking times for residents.
- m. Additional Observations Noted:
 - Trash and linen was noted on the floor on some wings during morning rounds. This was corrected after it was mentioned to Administration. There were no further concerns visualized with infection control standards throughout the facility during this reporting period.
 - Incontinence odors were noted on the 3rd floor at times, but seemed to be resolved by late morning. There were no further concerns noted during rounds with the incontinence odors.

ii. **Selected Chart Review**

A total of 72 charts have been reviewed as of December 3, 2014. The Ombudsman and his RN and MSW assistants will continue to review charts until the Ombudsman is relieved of any further responsibilities in this case.

Records selected were based on observation, request from administration, and random selection. Resident records were satisfactory. There are findings which are listed under initial findings at the conclusion of this report.

iii. **Clinical Review**

a. Restraints - As of December 3, 2014, there continues to be only three (3) residents requiring restraints. No additional restraint usage was noted.

b. Elopements – 72 of 72 resident records have elopement screens and wander guards are in place and monitored every shift. There have been no elopements during this reporting period

c. Smoking - There are currently 25 residents that request to smoke or use some type of tobacco in the Facility. Residents have current assessments and supervised by staff when outside.

d. Falls - There continues to be a reduction in the number of falls from July thru November. In July, 2014 there were 19 falls with 9 falls on the 11 p.m. - 7a.m. shift. In August, the total number of falls decreased to 10 with 4 on the 11-7 shift. The trend continued through October with total falls declining to 10 with 0 on the 11-7 shift and November numbers indicate only 4 falls with 0 on the 11-7 shift. Only one (1) significant injury occurred requiring an Emergency Room visit and there was a prompt return to the Facility. In December, there were only two (2) falls and neither resulted in an injury. Fall and Pain Assessments continue to be completed after any fall as well as care plan interventions updated to prevent falls with injury.

e. Psychoactive medications/Behaviors – Reviewed psychoactive med usage and behaviors for all 72 residents reviewed.

f. Dosages of doctor prescribed medications for behavior have been lowered to the lowest effective dosage at this time (this is called titration). Behaviors and meds are care planned, psychiatric services are available and provided if resident agrees. As of December 3, 2014, 72 residents were monitored and medical records appeared satisfactory.

iv. **Reportable Events**

During the period covered by this Second Report, there have been 2 reportable events called into the Department of Children and Families' Abuse hotline and/or local police. None were accepted by the Department of Children and Families nor substantiated as abuse, neglect, or exploitation by the Facility after it conducted its own follow-up and investigation.

v. **Weight Loss Records**

Weight loss report indicate three (3) patients with significant weight losses. Weights are documented consistently and have documentation to support the reasons for the weight loss, and indicate that each of them was unavoidable (*i.e.* beyond the control of anyone at the Facility). RD documentation is present and care plans updated. RN continued to follow up as well as significant weight changes are reviewed weekly in the facility Clinical Risk Meeting.

vi. Wound Reports

There are currently two (2) In House Acquired Wounds (*i.e.* wounds developed while a resident was in the facility) that have developed in late August to September, 2014. All have unavailability statements by the MD.⁴ All Medical record reviews indicate Braden scores⁵ current, wound documentation weekly and MD notes (wound care MD), weekly skin checks, and care plans present. Unavailability documentation is in place and signed by the MD.

The RN followed up and as of December 3, 2014, and all wounds have healed with the exception of two. One of these wounds is showing significant improvement and expected to heal by the end of the month. The second resident with a wound continues to require surgical intervention and debridement on a weekly basis. The wound is not expected to improve due to other clinical conditions that inhibit wound healing.

vii. Quality Indicator Report

CMS has a report called the MDS Quality Indicator (“QI’s”) Report which summarizes 24 quality indicators for nursing home residents. Quality Indicators are not definitive measures of the quality of care, but are “pointers” that indicate a potential problem area that may need further review for investigation. This tool can be used by the facility as a tool to rate its performance compared to the state and to target areas of care for improvement.

The Ombudsman and/or the RN reviewed the QI /QM for November, 2014. The Facility’s report reviewed by the Ombudsman and the Ombudsman R.N. was titled “CASPER Report: MDS 3.0 Quality Measure Monthly Comparison.” The QI/QM percentages reported in the Ombudsman’s Initial Report varied considerably from this month’s report because the information included in the Initial Report used a different index than that contained in this Report. Specifically, the Initial Report reflected a comparison between the Debtor and a national percentile, whereas the percentages included in this Second Report are the specific percentages at the Debtor’s Facility and are not measured against a national percentile.

- a. Hi Risk Pressure Ulcer – 10.5%: This indicator shows 10.5% of the residents in the Facility are at high risk for pressure ulcer formation. This is due to diagnosis, age, mobility, nutritional status, and skin concerns.

Follow up: With the MDS Care Plan Coordinator replacement, there has been an increase in the accuracy of the MDS. In addition, the Director of Nursing has provided increased education and monitoring of residents with high risk for wounds and follows in the weekly Clinical Risk Meeting.

- Certified Wound Care MD who visits weekly and assesses, measures, and gives treatment orders. The facility continues to complete weekly skin checks on

⁴ This information was obtained from CMS QI/QM Report.

⁵ Braden scores refers to a nationally recognized assessment score.

all residents on admission. This includes a daily check by non-licensed staff when providing ADL care.

The facility continues to utilize a wound care nurse that works Monday thru Friday and focuses on all wounds, assists MD with rounds and documentation, provides treatment to wounds and makes recommendations to RD and MD for treatment. The staff nurses on weekends were educated and in-serviced to provide wound care.

- Pressure reduction mattresses on all beds (in process of replacing all), and low air loss mattresses and roho cushions for residents with skin breakdown requiring enhanced pressure reduction,

- RD visits weekly to review and assess nutritional needs to encourage healing, and

- Clinical risk review weekly to review all skin and wound concerns.

b. Physical Restraints 4.7%: This indicator shows that 4.7% of the Facility residents had restraints.

Follow up: With the MDS Care Plan Coordinator replacement, there has been an increase in the accuracy of the MDS. In addition, the D.O.N. has provided increased education and monitoring of resident's potential for restraint usage and follows in the weekly Clinical Risk Meeting. All restraints are monitored by therapy at least monthly, and reviewed at Clinical Risk weekly for any side effects of restraint usage.

c. Antipsychotic medications short term – 4.3%, Antipsychotic medications long term – 34.8%, and Behaviors affecting others 38.3% .

Antipsychotic medication and behaviors affecting others indicators show the percentages of residents who take antipsychotic medications or who have behaviors that affect other residents.

Follow up: Review by the Director of Nursing indicated that these numbers are to be expected due to the type of residents that reside at the Facility which includes psychiatric diagnosis, behaviors affecting others, and end stage dementia. The Facility has four (4) psychiatrists/psychologists and MSW who visit the Facility at least 3-4 days a week to evaluate and treat any residents with psychiatric diagnosis, psychoactive medication usage, and inappropriate behaviors. Services that these groups provide at the Facility include focus treatment of high psychotic younger residents, treatment for Dementia / Alzheimer's Disease, behavior management, holistic approaches to treatment, medication management, titration and monitoring, drug and alcohol therapy, and group therapy. The licensed staff conduct quarterly evaluations to evaluate any movement disorders that have developed due to psychoactive medication usage, monitoring of targeted behaviors every shift to warrant medication usage, and weekly clinical risk meetings to ensure that proper diagnosis, lowest effective dosage, and behavior monitoring are all in compliance.

With the MDS Care Plan Coordinator replacement, there has been an increase in the accuracy of the MDS. In addition, the D.O.N. has provided increased education and monitoring of resident's potential for restraint usage and follows in the weekly Clinical Risk Meeting.

d. Increased ADL Help. 21% : This indicator shows that 21.2% of residents in the Facility require increased help with activities of daily living than previously reported.

Follow up: The Director of Nursing has investigated and determined this is an educational issue with the staff who document help with activities of daily living in their electronic record called CareTracker. This data is retrieved by the MDS Coordinator and implemented in the assessment record. The Facility has determined that there have been no declines in resident activity needs and have re-educated staff on proper documentation from observation. The Director of Nursing will monitor this area, as well as therapy, and review next month's indicators for improvement.

With the MDS Care Plan Coordinator replacement, there has been an increase in the accuracy of the MDS. In addition, the D.O.N. continues to educate and monitor those employees who utilize Care Tracker to ensure the documentation is correct.

i. Patient and Family Interviews

The Ombudsman and/or his nursing assistants have continued to meet with and interview residents and/or their families on each floor of the Facility. Residents and families stated their care was good or satisfactory with food noted as the highest rated department. Most concerns have been addressed to the residents' or families' satisfaction. The Ombudsman has indicated to the Administrator and the Director of Nursing several further opportunities to alleviate the concerns of several residents or family members. The RN has not received any concerns from residents or families during this reporting period to the Court.

j. Resident Council

The Resident Counsel is a meeting of any and all residents who want to participate, with a president (the Resident Counsel President) who is elected by the residents. The Resident Council President was interviewed by the Ombudsman's MSW assistant and the resident said she had a hard life. She attributes the Facility as being responsible for saving her life. Approximately 20-25 residents attend the monthly meetings. The President stated concerns by residents are taken seriously and are acted upon by Facility staff. The residents are overall pleased with each department.

The Ombudsman's RN continued to follow up on Resident Council concerns regarding snack machines. The Facility is in the process of providing snack machines outside in the smoking/activity area for residents to utilize if they desire.

k. Admissions & Census

Starting from November 7, 2014, there have been eight (8) admissions which is a combination of new admissions and residents who had been discharged from the hospital and who returned to the Facility from. Since November 10, 2014, the Facility has had a total of ten (10) resident discharges either to another facility or to a hospital. The Ombudsman understands that the Facility chose to restart new admissions after the filing of the Ombudsman's initial Report to the Court.

The Facility Census on December 15, 2014 was 86 residents, consisting of 85 in-house residents and one (1) bed hold for a resident.

l. Current Staffing

Staffing schedules were reviewed and staffing meets State Regulations. If the Facility has call-ins for sickness and is unable to replace staff with their own, then they make use of agency personnel. According to the Director of Nursing, all nursing positions have been filled other than three (3) part time CNA positions.

III. AHCA & OTHER SURVEYS

During the period covered by this Second Report, the Ombudsman is not aware of any further surveys by AHCA or CMS at the Debtor's Facility.

IV. ADDITIONAL FINDINGS DURING THE PERIOD OF THIS REPORT

- a.** Loss of key staff from resignations. Loss of staff has included T. Johnson, Administrator, and T. Martin interim administrator from a sister facility. In addition, the social service director recently left and was replaced with an MSW who is most capable but requires training for SNF requirements. The MSW's previous position was with Hospice. As of December 8, 2014, the MSW has not received the additional training from the sister facility social worker. In addition, the MDS Care Plan Coordinator has been replaced during this reporting period; but upon initial review, it is believed that the new MDS Coordinator is doing a good job. The Ombudsman's R.N. will continue to monitor the new Social Worker's training and the work of the new MDS coordinator until the Ombudsman is relieved of any further responsibilities in this case.
- b.** The R.N. noted the following observations for Facility Q.A. and follow up for opportunities for improvement which must be addressed are:
 - i.** The Facility had not been timely in its resident quarterly assessments in the prior reporting period. Record reviews indicate this has been resolved through the audit process developed by the Director of Nursing.
 - ii.** There was a need for staff to review monthly the physicians' orders to ensure old discontinued meds have been deleted from the physician orders in the

prior reporting period. Record reviews indicate that this has been resolved through auditing, education and ongoing monitoring by the Director of Nursing.

- iii. Care Plans were identified in the prior reporting period to need to be more specific, especially concerning activities for residents off the grounds when unsupervised and non-compliant behaviors and the care plans need to be more specific for wounds or weight loss. With the MDS Plan Coordinator replacement, there has been an increase in the accuracy of the MDS and care plans are more specific with appropriate interventions. This process will continue to be monitored until the end of the Patient Care Ombudsman's Court Appointment.

- c. The Consultant Pharmacist focused his findings on November 20, 2014:

- i. Noted eye drops and inhaler have no date opened on label.
- ii. Noted expired stock drug from date opened.
- iii. Noted few omissions on the inventory log

All areas were corrected the same day as the Consultant Visit. The Director of Nursing provided follow-up education in these areas and will monitor for further compliance.

V. ADDITIONAL RECOMMENDATIONS

In the Initial Report, the Ombudsman set forth a number of Initial Recommendations to the Debtor and Management they should or can do to improve upon the services and care being provided. The Ombudsman noted that the Debtor has put in a MDS communication tool and monitored it to assure compliance.

In addition, the Ombudsman had recommended the following additional items for Management to consider and/or implement. The updates are as follows:

- a. With respect to Clinical Review and Quality Assurance and Improvement, it is noted that on the Facility's secured/locked second floor, clarification would be beneficial to distinguish between secured policies from that of a locked unit policy. The administrator advised the Ombudsman that they have revised the admission policy and revised its brochure to no longer indicate a secure unit. The Facility is also in the process of obtaining a letter from each resident that they understand they are on a limited access floor.
- b. AIM's testing does not appear to be timely completed on a consistent basis. Update policies to ensure testing timely. The Facility has put in an MDS communication tool and monitors it to assure compliance.

- c. Issues with documentation omissions on Medication Records and Medication effectiveness documentation. Re-education of licensed staff by Director of Nursing on medication documentation with improvement was noted.
- d. We noted some residents without a diagnosis for medications. Thereafter, re-education was conducted by the Director of Nursing as to the need to include diagnosis on all medications given. These areas identified by the Pharmacy consultant were noted as corrected. Continue to provide additional education in this area to assure continued compliance.
- e. The Ombudsman and his RN and MSW assistants will continue to monitor the care being provided to patients during the upcoming 60 day period until his next required report or until the Ombudsman is discharged of any further responsibility by the Court.

VI. CONCLUSION

This report is the second report of the Ombudsman and is a summarization based upon numerous visits, interviews, meetings and document reviews conducted with management at all levels, staff and patients and/or guardians and family members to date. Those interviewed or spoken with have been cooperative in providing information to the Ombudsman, the RN and MSW, producing data and reports, and appear to have responded to questions in an honest and open fashion. As noted in his Initial Report, the Ombudsman continues to assume that the Debtor and others have provided all information requested and have not hidden or withheld anything from the Ombudsman, the RN, and the MSW. The Ombudsman has once again made a best effort, within the time constraints, to conduct a comprehensive review and assessment of the quality of care at the Debtor's Facility for the period in question, as set forth in this Report.

Based upon the information reviewed to date, and the observations during this period since the filing of the Initial Report, the Ombudsman believes that the health and welfare of the patients at the Debtor's Facility continue to be satisfactorily and adequately provided.

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Dated: December __, 2014

By: 
Robert Rosenthal, President of Health Care
Management Specialist, Inc., as Patient Care
Ombudsman

No. 15-13731-FF
In The United States Court of Appeals
for the Eleventh Circuit

BAYOU SHORES, SNF, LLC,

Appellant

v.

FLORIDA AGENCY FOR HEALTH
CARE ADMINISTRATION and THE
UNITED STATES OF AMERICA, ON
BEHALF OF THE SECRETARY OF THE
UNITED STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES,

Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF FLORIDA, TAMPA DIVISION

Case No. 8:14-cv-02816-T-30 (Lead Case) as consolidated with
8:14-cv-02617-T-30; 8:15-cv-00103-T-30; 8:15-cv-00128-T-30

THE HONORABLE JAMES S. MOODY, JR.

APPELLANT BAYOU SHORES, SNF, LLC'S
PETITION FOR REHEARING *EN BANC*

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**CERTIFICATE OF INTERESTED PERSONS AND CORPORATE
DISCLOSURE STATEMENT BY COUNSEL FOR APPELLANT**

Appellant, Bayou Shores, SNF, LLC, (“Bayou”), by and through its undersigned counsel and pursuant to Rule 26.1 of the Federal Rules of Appellate Procedure and Eleventh Circuit Rule 26.1, hereby re-files its certificate of interested persons and corporate disclosure statement and identifies the following persons and entities:

CORPORATE DISCLOSURE STATEMENT

In accordance with Fed. R. App. P. 28(a)(1), 26.1(a) and Eleventh Circuit Rule 26.1-2, Bayou files this statement disclosing that no parent corporation or any publicly held corporation owns or has ever owned any stock in Bayou.

CERTIFICATE OF INTERESTED PERSONS

AKERMAN SENTERFITT

BAKER, DONELSON, BEARMAN, CALDWELL & BERKOWITZ, PC

BAKER & HOSTETLER LLP

BARNETT, DENISE

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LUPINACCI, TIMOTHY M.

MATHEWS, MARGARET DIANE

MOODY, JR., HON. JAMES S.

MURPHY-DAVIS, COLLEEN

PARRISH, JIMMY D.

PAYNE, TIFFANY D.

PINELLAS COUNTY TAX COLLECTOR (NF)

SHEERAN, ANDREW T.

STREET, LESLIE G.

SYNOVUS BANK

TERZO, FRANK P.

THE UNITED STATES OF AMERICA, ON BEHALF OF THE SECRETARY
OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN
SERVICES

UNITED STATES TRUSTEE

VITALE, MICHAEL S.

WILLIAMS, STUART F.

WILLIAMSON, HON. MICHAEL G.

TABLE OF CONTENTS

CERTIFICATE OF INTERESTED PERSONS AND CORPORATE DISCLOSURE STATEMENT BY COUNSEL FOR APPELLANT	1
CORPORATE DISCLOSURE STATEMENT	1
CERTIFICATE OF INTERESTED PERSONS	1
STATEMENT OF COUNSEL PURSUANT TO 11th Cir. R. 35-5(c)	iv
STATEMENT OF THE ISSUES MERITING <i>EN BANC</i> CONSIDERATION.....	1
STATEMENT OF THE COURSE OF PROCEEDINGS AND DISPOSITION OF THE CASE	1
STATEMENT OF FACTS	3
ARGUMENT AND CITATION OF AUTHORITY	9
CONCLUSION.....	15
CERTIFICATE OF COMPLIANCE	17
CERTIFICATE OF SERVICE	17

TABLE OF AUTHORITIES.

	Page(s)
Cases	
<i>Bd. of Governors of Fed. Reserve Sys. v. MCorp., Fin., Inc.</i> , 502 U.S. 32 (1991).....	15
<i>Bowen v. Michigan Academy of Family Physicians</i> , 476 U.S. 667 (1986).....	14
<i>Central Va. Community College v. Katz</i> , 546 U.S. 356 (2006).....	11
<i>In re Custom Contractors, LLC</i> , 745 F.3d 1342 (11th Cir. 2014)	12
<i>Heckler v. Ringer</i> , 466 U.S. 602 (1984).....	13
<i>Jove Eng'g, Inc. v. I.R.S.</i> , 92 F.3d 1539 (11th Cir. 1996).....	13
<i>Kaiser v. Blue Cross of California</i> , 347 F.3d 1107 (9th Cir. 2003)	12
<i>Mathews v. Eldridge</i> , 424 U.S. 319 (1976).....	15
<i>In re Neavear</i> , 674 F.2d 1201 (7th Cir. 1982)	15
<i>Shalala v. Illinois Council on Long Term Care, Inc.</i> , 529 U.S. 1 (2000).....	14, 15
<i>In re Town & Country Home Nursing Servs., Inc.</i> , 963 F.2d 1146 (9th Cir. 1991)	iv, 10
<i>Tug Allie-B, Inc. v. U.S.</i> , 273 F.3d 936 (11th Cir. 2001)	11
<i>U.S.A. v. MacLeod Co., Inc. (In re MacLeod Co, Inc.)</i> , 935 F.2d 270 (6th Cir. 1991)	13

<i>United States v. Devall</i> , 704 F.2d 1513 (11th Cir. 1983)	12
<i>United States v. Mitchell</i> , 463 U.S. 206 (1983).....	12
<i>In re Univ. Md. Ctr.</i> , 973 F.2d 1065 (3d Cir. 1992)	iv, 10
<i>Weinberger v. Salfi</i> , 422 U.S. 749 (1975).....	13

Statutes

11 U.S.C. § 105(a)	6
11 U.S.C. § 106.....	11, 12, 13, 15
11 U.S.C. § 333	7
11 U.S.C. § 362(a)	4
11 U.S.C. § 365	7, 8, 12, 15
11 U.S.C. § 541(a)	4
11 U.S.C. § 1101(2)	9
11 U.S.C. §§1334	4, 11
42 U.S.C. § 405(g)	12
42 U.S.C. § 405(h)	1, 14
Contract Disputes Act	13
Medicare Act	9, 15

Rules

<u>11th Cir. R. 35-5(c)</u>	iv

Other Authorities

Panel Opinion, p. 27, ...	12

STATEMENT OF COUNSEL PURSUANT TO 11TH CIR. R. 35-5(C)

We express a belief, based on a reasoned and studied professional judgment, that this appeal involves questions of exceptional importance and upon which a split of circuit court authority exists concerning a bankruptcy court's jurisdiction to preside over a Chapter 11 reorganization of a health care business when the business is pursuing administrative review of a decision to terminate its provider agreements. *En banc* rehearing is warranted in order for the Eleventh Circuit to consider as a whole whether to depart from the precedent of other circuits, *see, e.g., In re Town & Country Home Nursing Servs., Inc.*, 963 F.2d 1146 (9th Cir. 1991); *In re Univ. Md. Ctr.*, 973 F.2d 1065 (3d Cir. 1992), thereby creating a split of authority on a question of exceptional importance about the jurisdiction of bankruptcy courts to resolve all matters connected to the bankruptcy estate.

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Bayou Shores SNF, LLC

/s/ Tiffany D. Payne
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/s/ Jeffrey T. Kuntz
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STATEMENT OF THE ISSUES
MERITING *EN BANC* CONSIDERATION

The issues meriting *en banc* consideration are, if a health care business has timely presented a claim in the proper administrative forum before filing a Chapter 11 case, whether 42 U.S.C. § 405(h) (“405(h)”) deprives a bankruptcy court of jurisdiction to: (i) evaluate whether or not the debtor’s provider agreements finally and irreversibly terminated before the Chapter 11 case was filed, and if not, (ii) determine whether the automatic stay protects the agreements, and, if so, (iii) enjoin termination of the agreements while the debtor proceeds through the administrative process, and (iv) permit the debtor to assume the agreements in a reorganization plan before the administrative review process is complete?

STATEMENT OF THE COURSE
OF PROCEEDINGS AND DISPOSITION OF THE CASE

After the Bankruptcy Court entered orders confirming (“Confirmation Orders”) Bayou Shores, SNF, LLC’s (“Bayou”) Chapter 11 plan (“Plan”) assuming its Medicare and Medicaid provider agreements finding that Bayou had cured pre-petition defaults under the agreements and provided adequate assurance it could perform its obligations under the agreements in the future, the District Court reversed the Confirmation Orders finding that the Bankruptcy Court lacked jurisdiction to enter them because Bayou had not exhausted its administrative remedies. (Dist. Ct. Doc. No. 72) (“Reversal Order”). Appeals of the Confirmation Orders were taken after Bayou substantially consummated the Plan.

Bayou sought a stay of the Reversal Order while it appealed the Reversal to the Eleventh Circuit. On July 20, 2015, the District Court entered an order partially granting Bayou's motion and authorizing a ninety [90] day stay noting that Bayou "may seek an additional stay from the Eleventh Circuit if it so chooses". When the stay expired before the appeal to the Eleventh Circuit was fully briefed, and pursuant to the District Court's instructions, on September 17, 2015, Bayou moved the Eleventh Circuit for a further stay pending appeal, which the Eleventh Circuit denied on October 8, 2015.

On October 14, 2015, Bayou moved the Eleventh Circuit to reconsider its ruling. On October 16, 2015, the Eleventh Circuit partially granted Bayou's motion, extending the stay for ten [10] days and directing Bayou to return to District Court to seek any further stay which Bayou quickly did. After an evidentiary hearing, the District Court entered an order granting a further stay concluding that (i): there is "no binding authority" on whether 405(h) deprives a bankruptcy court of jurisdiction; (ii) the issue is one of "first impression for the Eleventh Circuit" and one upon which the circuit and lower courts disagree. (Dist. Ct. Doc. No. 101, p. 3). In granting a stay, the District Court further concluded:

[A]bsent a stay, [Bayou Shores] high risk patients would be irreparably harmed because they require a skilled facility that can accommodate their needs. They also need stability and a daily routine that does not change. The Court also finds that, as of this date, it is un rebutted that Bayou Shores is operating in substantial compliance with all applicable regulatory requirements. Its patients are receiving

adequate care and do not want to leave the facility. [An administrator] testified that many of the patients' family members and/or guardians refused to transfer their loved ones despite the uncertainty of Bayou Shores' future because they are happy with Bayou Shores' care.

...

Bayou Shores' appeal boils down to a jurisdictional issue - one that the Eleventh Circuit has not addressed to date. During the pendency of that appeal, Bayou Shores is faced with closing its operations and displacing its staff and patients if the Court does not grant its request for a stay. After considering the evidence, the Court finds that Bayou Shores has met its burden to establish a stay. There is certainly substantial evidence of irreparable harm - to Bayou Shores, its patients, the patients' family and guardians, and the public. In contrast, an additional stay will not harm AHCA or HHS.

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.

On March 25, 2016, briefing in the Eleventh Circuit was complete. Oral argument was held on March 31, 2016 and on July 11, 2016 the Panel affirmed the Reversal Order.

STATEMENT OF FACTS

Bayou is a skilled nursing facility that cares for severely ill patients who are difficult to place due to the type and severity of their illnesses. (Dist. Ct. Doc. No. 77, Ex. E; Doc. No. 89, Exh. I). Most patients have mental illnesses such as schizophrenia or bi-polar disorder and also Alzheimers or dementia (Bk.Ct. Doc. No. 6, Comp. Exh. A; Doc. No. 25, Exh. E, p. 2, ¶3), and nearly all are indigent,

relying upon Medicaid to pay for their care. (Dist. Ct. Doc. No. 77, Ex. C). Medicaid funds supplied over 90% of Bayou's income. (Bk.Ct. Doc. No. 25, p. 3).

Bayou received three serious negative findings following surveys performed by the Agency for Healthcare Administration for the State of Florida ("AHCA"), which recommended to the United States of America, Department of Health and Human Services ("HHS") termination of Bayou's Medicare and Medicaid provider agreements. Bayou timely sought review of this decision in the administrative forum. To avoid the immediate cessation of its business, Bayou filed a Chapter 11 case before the termination process was complete, invoking the Bankruptcy Court's jurisdiction pursuant to 11 U.S.C. §§1334 ("1334") and 157(b) and the protection of the automatic stay of 11 U.S.C. § 362(a) ("362(a)") afforded to property of the estate pursuant to 11 U.S.C. § 541(a).

Seven [7] days later and without requesting relief from stay, a large team of AHCA personnel dropped letters at patient bedsides. The letters informed the patients their Medicare and Medicaid benefits would be terminated and that they were welcome to remain at Bayou if they paid for their own care (the "Patient Letters"). (Bk. Ct. Doc. No. 25, Exh. C). Twenty four [24] of Bayou's long term residents were over 80 years old. (Dist. Ct. Doc. No. 77, p. 2; Ex. A). Twenty seven [27] residents were over 65 and had lived in Bayou for over five [5] years.

Id. There was simply no way for these elderly, indigent, and severely ill patients to pay for their own care.

In response, Bayou filed an emergency motion with the Bankruptcy Court requesting a finding that the automatic stay applied and/or a temporary injunction to protect the flow of funds to the patients and to allow Bayou to remain open while it pursued its administrative remedies. (“Emergency Motion”). (Bk. Ct. Doc. No. 25). Bayou employed approximately 168 people and housed 129 patients. (Bk. Ct. Doc. No. 6, p. 7). Absent the automatic stay, Bayou would have had to terminate its employees and discharge its patients. AHCA filed no response to the Emergency Motion. Counsel for HHS argued that: (i) the provider agreements had already terminated, (ii) the Bankruptcy Court lacked subject matter jurisdiction over them, and regardless, (iii) the automatic stay did not apply because AHCA’s actions in delivering the Patient Letters fell within the police power exception in 362(b)(4). (Bk. Ct. Doc. No. 42, pp. 2, 6-16).

After taking evidence and testimony regarding the termination process, the Bankruptcy Court concluded neither agreement had terminated, carefully limiting its analysis to whether termination had, or had not, finally and irreversibly occurred (Bk. Ct. Doc. No. 80, pp. 112-19), never questioning the wisdom of HHS and AHCA in deciding to terminate, and specifically recognizing that HHS and AHCA elected to terminate as a result of serious deficiencies that occurred before

the Chapter 11 case. (Bk. Ct. Doc. No. 80, p. 71, *ll.* 9-25; p. 72, *ll.* 1-8).¹ The Bankruptcy Court also concluded AHCA was acting in its pecuniary interests and not acting to protect patient health, safety and welfare in delivering the Patient Letters, so the automatic stay applied. (Bk. Ct. Doc. No. 35, ¶¶ 4, 7).

Further, after receiving testimony on the potential harm to Bayou's psychiatric patients if they were forcibly removed ("transfer trauma"), the Bankruptcy Court temporarily enjoined AHCA pursuant to 11 U.S.C. § 105(a) ("105(a)") from removing patients and terminating their benefits while Bayou proceeded through the administrative process since, at the end of the process, it was possible the decision to terminate the agreements may be reversed by a reviewing court. (Bk. Ct. Doc. No. 35, ¶¶ 8-7). AHCA and HHS separately appealed this decision to the District Court but failed to seek a stay pending appeal (collectively, "First Appeals"). (Bk. Ct. Doc. Nos. 88, 156). The District Court consolidated the First Appeals and the Chapter 11 case continued, unstayed.

Meanwhile, the Bankruptcy Court approved Bayou's retention of an expert in patient care and regulatory compliance to oversee Bayou's operations and to recommend and implement any necessary operational or procedural changes so Bayou would remain in compliance during the Chapter 11 case. (Bk. Ct. Doc. No.

¹ Rendering a determination on whether or not a termination had occurred is analytically different than reviewing the reasons behind the decision to terminate; the former is a question of "if" and the latter is a question of "why."

153 and 175). The Bankruptcy Court also appointed an independent patient care ombudsman (“PCO”) pursuant to 11 U.S.C. § 333 (“333”) to oversee patient welfare. The PCO filed two reports concluding Bayou’s patients were well cared for and content. (Bk. Ct. Doc. Nos. 178, 252). Bayou paid over \$126,000 in fees and costs for expert oversight and the PCO. (Bk. Ct. Doc. Nos. 295, 302, 303).

Also early on in the Chapter 11 case, the patients, desperate to remain at Bayou, requested a mediation between Bayou, AHCA, and HHS. (Bk. Ct. Doc. Nos. 83, 112). AHCA and HHS opposed mediation (Bk. Ct. Doc. Nos. 93 and 121), which impasssed. Never during the Chapter 11 case did AHCA or HHS visit Bayou to evaluate patient welfare; they had made their decision, and no amount of effort or expense put forth by Bayou towards patient care and compliance would make a difference, nor would the pleas of the patients, their doctors, families or guardians to allow patients to remain at Bayou and still receive benefits during the administrative process. AHCA believed Bayou’s “current quality of care [was] irrelevant.” (Dist. Ct. Doc. No. 93, p. 11). In fact, AHCA recommended transfer of Bayou’s patients to facilities on a “watch list” for conditions posing immediate jeopardy. (Dist. Ct. Doc. No. 89, Exh. I).

As the First Appeals were pending, Bayou filed a Chapter 11 plan and disclosure statement proposing to assume its provider agreements (Bk. Ct. Doc. No. 186, p. 29-30) pursuant to 11 U.S.C. § 365 (“365”). The Bankruptcy Court

established an objection deadline and scheduled an evidentiary hearing. (Bk. Ct. Doc. No. 188). AHCA did not file an objection to the Plan or to Bayou's assumption of the Medicaid provider agreement, HHS objected to confirmation (Bk. Ct. Doc. No. 242, pp. 4-6) and to Bayou assuming the Medicare provider agreement (Bk. Ct. Doc. No. 255), arguing that the agreement did not exist and therefore could not be assumed. (Bk. Ct. Doc. No. 255, p. 1). No objection was filed regarding Bayou's assumption of the Medicaid provider agreement.

Pursuant to 11 U.S.C. § 365 ("365"), the Bankruptcy Court had to determine whether Bayou met the test to assume the provider agreements. If, as here, a debtor has defaulted under a contract, the debtor cannot assume the contract unless it cures, or provides adequate assurance it will promptly cure, any default and that it can satisfactorily perform under the contract in the future. 365(b)(1)(C). The Bankruptcy Court took evidence on Bayou's efforts to cure the pre-petition defaults and on Bayou's procedures to assure no future defaults would occur. Based on the evidence, the Bankruptcy Court concluded Bayou satisfied the standard to assume the provider agreements and directed Bayou to submit an order confirming the Plan (Bk. Ct. Doc. No. 282, p. 22, ¶ 2) which provided for the assumption of the provider agreements (Bk. Ct. Doc. No. 285, p. 9, ¶ 2; p. 15, ¶ 19). When the Plan became effective, all relief ordered pursuant to 105 and/or 362(a) was dissolved. (Bk. Ct. Doc. No. 285, p. 13, ¶ 10; p. 17, ¶ 26). The Plan

was substantially consummated pursuant to 11 U.S.C. § 1101(2) (Bk. Ct. Doc. No. 288) after HHS and AHCA waived the stay of the Confirmation Orders. *See* Bk. Ct. Doc. No. 281, 12/22/14 TR. p. 21, *ll.* 13-16.

HHS and AHCA appealed the Confirmation Orders (Doc. No. 282 and 285). Bayou filed motions to dismiss the First Appeals as well as the appeals of the Confirmation Orders (Dist. Ct. Doc. Nos. 21, 54), each of which the District Court denied (Disc. Ct. Doc. Nos. 31, 61, 65), consolidating the appeals of the Confirmation Orders with the First Appeals. (Dist. Ct. Doc. No. 38, p. 1). Thereafter, the District Court issued the Reversal Order (Dist. Ct. Doc. No. 72) and Bayou appealed the decision to this Court. (Dist. Ct. Doc. No. 84).

ARGUMENT AND CITATION OF AUTHORITY

The Panel Opinion holds that a statute ought to be interpreted contrary to its plain language in order to divest bankruptcy courts of jurisdiction over assets of a debtor's estate. The Panel's holding splits with the Third and Ninth Circuits, both of which have held that the Medicare Act ought to be read as written, and ought not be rewritten by courts based on inferences about what Congress meant to, but did not, say. The result reached by the Panel is not merited by the facts or the law.

First, the panel incorrectly concluded Bayou must exhaust administrative remedies before its assets could be administered by the Bankruptcy Court, in direct conflict with conclusions of the Third and Ninth Circuits that "where there is an

independent basis for bankruptcy court jurisdiction, exhaustion of administrative remedies pursuant to other jurisdictional statutes is not required.” *In re Town & Country Home Nursing Servs., Inc.*, 963 F.2d 1146, 1154 (9th Cir. 1991); *In re Univ. Md. Ctr.*, 973 F.2d 1065, 1073-74 (3d Cir. 1992). The facts in this case demonstrate why the Third and Ninth Circuit are correct: requiring exhaustion renders a bankruptcy court powerless to do its job as Congress intended.

As detailed above, after AHCA delivered the Patient Letters, the Bankruptcy Court held a hearing where Bayou admitted uncontroverted evidence and unrebutted testimony reflecting the specific harms that would befall Bayou as a going concern, its 168 employees, and its 129 patients, if exhaustion was required. In addition, on *four* separate occasions during the appellate process, Bayou requested a stay pending appeal explicitly detailing facts unequivocally demonstrating exhaustion should not be required. See, Dist. Ct. Doc. No. 77 (seeking stay from District Court); Time Sensitive Motion to Stay Pending Appeal, filed September 17, 2015 (seeking stay from Eleventh Circuit); Emergency Motion for Reconsideration, filed October 14, 2015, (seeking Eleventh Circuit’s reconsideration of order denying stay); Dist. Ct. Doc. No. 89, filed October 21, 2015 (seeking further stay from District Court). In evidentiary hearings before both the Bankruptcy and District Courts resulting in awards of injunctive relief (Bk.Ct. Doc. Nos. 35 and 78) and stay pending appeal (Dist. Ct. Doc. No. 101), Bayou

proved that, absent such, it would be forced to close and terminate its employees, causing, most critically, an interruption in the course of treatment prescribed to its patients which required the same routines in the same environments with the same caretakers, contrary to the wishes of the patients, their doctors, families or guardians. Bayou also demonstrated that no nearby beds were available in which to place Bayou's patients. (Dist. Ct. Doc. No. 89, Exh. I). This combination of facts, accepted during two evidentiary hearings and detailed in no less than four separate motions, *unequivocally demonstrated the futility of requiring administrative exhaustion under these circumstances*. A critical feature of every bankruptcy case is the court's exercise of exclusive jurisdiction over all of the debtor's property. *Central Va. Community College v. Katz*, 546 U.S. 356 (2006). Requiring exhaustion before the Bankruptcy Court could exercise jurisdiction over Bayou's estate defeats the purpose of bankruptcy cases as Congress conceived them.

The Panel incorrectly concluded that 405(h), despite its plain language, contains a 1334 jurisdictional bar due to a 32 year old codification error still uncorrected today.² Regardless, 405(h) cedes to 11 U.S.C. § 106 ("106") as 106 is the later codified statute. *Tug Allie-B, Inc. v. U.S.*, 273 F.3d 936 (11th Cir. 2001) ("if two statutes conflict, the more recent or more specific statute controls") citing

² The Panel engaged in exhaustive analytical acrobatics reaching back 146 years to explain why 405(h) should not be read on its face when Congress has issued no clarifying amendment to 405(h) during the last 32 years. That Congress has never elected to do so suggests that the only error is that of the Panel in adding language to a statute that Congress never wrote.

United States v. Devall, 704 F.2d 1513, 1518 (11th Cir. 1983) (later enacted statute prevails). All relief ordered by the Bankruptcy Court, was awarded pursuant to 105, 362, 365 and 1141; Congress *expressly* waived sovereign immunity for each of these statutes in 1994, supplying bankruptcy courts with jurisdiction to consider issues and enter orders against the government accordingly. (Init. Br. Pgs. 37, 39, 49).

In its discussion of 106, the Panel cites dicta from *Kaiser v. Blue Cross of California*, 347 F.3d 1107, 1117 (9th Cir. 2003) suggesting that 106(a) may not apply “since any consideration of claims against the government in [debtor]’s bankruptcy would likely require consideration of the merits of the Medicare claims, again invoking 42 U.S.C. § 405(g).” Panel Opinion, p. 27, *quoting Kaiser* at 1117. Ignored by the Panel, however, is *Kaiser*’s conclusion just following the dicta: “Absent a waiver of sovereign immunity, courts have no subject matter jurisdiction over cases against the government.” *Kaiser*, at 1117 citing *United States v. Mitchell*, 463 U.S. 206, 212 (1983). In other words, if sovereign immunity is waived, the courts have jurisdiction.

As this Court explained in *In re Custom Contractors, LLC*, 745 F.3d 1342, 1347 (11th Cir. 2014), [s]overeign immunity acts as a jurisdictional bar,” and Congress removed this bar for the specifically enumerated bankruptcy provisions in 106. Thus, when Congress amended 106(a) in 1994, ten years *after* the 1984

codification of 405(h), it expressly afforded bankruptcy courts the power to “hear and determine any issue” and to “issue against a governmental unit an order” under specific bankruptcy code provisions, at least two of which (105 and 362) enable a bankruptcy court to keep a debtor’s operations alive while it reorganizes in Chapter 11. *Jove Eng’g, Inc. v. I.R.S.*, 92 F.3d 1539, 1549 (11th Cir. 1996) (“As amended in 1994... 11 U.S.C. § 106 provides an unequivocal, express waiver of sovereign immunity for specifically enumerated bankruptcy provisions” including “Sections 105 [and] ... 362”... of this title.”). Indeed, the Sixth Circuit has expressly held that “106(a) does not contain an administrative exhaustion requirement.” *U.S.A. v. MacLeod Co., Inc. (In re MacLeod Co, Inc.)*, 935 F.2d 270 (6th Cir. 1991) (finding that the bankruptcy court did not abuse its discretion by not deferring to the Contract Disputes Act under the doctrine of primary jurisdiction³) (unpublished).

To reach its interpretation of 405(h), the Panel relied upon Supreme Court cases issued long before Congress amended 106 in 1994 and which did not pertain to express waivers of sovereign immunity, *Weinberger v. Salfi*, 422 U.S. 749 (1975)⁴ and *Heckler v. Ringer*, 466 U.S. 602 (1984). In addition, the one Supreme Court case the Panel relied upon that was decided after 106’s 1994 amendment,

³ Neither AHCA nor HHS sought to invoke the doctrine of primary jurisdiction in the Bankruptcy Court.

⁴ Notably, the three judge dissent in *Salfi* was “convinced the Court is quite wrong about the intended reach of s 405(h) and that its construction attributes to Congress a purpose both contrary to all established notions of administrative exhaustion and absolutely without support in the clear language or legislative history of the statute...” *Salfi*, at U.S. 749.

Shalala v. Illinois Council on Long Term Care, Inc., 529 U.S. 1 (2000), is easily distinguishable. In *Shalala* (a non-bankruptcy case), a group of nursing homes invoked 1331 federal question jurisdiction and sued the Secretary mounting an anticipatory challenge to the validity of certain Medicare regulations. Unlike Bayou, the nursing homes did not comply with the “nonwaivable and nonexcusable requirement that an individual present a claim to the agency before raising it in court.” 529 U.S. at 15. Unlike Bayou, in *Shalala* there were no claims that sovereign immunity was waived. Still, *Shalala* does contain critical takeaways unrecognized by the Panel. In *Shalala*, the Court announced that its ruling in *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986) should be read “as *holding* that § 1395ii does not apply § 405(h) where application of § 405(h) would not simply channel review through the agency, but would mean no review at all.” *Shalala*, at 1096-1097. In *Shalala*, the Court found that the nursing homes had “not shown anything other than potentially isolated instances of the inconveniences sometimes associated with the postponement of judicial review”, 529 U.S. at 1099. By contrast, here, on multiple occasions, Bayou proved significant irreparable harm not just to itself as a going concern but also to its patients if operations were shuttered during the (extremely slow) administrative process. The irreparable harm would occur long before any judicial review contemplated in 405(h) and (g). Bayou respected and never flouted the

administrative process, despite its belief that a plain language reading of 405(h) should prevail and despite its arguments that the Bankruptcy Court did indeed have jurisdiction to enter orders pursuant to 105, 362, 365, and 1141 as a result of 106.⁵

Shalala also specifically noted that in *Mathews v. Eldridge*, 424 U.S. 319, 331-331 (1976) it concluded that a collateral claim and potential irreparable injury resulting from delayed review satisfied the ‘final decision’ requirement of 405(g)” where respondent had complied with the strictures of 405(h) by presenting a claim rather than disregarding them. *E.g.*, *In re Neavear*, 674 F.2d 1201 (7th Cir. 1982) (debtor failed to exhaust Social Security Administration administrative remedies, but was not required as a condition of obtaining relief in the bankruptcy court to pursue lengthy administrative appeals). The same is true here.

CONCLUSION

Rehearing *en banc* is merited and critical for the Eleventh Circuit to consider as a whole the questions of exceptional importance squarely presented herein regarding a bankruptcy court’s jurisdiction to preside over and administer a debtor’s estate, and to decide as a whole whether to depart from the precedent of the Third and Ninth Circuits concluding the Medicare Act must be read as written.

⁵ The Panel also relied upon *Bd. of Governors of Fed. Reserve Sys. v. MCorp., Fin., Inc.*, 502 U.S. 32 (1991) which was decided before the 1994 amendments to 106. Among other differences, *MCorp* sought to stay administrative proceedings pursuant to 362 whereas Bayou did not.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

This is to certify that this petition complies with Federal Rule of Appellate Procedure 32(a)(7) and does not exceed 15 pages.

/s/ Tiffany D. Payne

Tiffany D. Payne

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on August 25, 2016, the foregoing *Appellant Bayou Shores, SNF, LLC's Petition for Rehearing En Banc* was electronically filed via the Court's Electronic Case Files System. I FURTHER CERTIFY, in compliance with Rule 25, Federal Rule of Appellate Procedure, Eleventh Circuit General Order 37, that the foregoing was sent by the Court's ECF system, via a "Notice of Docket Activity" e-mail to the following:

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/s/ Tiffany D. Payne

Tiffany D. Payne

UNITED STATES BANKRUPTCY COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION
www.flmb.uscourts.gov

In re:

Case No. 8:14-bk-09521-MGW
Chapter 11

Bayou Shores SNF, LLC,

Debtor.

**MEMORANDUM OPINION
AND ORDER ON CONFIRMATION**

The Court can only confirm a debtor's proposed plan if it is feasible. Here, the Debtor, which operates a skilled nursing facility that derives 90% of its revenue from Medicare and Medicaid patients, has proposed a chapter 11 plan that is funded from its continuing operations. All of the creditors in the case have voted in favor of the plan. But the United States Department of Health & Human Services ("HHS") has objected that the plan is not feasible because it says the Debtor's Medicare provider agreement was terminated prepetition, and as a consequence, so was its Medicaid provider agreement. This Court must now decide whether the Debtor's plan is feasible.

The Court concludes the plan is feasible because the Debtor has the right to assume the Medicare provider agreement under Bankruptcy Code § 365. Although HHS, through the Center for Medicare & Medicaid Services ("CMS"),¹ gave the Debtor notice it was terminating its Medicare provider agreement prepetition, that termination was not complete and irreversible until the appeals process was complete. And the appeals process was not completed prepetition. For that reason, the Medicare provider agreement can be assumed under Bankruptcy Code § 365, which means the Debtor's Medicaid provider agreement does not terminate as a matter of law.

¹ CMS is the operating component of HHS charged with administering the Medicare and Medicaid programs.

Because the Debtor's Medicare and Medicaid provider agreements remain in effect, the Court concludes the Debtor's plan is feasible and should be confirmed.

Background

The Debtor cares for patients with severe psychiatric conditions

The Debtor owns and operates a 159-bed skilled nursing facility known as the Rehabilitation Center in St. Petersburg, Florida.² The Debtor currently has 109 patients, most of whom have Alzheimer's, dementia, or other serious psychiatric conditions.³ The Debtor is one of the few facilities—if not the only one—in the area that is capable of meeting the needs of patients with challenging psychiatric needs.⁴

The Debtor relies on Medicare and Medicaid revenue

All but a handful of the Debtor's patients are on Medicaid or Medicare. Medicare, of course, is a federal program that provides payment for skilled nursing services for aged or disabled individuals. Similarly, Medicaid is a joint federal and state program that provides medical assistance to low-income individuals who are disabled. Over 90% of the Debtor's revenue is derived from Medicare and Medicaid.⁵

CMS and AHCA conduct surveys to ensure providers are complying with the Medicare and Medicaid program requirements

To receive payment under the Medicare and Medicaid programs, a skilled nursing facility such as the Debtor must comply with the requirements set forth in 42 C.F.R. Part 483, Subpart B. Skilled nursing facilities like the Debtor are subject to standard, special, and other surveys by the

² Doc. No. 250 at ¶ 4; Doc. No. 266 at ¶ 4.

³ Doc. No. 250 at ¶ 4; Ex. 20 at 33-34 & 38.

⁴ Ex. 20 at 29.

⁵ Doc. No. 250 at 2 n.1; Doc. No. 266 at 2 n.1.

State or CMS—depending on whether the facility participates in one or both programs—to certify they are in compliance with applicable federal law.⁶ If a skilled nursing facility is certified to be in noncompliance, then CMS may terminate any Medicare provider agreements that are in effect at the time or apply alternative remedies instead of—or in addition to—termination.⁷

In determining which remedies to apply, CMS must determine the seriousness of the deficiency that has caused the facility to be noncompliant.⁸ The seriousness of a deficiency generally ranges from “no actual harm with a potential for minimal harm” to “immediate jeopardy to resident health or safety.”⁹ “Immediate jeopardy” means “a situation in which the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.”¹⁰ Regardless of which remedies CMS decides to apply, a skilled nursing facility must complete a “plan of correction” that describes the actions the facility will take to correct any cited deficiencies and the date by which the deficiencies will be corrected.¹¹

The Debtor is cited for three deficiencies

Between February 2014 and July 2014, the Debtor was cited for deficiencies—and determined to be in noncompliance—three separate times.¹² The first deficiency had to do with

⁶ 42 C.F.R. § 488.308.

⁷ 42 C.F.R. § 488.330(b)(2).

⁸ 42 C.F.R. § 488.404(a). The possible remedies (instead of or in addition to termination of the provider agreement) include: temporary management, denial of payment, civil monetary penalties, state monitoring, transfer of residents, closure of the facility, and directed plan of correction. 42 C.F.R. § 488.406(a).

⁹ 42 C.F.R. § 488.404(b).

¹⁰ *Id.*

¹¹ 42 C.F.R. § 488.408(f).

¹² Ex. 20 at 19-28.

recordkeeping. A February 2014 survey revealed that, as a result of the facility's transition to electronic medical records, some of the residents' files contained conflicting entries with respect to "Do No Resuscitate Orders."¹³ The second deficiency had to do with admissions procedures. In March 2014, an individual with a history of sexual exploitation or abuse was admitted to the Debtor's facility.¹⁴ Staff members, however, failed to identify this threat and placed him in a room with another resident.¹⁵ Fortunately, the patient with the history of abuse—who was in the facility for less than 24 hours—did not touch or otherwise harm the other resident. The third deficiency had to do with facility security. In July 2014, a resident on the Debtor's second-floor secure unit left the facility with visitors and was found unharmed on a nearby street corner fifteen minutes later.¹⁶ Although no resident was hurt in any of the three incidents, the Debtor was nevertheless cited for "immediate jeopardy" on each occasion.¹⁷

The Debtor is brought back into substantial compliance after the first two deficiencies

The Debtor immediately cured the first two deficiencies.¹⁸ In the case of the "Do Not Resuscitate" orders, the Debtor made sure that the orders for each resident matched.¹⁹ If a patient had a "Do Not Resuscitate Order," the facility made sure the physician order said the patient was not to be resuscitated.²⁰ As for the admissions procedures, the Debtor wrote a new set of policies

¹³ *Id.* at 20-21.

¹⁴ *Id.* at 21.

¹⁵ *Id.* at 21-22.

¹⁶ *Id.* at 24-25.

¹⁷ *Id.* at 19-28.

¹⁸ *Id.* at 20-23.

¹⁹ *Id.* at 21.

²⁰ *Id.*

and procedures governing abuse of residents.²¹ After the Debtor cured the first two deficiencies, CMS revisited the facility and determined the Debtor was in substantial compliance.²² On May 29, 2014, CMS notified the Debtor it was in substantial compliance with the Medicare and Medicaid requirements as of May 13, 2014.²³

The Debtor immediately cures the third deficiency

As with the first two deficiencies, the Debtor immediately cured the third deficiency. Specifically, the Debtor implemented an entirely new system for screening and assessing patients for potential elopement issues and changed the procedure for guests and patients to access the facility's secure unit.²⁴ The Debtor also took the additional step of hiring a third-party consultant—David Hoffman & Associates—to conduct an extensive review of the corrective measures the Debtor had taken and determine whether the Debtor had been brought back into substantial compliance.²⁵ On July 17, 2014, just one week after the survey that led to the third deficiency, the Debtor provided CMS with a detailed list of the steps it had taken to remove the “immediate jeopardy” and bring its facility back into substantial compliance.²⁶ Rather than revisit the facility to certify it was in substantial compliance, as is apparently customary where there is no actual harm to residents, CMS instead opted to terminate the Debtor's Medicare provider agreement.²⁷

²¹ *Id.* at 22.

²² *Id.* at 23.

²³ Ex. 2.

²⁴ Exs. 4 & 5; *see also* Ex. 20 at 23-24.

²⁵ Doc. No. 250 at ¶¶ 10-11; *see also* Ex. 20 at 25-27.

²⁶ Exhibit 4; *see also* Ex. 20 at 25. The Debtor had apparently implemented the corrective measures as of July 17, 2014. Hoffman then reviewed those corrective measures on July 29-30, 2014. Doc. No. 250 at ¶¶ 10-11.

²⁷ Ex. 20 at 27-28, 32 & 48-49; Doc. No. 250 at ¶ 12.

CMS terminates the Debtor's Medicare provider agreement

On July 22, 2014, CMS notified the Debtor that it was terminating the Debtor's Medicare provider agreement effective August 3, 2014, which would also result in termination of the Debtors' Medicaid provider agreement.²⁸ The Debtor appealed the termination of its Medicare provider agreement and requested an expedited hearing before an administrative law judge. The appeal of the decision to terminate the provider agreement, however, did not prevent CMS from denying payment to the Debtor, which would have set a catastrophic chain of events in motion: denial of payment would have caused the Debtor to default under its lease, default under its lease would have forced the Debtor to close its facility, closure of the facility would have forced the transfer of the Debtor's patients, many of whom would have had no place to go or would have potentially been harmed by the transfer.²⁹

*The district court temporarily enjoins CMS
from terminating the Medicare provider agreement*

So on August 1, 2014, two days before the Medicare provider agreement was terminated, the Debtor sought and obtained an ex parte temporary restraining order from district court that enjoined CMS from terminating the agreement through August 15, 2014.³⁰ HHS then moved to dissolve the temporary restraining order based on the district court's lack of subject-matter jurisdiction.³¹ According to HHS, 42 U.S.C. § 405 mandates that the Debtor exhaust all of its administrative remedies before it can bring a claim under the Medicare statute in district court. In particular, 42 U.S.C. § 405(h) precluded the district court from (i) reviewing an agency decision

²⁸ Ex. 3.

²⁹ Exhibit 20 at 29-32.

³⁰ The Debtor filed an action in district court for the Middle District of Florida (Tampa Division) styled *Bayou Shores SNF, LLC v. Sylvia Mathews Burwell*, Case No. 8:14-cv-1849-T-33-MAP.

³¹ Dist. Ct. Doc. No. 22.

before all administrative remedies were exhausted; or (ii) taking jurisdiction over a Medicare-related claim against the United States under 28 U.S.C. § 1331, which grants district courts original jurisdiction over all actions arising under the laws of the United States.³² The district court agreed that it lacked subject-matter jurisdiction over the dispute because the Debtor had not exhausted its administrative remedies, and as a consequence, it dissolved its temporary restraining order on August 15, 2014.³³

The Debtor files for bankruptcy

Mere hours after the district court dissolved the temporary restraining order, the Debtor filed this chapter 11 case. A week later, the Debtor sought a ruling from this Court that the automatic stay precluded termination of its Medicare provider agreement.³⁴ At the conclusion of a final evidentiary hearing on the Debtor's motion, this Court enjoined termination of the Medicare provider agreement pending completion of the administrative appeals process. Since then, the Debtor has fast-tracked this case to confirmation, proposing a plan within four months of filing this case.³⁵

The Debtor's proposed plan enjoys the support of all of the creditors in the case, including a secured lender holding an \$11 million claim and unsecured creditors holding more than \$2 million in claims.³⁶ The plan also satisfies all of the requirements of Bankruptcy Code § 1129(a) with the exception of perhaps one: feasibility. HHS objects that confirmation is not feasible because the Debtor relies almost exclusively on Medicare and Medicaid for revenue, and

³² *Id.*

³³ Dist. Ct. Doc. No. 35.

³⁴ Doc. No. 25.

³⁵ Doc. Nos. 185 & 186.

³⁶ Doc. No. 249-1.

those agreements have (or will be) terminated.³⁷ HHS also objects to the Debtor's attempt to assume the Medicare provider agreement based on its purported prepetition termination.³⁸ This Court must now determine whether the Debtor's proposed plan is feasible in light of that purported termination.

Conclusions of Law

The Court has jurisdiction over the parties' Medicare-related dispute

As a threshold matter, HHS contends that this Court lacks subject-matter jurisdiction over the parties' dispute. According to HHS, "no court has any jurisdiction over any aspect of a Medicare determination, other than to perform a prescribed form of judicial review of a final administrative decision by the Secretary."³⁹ Because of that, HHS reasons that the Debtor is precluded from raising any challenge to the termination of its Medicare provider agreement before this Court. HHS's argument, however, misses the mark.

It is true that federal courts are generally precluded from exercising federal question jurisdiction over Medicare issues.⁴⁰ The statute the district court relied on in dissolving the temporary restraining order—and the statute HHS presumably relies on here—says as much:

The findings and decision of the Commissioner of Social Security after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Commissioner of Social Security shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Commissioner of Social

³⁷ HHS contends its Medicare provider agreement has already been terminated. And the parties generally agree that AHCA is obligated to terminate its Medicaid provider agreement once the Medicare provider agreement has been terminated. But there is some question whether termination of the Medicaid provider agreement occurs by operation of law or requires some other action by AHCA.

³⁸ Doc. Nos. 229 & 255.

³⁹ Doc. No. 277 at 2.

⁴⁰ 42 U.S.C. § 405(h).

Security, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.⁴¹

But this Court's jurisdiction is not based on 28 U.S.C. § 1331 or § 1346.

This Court has independent grounds for exercising jurisdiction: 28 U.S.C. § 1334. Under § 1334, this Court has jurisdiction over all civil proceedings arising under title 11, arising in a case under title 11, or related to a proceeding under title 11. This bankruptcy case, of course, arises under title 11.⁴² Confirmation is a contested matter that arises in a case under title 11. And any dispute over the Debtor's ability to assume the Medicare provider agreement is "related to" this title 11 case since the outcome of that dispute could conceivably have an effect on the Debtor's bankruptcy estate.⁴³ Accordingly, this Court has subject matter jurisdiction over this case, confirmation, and the parties' dispute over whether the Debtor has the authority to assume its Medicare provider agreement under 28 U.S.C. § 1334(b).

In fact, the court in *First American Health Care of Georgia, Inc. v. HHS* recognized that bankruptcy courts have jurisdiction over some Medicare-related disputes under 28 U.S.C. § 1334.⁴⁴ In *First American*, the Debtor filed an adversary proceeding seeking turnover of certain periodic income payments it claimed it was entitled to under the Medicare program. HHS moved to dismiss the adversary proceeding because 42 U.S.C. § 405(h) expressly precluded federal

⁴¹ *Id.*

⁴² Technically, the district court for this district has subject-matter jurisdiction over these proceedings. The district court is statutorily empowered to refer all of these proceedings to this Court, which it has done by a standing order of reference.

⁴³ A bankruptcy court has "related to" jurisdiction if the outcome of a proceeding could conceivably have an effect on the estate being administered. *Miller v. Kemira (In re Lemco Gypsum, Inc.)*, 910 F.2d 784, 788 (11th Cir. 1990) (adopting the test articulated in *Pacor, Inc. v. Higgins*, 743 F.2d 984, 994 (3d Cir. 1984)).

⁴⁴ 208 B.R. 985, 988 (Bankr. S.D. Ga. 1996). The Court later vacated its ruling based on a settlement agreement between the parties. *First Am. Health Care of Georgia, Inc. v. HHS*, 1996 WL 282149 (Bankr. S.D. Ga. 1996). But that does not change the bankruptcy court's analysis, which this Court finds persuasive.

courts from exercising federal question jurisdiction over Medicare claims.⁴⁵ In denying HHS's motion to dismiss, the *First American* court acknowledged that 42 U.S.C. § 405(h), as originally drafted, precluded bankruptcy jurisdiction over all Medicare disputes. But the Court correctly observed that Congress passed 28 U.S.C. § 1334 in 1984, which conferred bankruptcy jurisdiction on the district court, and nothing in 42 U.S.C. § 405(h) precludes a court from exercising bankruptcy jurisdiction over Medicare disputes under 28 U.S.C. § 1334.⁴⁶

The Court is aware that some courts have held that omission of 28 U.S.C. § 1334 was essentially a scrivener's error.⁴⁷ Those courts begin by observing that 42 U.S.C. § 405(h) previously precluded federal courts from exercising all jurisdiction—including bankruptcy jurisdiction—over Medicare-related claims by prohibiting any action under “section 24 of the Judicial Code of the United States.”⁴⁸ Section 24 previously contained virtually all of the jurisdictional grants to the district court, including bankruptcy jurisdiction.⁴⁹ In 1984, Congress replaced the reference to “section 24” with the phrase “section 1331 or 1346.” Since the legislative history regarding that amendment provides the amendment was not to be “construed as changing or affecting any right, liability, status, or interpretation which existed” previously, some courts have ruled that Congress intended 42 U.S.C. § 405(h) to preclude the exercise of bankruptcy jurisdiction under 28 U.S.C. § 1334.⁵⁰

⁴⁵ *Id.* at 987.

⁴⁶ *Id.* at 988-89.

⁴⁷ See, e.g., *In re St. Johns Home Health Agency, Inc.*, 173 B.R. 238, 244 (Bankr. S.D. Fla. 1994).

⁴⁸ *Id.* at 244.

⁴⁹ *Id.*

⁵⁰ *Id.*

There is one problem with that view: This Court is not free to consider the legislative history of a statute when the statute's text is plain and unambiguous.⁵¹ Here, the text of 42 U.S.C. § 405(h) is plain and unambiguous. It plainly provides that federal courts are precluded from exercising jurisdiction on only two bases: 28 U.S.C. §§ 1331 and 1346. Because 42 U.S.C. § 405(h), by its terms, does not preclude this Court from exercising jurisdiction under 28 U.S.C. § 1334, this Court has subject-matter jurisdiction.

The only plausible argument against this Court having subject-matter jurisdiction is the second sentence of 42 U.S.C. § 405(h), which limits the ability of federal courts to review the findings of fact or an agency decision. Of course, that is not what this Court is doing. HHS had made it plain throughout its various filings in this case that CMS's decision to terminate the Debtor's Medicare provider agreement—the central issue in this case—is not subject to appeal.⁵² The only properly appealable issue is CMS's determination that the Debtor was in noncompliance with the Medicare program requirements. But this Court, as part of its executory contract analysis discussed below, assumes that the Debtor was, in fact, in noncompliance. Because this Court assumes the Debtor was in noncompliance, it is not reviewing any findings of fact or agency decision, and as a consequence, 42 U.S.C. § 405(h) does not preclude this Court from considering whether the Debtor can assume its Medicare provider agreement under Bankruptcy Code § 365.

⁵¹ *Circuit City Stores, Inc. v. Adams*, 532 U.S. 105, 118 (2001) (refusing to examine legislative history where the face of the statutory provision was unambiguous); *Garcia v. Vanguard Car Rental USA, Inc.*, 540 F.3d 1242, 1247 (11th Cir. 2008) (explaining that courts “may consult legislative history to elucidate a statute’s ambiguous or vague terms, but legislative history cannot be used to contradict unambiguous statutory text or to read an ambiguity into a statute which is otherwise clear on its face”); *CBS Broad., Inc. v. EchoStar Commc’ns Corp.*, 265 F.3d 1193, 1213 (11th Cir. 2000) (explaining that “resort to legislative history is unnecessary, and indeed, improper, where the statute’s terms are plain and unambiguous”).

⁵² Doc. No. 277 at 6.

The Debtor can assume the Medicare provider agreement

Under Bankruptcy Code § 365, a debtor may assume an executory contract. The Bankruptcy Code does not define “executory contract.” In the absence of a definition, courts have generally followed two approaches to determining whether a contract is executory. Under the first approach, proposed by Professor Vern Countryman, a contract is executory if it is so far unperformed that the failure of either party to complete performance would constitute a material breach of the contract.⁵³ Under the second approach, aptly named the “functional approach,” courts “abandon the traditional focus on the ‘executoriness’ of contracts in bankruptcy in favor of a more practical, functional approach.”⁵⁴ Regardless of which test is applied, though, the majority of courts have concluded that Medicare provider agreements are executory contracts, a proposition HHS does not appear to dispute.⁵⁵ What would otherwise be an executory contract, however, cannot be assumed under Bankruptcy Code § 365 if the contract was terminated prepetition because there is nothing left for the Debtor to assume.

The central issue in this bankruptcy case is whether the Debtor’s Medicare provider agreement was terminated prepetition. According to HHS, the Medicare provider agreement was terminated on August 3, 2014—the date specified in HHS’s July 22 notice. The Debtor, however, contends the agreement could not have been terminated prepetition because the right to terminate the agreement expired when the Debtor brought its facility back into substantial

⁵³ *Walton v. Clark & Washington, P.C.*, 454 B.R. 537, 543 (Bankr. M.D. Fla. 2011).

⁵⁴ Bankruptcy Law Manual § 9B:3 (5th ed. 2014); *see also Clark & Washington*, 454 B.R. at 543 (explaining that “[u]nder the functional approach, a court looks to the benefits a debtor and its estate would gain if a contract is assumed or rejected.”).

⁵⁵ *In re University Med. Center*, 973 F.2d 1065, 1075 n.13 (3d Cir. 1992); *In re Monsour Med. Center*, 11 B.R. 1014, 1018 (W.D. Pa. 1981); *In re Vital Signs Homecare, Inc.*, 396 B.R. 232, 239 (Bankr. D. Mass. 2008); *In re Heffernan Memorial Hosp. Dist.*, 192 B.R. 228, 231 (Bankr. S.D. Cal. 1996).

compliance, which was on July 18, 2014. The Court concludes the Debtor is correct (i.e., the Medicare provider agreement was not terminated) but for the wrong reason.

The Debtor relies on 42 C.F.R. § 488.454, entitled “Duration of Remedies,” in support of its argument.⁵⁶ That regulation does provide that certain remedies HHS is entitled to invoke do expire when a revisit by CMS confirms that facility has been brought back into substantial compliance.⁵⁷ Expiration of certain remedies can even predate a revisit if the facility can supply HHS with acceptable documentation showing the facility was in substantial compliance at some point before the revisit survey.⁵⁸ But as HHS correctly points out, the regulation the Debtor relies on deals with “alternative remedies” other than termination.⁵⁹

In the Court’s view, the answer is much simpler. In order for a prepetition termination of contract to cut off a debtor’s rights under § 365, the termination must be complete and not subject to reversal.⁶⁰ Here, the Debtor had a right to appeal termination of the provider agreement. While that appeal may be limited in scope, the fact remains that termination of the provider agreement is not complete—and is, in fact, subject to reversal—until the appeals process is complete. Because the appeals process was not complete before this case was filed, the contract was not “terminated” prepetition for purposes of § 365.

Concluding that a Medicare provider agreement is “terminated”—for purposes of § 365—before the appeals process is complete would lead to absurd results. Consider the

⁵⁶ Doc. No. 278 at 18-21.

⁵⁷ 42 C.F.R. § 488.454(a)(1)-(2).

⁵⁸ 42 C.F.R. § 488.454(e).

⁵⁹ Doc. No. 277 at 2-4.

⁶⁰ *In re Fontainebleau Hotel Corp.*, 515 F.2d 913, 915 (5th Cir.1975); *see also Moody v. Amoco Oil Co.*, 734 F.2d 1200, 1212 (7th Cir. 1984); *In re Bricker*, 43 B.R. 344, 347 (Bankr. D. Ariz. 1984).

following hypothetical: a debtor that operates a skilled nursing facility has its Medicare provider agreement terminated because it was improperly cited for noncompliance. The debtor immediately appeals the finding of noncompliance. But because CMS stops payment for Medicare residents, the debtor is forced to file for bankruptcy. If the Court were to adopt HHS's view, the debtor in that hypothetical scenario could never assume its Medicare provider agreement since it is highly unlikely the appeals process will be complete before the debtor files for bankruptcy. The only way to preserve a debtor's right to appeal a finding of noncompliance is to consider a Medicare provider agreement terminated—for purposes of § 365—once the appeals process is complete.

Here, the appeals process was not complete prepetition. So termination of the Medicare provider agreement in this case was not complete and irreversible as of the petition date. For that reason, the Medicare provider agreement is subject to being assumed. The only remaining question is whether the Debtor satisfies the requirements for assuming the provider agreement under Bankruptcy Code § 365.

To assume an executory contract that is in default, a debtor must prove that it can promptly cure the default and provide adequate assurance of future performance.⁶¹ Although HHS has challenged the Debtor's right to assume the Medicare provider agreement, it has made no effort to challenge the Debtor's contention that it has cured the existing default and provided adequate assurances of future performance, instead deciding to rely solely on its argument the agreement cannot be assumed because it was terminated prepetition.⁶² HHS also appears to be arguing—at least implicitly—that the § 365 requirements do not apply to Medicare provider

⁶¹ 11 U.S.C. § 365(b); *In re Chapin Revenue Cycle Mgmt.*, 343 B.R. 728, 730 (Bankr. M.D. Fla. 2006).

⁶² Doc. No. 255.

agreements because a skilled nursing facility or other provider has no right to cure a deficiency. The Court is sympathetic to HHS's argument, but as the Third Circuit Court of Appeal recognized in *In re University Medical Center* over twenty years ago, "Congress' failure to legislate special treatment for the assumption or rejection of Medicare provider agreements indicates that assumption of these agreements, like that of other executory contracts, should be deemed subject to the requirements of section 365, unless and until Congress decides otherwise."⁶³

Given the unrefuted evidence at confirmation, the Court easily concludes the Debtor has satisfied the requirements for assuming the Medicare provider agreement. It cannot be disputed—given CMS's notice that the Debtor was in substantial compliance as of May 13, 2014—that the Debtor previously cured the initial two deficiencies in a timely matter. That leaves only the third deficiency. The Debtor offered into evidence the "allegation of compliance" it submitted to CMS on July 17 & 28, 2014 that outlines the steps it took to cure the final deficiency and remove any immediate jeopardy.⁶⁴ As part of the corrective measures it took, the Debtor retained a third-party consultant (David Hoffman) who has concluded that the Debtor is currently in substantial compliance with the Medicare program requirements and that the Debtor's patients are being adequately cared for.⁶⁵

Hoffman's conclusions are consistent with the opinions offered by the Patient Care Ombudsman. At the outset of this case, the Court issued an order to show cause to determine whether it was necessary to appoint a patient care ombudsman for the protection of the Debtor's

⁶³ 973 F.2d 1065, 1077 (3d Cir. 1992).

⁶⁴ Exs. 4 & 5.

⁶⁵ Doc. No. 250 at ¶¶ 10 & 11; Ex. 20 at 44-49.

patients.⁶⁶ Ultimately, the Court directed the U.S. Trustee to appoint a patient care ombudsman to monitor the quality of patient care and represent the interests of patients in this case. The U.S. Trustee appointed Robert Rosenthal, president of Health Care Management Specialist, Inc., as Patient Care Ombudsman.⁶⁷ So far, the Patient Care Ombudsman has issued two reports indicating that the Debtor is adequately and satisfactorily providing for the health and welfare of the Debtor's patients.⁶⁸ Significantly, HHS opted not to offer any evidence—presumably because it could not—that the Debtor is not currently in substantial compliance with the Medicare program requirements (i.e., that the Debtor has not cured the prepetition default).

And the Court is persuaded that the Debtor has provided adequate assurances of future performance. In part, those assurances are based on the corrective actions the Debtor has taken to cure the previous deficiencies and the fact that the Debtor has been satisfactorily and adequately providing for patients' health and welfare under the watchful eye of the Patient Care Ombudsman since this case was filed. It is also based on the fact that the Debtor has retained Hoffman in an ongoing role to evaluate the Debtor's regulatory compliance and Hoffman's willingness to remain on as an advisor as long as necessary to ensure the Debtor is adequately and satisfactorily protecting its residents and complying with applicable regulations. Not to mention, HHS has again failed to offer any evidence refuting the Debtor's ability to perform in

⁶⁶ Doc. No. 36.

⁶⁷ Doc. No. 97. Although Rosenthal is not a doctor or nurse, he has extensive experience operating healthcare and assisted living facilities. AHCA has previously recommended Rosenthal as a receiver for a number of assisted living and skilled nursing facilities. And AHCA submitted his name to the U.S. Trustee for consideration in this case, as well. Because Rosenthal is not a medical professional, the Court authorized him to hire healthcare assistants (such as registered nurses and social workers), including RB Health Partners, Inc., to assist him in his review of the Debtor's operations.

⁶⁸ Doc. No. 178-1 at 21; Doc. No. 252 at 17.

the future. Accordingly, the Court concludes the Debtor has satisfied the requirements of § 365 and is permitted to assume its Medicare provider agreement.

The Debtor's plan is feasible even though AHCA
indicates it intends to deny renewal of the Debtor's license

The only remaining issue that needs to be considered—even though not raised in an objection to confirmation—is whether the Debtor's plan is feasible despite the fact that AHCA has indicated it intends to seek revocation or deny renewal of the Debtor's nursing home license. Back in June, after the second deficiency had been cited and the facility had been brought back into substantial compliance, AHCA filed an administrative complaint seeking to revoke the Debtor's license.⁶⁹ That administrative proceeding has since been abated. But in the meantime, the Debtor filed an application to renew its license. AHCA says it intends on denying the Debtor's application to renew its license, and more recently, AHCA asked the Court to modify its injunction to permit AHCA to either deny the Debtor's license renewal application or invoke the administrative process to revoke the Debtor's license since neither action is prohibited by the automatic stay.⁷⁰

AHCA appears to raise two grounds for refusing to renew or seeking to revoke the Debtor's license. First, AHCA says Florida law requires that it deny renewal of or revoke the Debtor's license because its Medicare and Medicaid provider agreements have been terminated. Second, AHCA says the three deficiencies previously discussed are grounds for both refusing to renew and revoking the Debtor's license. It appears AHCA is correct that refusing to renew the Debtor's license on either ground, at least theoretically, does not run afoul of the automatic stay.

⁶⁹ Doc. No. 246-3.

⁷⁰ Doc. No. 246.

As AHCA contends, Bankruptcy Code § 362(b)(4) does, in fact, except from the automatic stay actions to enforce a state's police or regulatory powers. In determining whether a government's actions qualify as police powers, courts generally apply the "pecuniary" purpose and "public policy" tests.⁷¹ Under those tests, courts consider whether the government action is intended to protect the public safety or welfare or effectuate public policy, on the one hand, or protect the government's pecuniary interest or adjudicate private rights, on the other hand:

There are two tests for determining whether agency actions fit within the section 362(b)(4) exception: (1) the "pecuniary purpose" test and (2) the "public policy" test. Under the pecuniary purpose test, the court determines whether the government action relates primarily to the protection of the government's pecuniary interest in the debtor's property or to matters of public safety and welfare. If the government action is pursued solely to advance a pecuniary interest of the governmental unit, the stay will be imposed. The public policy test "distinguishes between government actions that effectuate public policy and those that adjudicate private rights."⁷²

AHCA says its actions satisfy both tests because it is attempting to protect the public safety and welfare and effectuate public policy by denying the Debtor's license renewal application or seeking to revoke the Debtor's license.

The Court agrees that AHCA's refusal to renew or intent to revoke the Debtor's license is an attempt to protect the public safety and welfare. That is perhaps best illustrated by comparing AHCA's actions to those of HHS. In enjoining HHS from terminating the Debtor's Medicare provider agreements, the Court reasoned, in part, that HHS's actions did not fall within the "police powers" exception to the automatic stay.⁷³ That was because it was apparent to the Court that HHS was only seeking to protect its pecuniary interest in terminating the Debtor's Medicare

⁷¹ *In re Pollock*, 402 B.R. 534, 536-38 (Bankr. N.D.N.Y. 2009); *In re Allegheny Health, Educ. Research Found.*, 252 B.R. 309, 327 (W.D. Pa. 1999); *In re Selma Apparel Corp.*, 132 B.R. 968, 969-70 (Bankr. S.D. Ala. 1991).

⁷² *Universal Life Church, Inc. v. United States*, 128 F.3d 1294, 1297 (9th Cir. 1997) (internal citations omitted).

⁷³ Ex. 20 at 89-91.

provider agreement. After all, HHS made no attempt to shut down the Debtor's facility. As far as HHS was concerned, the Debtor could continue to operate its facility and provide care for its patients; HHS simply was not going to pay for it. By contrast, by refusing to renew the Debtor's license, AHCA is essentially attempting to shut down the Debtor's facility because it believes the Debtor's operations are jeopardizing the patients' safety and welfare. While it may be an open question whether shutting down the Debtor's facility is in the best interest of its patients, there can be no question the attempt to shut it down is an effort by AHCA to protect what it believes is in the best interests of the patients' safety and welfare.

But the Court concludes that the Debtor's plan is still feasible notwithstanding AHCA's unwillingness to renew the Debtor's license. For starters, AHCA is collaterally estopped from raising the first ground—i.e., termination of the Medicare and Medicaid provider agreements—as a basis for refusing to renew or seeking to revoke the Debtor's license. This Court has ruled that the Debtor has the right to assume the Medicare provider agreement. And the only basis for terminating the Medicaid provider agreement was that the Medicare provider agreement had been terminated. Since that is no longer the case, the Medicaid provider agreement remains in effect. So the only grounds for refusing to renew or seeking to revoke the Debtor's license are the three deficiencies the Debtor has previously been cited for.

Under Florida law, AHCA does have the right to revoke the Debtor's license if the Debtor has been cited for two "class 1 deficiencies" arising from unrelated circumstances during the same survey or from separate surveys during a 30-month period.⁷⁴ AHCA contends that the three deficiencies the Debtor has been cited for constitute "class 1 deficiencies" under Florida law. As a result AHCA contends it is required to revoke or deny renewal of the Debtor's license.

⁷⁴ § 400.121(3)(c)-(d), Fla. Stat.

But Florida's Medicaid statutes provide additional protections that are not afforded under the Medicare regulations.

Critically, under the Medicare regulations, the Debtor has no right to challenge the termination of a Medicare provider agreement. The Debtor can challenge the underlying finding of noncompliance that gave rise to termination; but once noncompliance has been established, it appears the Debtor cannot challenge termination of the provider agreement. Florida's Medicaid statutes are different. Under section 400.121, Florida Statutes, the Debtor has the right to present factors that mitigate against revocation or nonrenewal of its license.

Although this Court has no say on whether revocation is appropriate under the circumstances—that decision is up to AHCA under section 400.121, Florida Statutes—it is apparent to the Court that there are a number of mitigating factors that could reasonably lead to the conclusion revocation is not appropriate. For one, the three deficiencies were isolated incidents, and each of them was cured immediately. Moreover, the Debtor has been operating its facility for the last five months in apparent substantial compliance with the Medicare and Medicaid requirements and, according to the Patient Care Ombudsman, in a manner that adequately and satisfactorily provides for the patients' health and welfare.⁷⁵ Finally, and perhaps most importantly, the Debtor's facility serves a particularly needy population (i.e., patients with severe psychiatric conditions) that may have trouble finding another skilled nursing facility, and to the extent they can find one, the patients may be at a greater risk if they transfer—because of a phenomenon known as transfer trauma—than if they remained at the Debtor's facility. All of this is to say that AHCA's stated intention of refusing to renew—or seeking to revoke—the Debtor's

⁷⁵ Doc. No. 178-1 at 21; Doc. No. 252 at 17.

license does not sound the death knell for the Debtor's business, and as such, it is not a basis for concluding the Debtor's plan is not feasible.

The Court recognizes there are cases holding that feasibility is not established when a debtor's prospects hinge on the uncertain outcome of pending litigation.⁷⁶ And it is true the Debtor's license renewal or revocation is uncertain. But what is certain is that denial of confirmation—before the Debtor has even had the opportunity to avail itself of its rights under Florida's license revocation statutes—will displace 109 nursing patients, many of whom suffer from severe psychiatric conditions and will have difficulty finding a place to go. And HHS and AHCA would be hard-pressed to argue there is harm to allow the Debtor to go forward under a confirmed plan until the licensure renewal or revocation issue is fully adjudicated considering that HHS has made no attempt to close the Debtor's facility (even though it has that right under the Medicare regulations) and AHCA has abated its efforts to do so (and allowed the Debtor to operate) since July. So while the Debtor's plan does hinge on the uncertain resolution of the pending licensure renewal or revocation action, the Court cannot allow what appears to be a litigation tactic to derail the Debtor's confirmation and displace over 100 nursing home patients.⁷⁷

Conclusion

The sole issue before this Court on confirmation is whether the Debtor's plan is feasible. Because the Debtor has the right to assume its Medicare provider agreement, the Court concludes the plan is feasible. And the fact that AHCA intends to seek revocation or deny

⁷⁶ Doc. No. 242, citing *in re Am. Capital Equip.*, 688 F.3d 145, 156 (3d Cir. 2012); *In re Ewald*, 298 B.R. 76, 82 (Bankr. E.D. Va. 2002); *In re Gregory & Parker, Inc.*, 2013 WL 2285671, at *7 (Bankr. E.D.N.C. May 23, 2013).

⁷⁷ The Court says that raising the licensure renewal or revocation appears to be a litigation tactic because, although AHCA filed its administrative complaint back in July, it did not raise revocation of the Debtor's license (which is technically separate from licensure renewal) until four months after the Court enjoined CMS from terminating the Medicare provider agreement and shortly before confirmation.

renewal of the Debtor's license does not change this Court's feasibility analysis. Accordingly, it is

ORDERED:

1. The Debtor has satisfied the requirements of Bankruptcy Code § 1129 for confirming its proposed chapter 11 plan.
2. The Debtor shall prepare a confirmation order finding that the specific requirements of Bankruptcy Code § 1129 have been met, incorporating the relevant terms of this Memorandum Opinion, and confirming the Debtor's proposed chapter 11 plan.
3. This order is a nonfinal order and will not become a final order until entry of a confirmation order.

DATED: _____.

Michael G. Williamson
United States Bankruptcy Judge

Attorney Elizabeth A. Green is directed to serve a copy of this order on interested parties and file a proof of service within 3 days of entry of this order.

Elizabeth A. Green, Esq.
Baker & Hostetler LLP
Counsel for Debtor

Andrew Sheeran, Esq.
Counsel for Agency for Health Care Administration

Sean Flynn, Esq.
Office of the United States Attorney
Counsel for U.S. Department of Health & Human Services

AMERICAN BANKRUPTCY INSTITUTE

Case 8:14-bk-09521-MGW Doc 378 Filed 06/29/15 Page 1 of 13
Case 8:14-cv-02816-JSM Document 72 Filed 06/26/15 Page 1 of 13 PageID 5011

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

In re:

BAYOU SHORES SNF, LLC,

CASE NO: 8:14-bk-9521-MGW

Debtor.

FLORIDA AGENCY FOR HEALTH CARE
ADMINISTRATION and THE UNITED
STATES OF AMERICA, ON BEHALF
OF THE SECRETARY OF THE UNITED
STATES DEPARTMENT OF HEALTH
AND HUMAN SERVICES,

CASE NO: 8:14-cv-02816-T-30
(Lead Case) as consolidated with
8:14-cv-02617-T-30;
8:15-cv-00103-T-30; and
8:15-cv-00128-T-30

Appellants,

v.

BAYOU SHORES SNF, LLC,

Appellee.

FILED VIA MAIL
JUN 29 2015
CLERK OF DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

ORDER

THIS CAUSE came before the Court on appeal of the Bankruptcy Court's entry of an injunction prohibiting any action to terminate the Debtor's Medicare and Medicaid provider agreements (the September 5, 2014 Order) and subsequent entry of a confirmation order that ordered the assumption of the Medicare and Medicaid provider agreements (the Confirmation Order) (collectively, the "Orders"). The Court consolidated four appeals related to the Orders. The appeals present numerous arguments; the heart of the appeals,

however, deals with the Bankruptcy Court's jurisdiction to enjoin the termination of and later order the assumption of the Debtor's Medicare and Medicaid provider agreements. The Court concludes that the Bankruptcy Court's Orders violated the Medicare jurisdictional bar set forth in 42 U.S.C. § 405(h); this jurisdictional bar moots any remaining arguments on appeal.

The Court has jurisdiction to hear this bankruptcy appeal under 28 U.S.C. § 158(a).

STANDARD OF REVIEW

A district court reviews a bankruptcy court's findings of fact for clear error and conclusions of law *de novo*. See *In re JLI, Inc.*, 988 F.2d 1112, 1116 (11th Cir. 1993).

BACKGROUND

Although the disposition of the consolidated appeals turns solely on a question of law, a brief summary of the background facts is helpful. The Debtor Bayou Shores SNF, LLC operates a skilled nursing facility, the Rehabilitation Center of St. Petersburg. Most of the Debtor's patients have Alzheimer's disease, dementia, or other serious psychiatric conditions; it is one of the few facilities in the area that accommodates patients with challenging psychiatric needs.

The Debtor provides Medicare and Medicaid services through provider agreements issued by the federal and state government under the Social Security Act's Medicare and Medicaid provisions. Most of the Debtor's patients are on Medicare or Medicaid. Over ninety percent of the Debtor's revenue is derived from Medicare and Medicaid.

A skilled nursing facility like the Debtor must comply with the requirements set forth in 42 C.F.R. Part 483, Subpart B, to receive payment under the Medicare and Medicaid programs. As such, the Debtor is subject to surveys conducted by the Centers for Medicare and Medicaid Services (“CMS”), an agency of the United States Department of Health and Human Services. CMS may take certain actions, including termination of the Medicare and Medicaid provider agreements, if a survey reflects that a facility is not compliant with the applicable regulations.

The Agency for Health Care Administration (“AHCA”), the Florida state agency that performs nursing home surveys and that administers the Medicaid program in Florida, conducted surveys of the Debtor in approximately February, March, and July of 2014. Each time, the Debtor was cited for deficiencies and determined to be in noncompliance.¹ Ultimately, based on AHCA’s July 2014 survey, CMS exercised its discretion to terminate the Debtor’s Medicare provider agreement.

In a letter dated July 22, 2014, CMS notified the Debtor that AHCA’s survey demonstrated that the Debtor was not in substantial compliance with Medicare and Medicaid requirements and that the conditions constituted immediate jeopardy to residents’ health and

¹ The facts surrounding the surveys, CMS’ determinations of noncompliance, and the Debtor’s actions in response to same are outlined in the Bankruptcy Court’s “Memorandum Opinion and Order on Confirmation” and need not be repeated here because they are not relevant to the Court’s conclusion that the Bankruptcy Court lacked jurisdiction to take action related to the termination of the Medicare and Medicaid provider agreements. (Dkt. 45-36).

safety. The letter stated that the Debtor's "Medicare provider agreement will be terminated at 11:59 pm on August 3, 2014" and that Medicare and Medicaid payments would continue for only 30 days from that date. (Dkt. 1-20).

On August 1, 2014, the Debtor filed a Verified Complaint for Injunctive Relief and Mandamus in the federal district court for the Middle District of Florida (Tampa Division). Specifically, in that action, *Bayou Shores SNF LLC v. Sylvia Mathews Burwell, et al.*, Case No. 8:14-cv-1849-T-33-MAP (the "Civil Action"), the Debtor sought and obtained an *ex parte* temporary restraining order ("TRO") that enjoined CMS from terminating the Medicare and Medicaid provider agreements through August 15, 2014.

On August 11, 2014, the Secretary moved to dismiss the Civil Action for lack of subject matter jurisdiction. On August 15, 2014, the district court granted the United States' motion, dismissed the Civil Action, and dissolved the TRO. The district court concluded that Medicare's jurisdictional bar, 42 U.S.C. § 405(h), precluded the court from exercising jurisdiction over the controversy prior to the Debtor exhausting its administrative remedies. It was undisputed that the Debtor had not exhausted its administrative remedies.

Less than one hour after the district court issued its order in the Civil Action dissolving the TRO, the Debtor filed a Voluntary Petition for Chapter 11 bankruptcy. In the bankruptcy action, the Debtor filed an emergency motion to enjoin CMS and AHCA from terminating the Debtor's Medicare and Medicaid provider agreements. On August 25, 2014, the Bankruptcy Court entered an order provisionally granting the Debtor's motion subject

to a final evidentiary hearing. (Dkt. 1-15). The Bankruptcy Court noted that it had jurisdiction to consider the motion under 28 U.S.C. § 1334 and that the Debtor had made a “prima facie showing that [its] Medicare and Medicaid provider agreements [were] property of the estate sufficient to warrant the entry of an order providing that the automatic stay [prohibited] CMS, AHCA, and/or any managed care provider from taking action to terminate the Debtor’s Medicare and/or Medicaid provider agreements.” *Id.*

On August 26, 2014, the Bankruptcy Court held an evidentiary hearing. On September 5, 2014, based on the evidence presented at the evidentiary hearing, the Bankruptcy Court issued its “Order Granting Debtor’s Emergency Motion to Enforce the Automatic Stay and/or for an Order Pursuant to 11 U.S.C. § 105, Prohibiting Any Action to Terminate Debtor’s Medicaid and Medicare Provider Agreements, to Deny Payment of Claims and/or to Relocate Residents” (the “September 5, 2014 Order”). The September 5, 2014 Order granted the Debtor’s motion “for the reasons stated in open Court.” (Dkts. 1-31 and 1-2).

At the August 26, 2014 hearing, the Bankruptcy Court noted that it had jurisdiction under section 1334. It also concluded that the Medicare provider agreement was not terminated prior to the Debtor’s bankruptcy filing; as such, the provider agreement was an executory contract that could be assumed. (Dkt. 1-31). The Bankruptcy Court stated that it had a responsibility to “look at the big picture,” that is, “the welfare and concern for the

patients.” *Id.* at 116:6-11. Based on the testimony presented at the evidentiary hearing, the Bankruptcy Court concluded that the Debtor’s patients were not “in any danger.” *Id.*

Both AHCA and the United States of America, on behalf of the Secretary of the United States Department of Health and Human Services (“Secretary”) appealed the September 5, 2014 Order (the “First Appeals”). These are the First Appeals in front of this Court. In relevant part, both AHCA and the Secretary argue that the Bankruptcy Court lacked jurisdiction to enjoin the terminations of the Debtor’s provider agreements.

During the pendency of the First Appeals, the Bankruptcy Court issued the Confirmation Order that asserted jurisdiction over, and ordered the assumption of, the Debtor’s Medicare and Medicaid provider agreements. Both AHCA and the Secretary appealed the Confirmation Order (the “Second Appeals”) and argue, in relevant part, that the Bankruptcy Court was without jurisdiction to take any action related to the Medicare and Medicaid provider agreements. These are the Second Appeals before this Court. The jurisdictional arguments in the First and Second Appeals are essentially the same: 42 U.S.C. § 405(h), the Medicare jurisdictional bar, precluded the Bankruptcy Court from taking *any* action related to the provider agreements until the Debtor had exhausted its administrative remedies.

As explained below, the Bankruptcy Court erred as a matter of law because 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.

DISCUSSION

In its "Memorandum Opinion and Order on Confirmation," the Bankruptcy Court concluded, as a matter of law, that it had jurisdiction under 28 U.S.C. § 1334. Specifically, under section 1334, the Bankruptcy Court held that it had jurisdiction "over all civil proceedings arising under title 11, arising in a case under title 11, or related to a proceeding under title 11." (Dkt. 45-36). The Bankruptcy Court noted that "any dispute over the Debtor's ability to assume the Medicare provider agreement is 'related to' [the] title 11 case since the outcome of that dispute could conceivably have an effect on the Debtor's bankruptcy estate." *Id.*² The Court finds error in this conclusion of law because it ignores the jurisdictional bar contained in the Medicare Act. The Bankruptcy Court exceeded its subject matter jurisdiction when it interfered with CMS' termination of the provider agreements.

Under 42 U.S.C. § 1395cc(h)(1), an institution, like the Debtor in this case, that is "dissatisfied with a determination by the Secretary ... described in subsection (b)(2) of this section shall be entitled to a hearing thereon by the Secretary ... and to judicial review of the Secretary's final decision *after such hearing* as is provided in section 405(g) of this title."

² As stated above, the Bankruptcy Court's prior rulings also implied that it was exercising jurisdiction under section 1334.

(emphasis added). The referenced subsection (b)(2) outlines the Secretary's power to terminate a Medicare provider agreement in certain situations, including situations in which "the provider fails to comply substantially with the provisions of the agreement, [or] with the provisions of [the Medicare Act] and regulations thereunder." 42 U.S.C. § 1395cc(b)(2)(A).

Upon an exhaustion of the administrative remedies and upon the issuance of a final agency decision by the Secretary, a provider may seek judicial review. *See* 42 U.S.C. § 405(g). Under section 405(g): "Any individual, after any final decision of the [Secretary] made after a hearing to which he was a party ..., may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the [Secretary] may allow." Thus, with respect to a Medicare dispute, the judicial review provision at section 405(g) is the "exclusive source of federal court jurisdiction." *See Jackson v. Astrue*, 506 F.3d 1349, 1353 (11th Cir. 2007).

Clearly, the Secretary's decision to terminate the Debtor's provider agreements is an issue that arises under Medicare because termination of a provider agreement is specifically covered under the Medicare statute and regulations. Thus, a court, including the Bankruptcy Court here, is barred from exercising jurisdiction over the parties' dispute except for conducting judicial review of the Secretary's final decision. The Medicare Act incorporates 42 U.S.C. § 405(h) under 42 U.S.C. § 1395ii. Section 405(h) states: "[n]o findings of fact or decision of the [Secretary] shall be reviewed by any person, tribunal, or governmental agency except as herein provided" and no action against the Secretary "shall be brought

under section 1331 or 1346 of Title 28 to recover on any claim arising under” the Medicare Act. There 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) *after* administrative remedies have been exhausted and the Secretary has issued a final agency decision.

Here, the Debtor did not exhaust its administrative remedies with respect to the Secretary’s decision to terminate its provider agreements. Rather, after the district court concluded that it lacked jurisdiction and dissolved the TRO, the Debtor filed for Chapter 11 bankruptcy and argued that the provider agreements were property of the estate. The Bankruptcy Court then enjoined any termination of the provider agreements which essentially thwarted the administrative process and allowed the Debtor to circumvent its administrative obligations. But the Bankruptcy Court was without jurisdiction to interpose itself in the process, including entering an injunction to enjoin the provider agreements’ termination. *See Bayou Shores SNF, LLC v. Burwell*, No. 8:14-cv-1849-T-33MPA, 2014 WL 4059900 (M.D. Fla. Aug. 15, 2014) (holding that the district court was without jurisdiction to enjoin the termination of the provider agreements prior to exhaustion of administrative remedies); *Cathedral Rock of North Coll. Hill v. Shalala*, 223 F.3d 354 (6th Cir. 2000) (same); *Affil. Prof'l Home Health Care v. Shalala*, 164 F.3d 282 (5th Cir. 1999) (same); *Livingston Care Ctr., Inc. v. United States*, 934 F.2d 719 (6th Cir. 1991) (same); *Americana Healthcare Corp. v. Schweiker*, 688 F.2d 1072 (7th Cir. 1982) (same); *Forum*

Healthcare Grp., Inc. v. Ctrs. for Medicare & Medicaid Servs., 495 F. Supp. 2d 1321 (N.D. Ga. 2007) (same); *Trade Around the World of PA v. Shalala*, 145 F. Supp. 2d 653 (W.D. Pa. 2001) (same); *Northwest Healthcare, L.P. v. Sullivan*, 793 F. Supp. 724 (W.D. Tex. 1992) (same).

The Bankruptcy Court concluded that its jurisdiction was not barred under section 405(h) because section 405(h) does not expressly proscribe bankruptcy jurisdiction under 28 U.S.C. § 1334. The Eleventh Circuit has not directly addressed this issue. But the majority of courts that have considered the omission of section 1334 (and other jurisdictional grants) from section 405(h) have examined Congress' intent when it enacted the jurisdictional bar and concluded that the omission of section 1334 and other jurisdictional grants (like section 1332) was inconsistent with that intent. The Court agrees with this majority view.

"When originally enacted, the third sentence in section 405(h) specifically prohibited any action under 'Section 24 of the Judicial Code of the United States.'" *In re Hosp. Staffing Servs., Inc.*, 258 B.R. 53, 57-58 (Bankr. S.D. Fla. 2000). Section 24 (codified at 28 U.S.C. § 41) contained virtually all jurisdictional grants, including bankruptcy jurisdiction. *See Amendments to Title II of the Social Security Act*, § 201, 53 Stat. 1362, 1371 (1939). Jurisdictional grants were placed in separate sections when the judicial code was subsequently revised in 1948. *See Pub.L.No. 80-773*, 62 Stat. 869, 930-35 (1948).

In 1984, Congress revised the Social Security Act's jurisdictional bar, 42 U.S.C. § 405(h) and replaced "Section 24" with "Section 1331 or 1346." Upon this amendment,

Congress stated “none of such amendments shall be construed as changing or affecting any right, liability or status or interpretation which existed.” Pub.L. 98–369, § 2664(b), 98 Stat. 1171-72 (1984).

“Many courts have analyzed the amendments to section 405(h) and determined that the jurisdictional bar applies to all cases in which administrative remedies have not been exhausted, and not simply those in which jurisdiction is asserted under § 1331 or § 1346.” *In re Hosp. Staffing Servs.*, 258 B.R. at 57-58 (citing *Midland Psychiatric Assocs., Inc. v. United States*, 145 F.3d 1000, 1004 (8th Cir.1998); *Bodimetric Health Servs., Inc. v. Aetna Life & Cas.*, 903 F.2d 480, 488-89 (7th Cir.1990); *Total Renal Labs., Inc. v. Shalala*, 60 F. Supp. 2d 1323, 1331 (N.D. Ga. 1999)).

In *Bodimetric Health Services*, the Seventh Circuit analyzed in detail the technical amendments to section 405(h) and rejected the argument that diversity jurisdiction, 28 U.S.C. § 1332, could be used to evade section 405(h)’s jurisdictional bar because section 405(h) did not expressly reference section 1332. The same analysis and conclusion have applied in the bankruptcy context. *See In re Hosp. Staffing Servs.*, 258 B.R. at 57-58 (“It is clear that the Bankruptcy Court considered the history of § 405(h) and the cases analyzing § 405(h) and correctly concluded that it had no jurisdiction over Appellant’s Complaint.”); *In re St. Johns Home Health Agency, Inc.*, 173 B.R. 238, 244 (Bankr. S.D. Fla. 1994) (“[T]he omission of 28 U.S.C. § 1334 from the amended version of 42 U.S.C. § 405(h) was not meant to create bankruptcy jurisdiction where it previously was precluded. The intent and effect of the 1984

amendments are that bankruptcy court jurisdiction under § 1334 for claims arising under the Medicare Program is and remains precluded by § 405(h).”); *see also In re St. Mary Hosp.*, 123 B.R. 14, 17 (E.D. Pa. 1991).

The Bankruptcy Court dismissed these decisions as “improperly considering the legislative history of a statute when the statute’s text is plain and unambiguous.” (Dkt. 45-36). The Court respectfully disagrees and aligns itself with the majority view. As no other independent basis for jurisdiction existed to enjoin and order the assumption of the Medicare and Medicaid provider agreements, the Bankruptcy Court’s Orders, to the extent that they impacted those agreements, must be reversed.

Finally, it is worth noting that the Court need not determine the exact timing of any termination of the provider agreements (a hotly contested issue on appeal) because, even if the provider agreements had not been terminated prior to the bankruptcy filing, any action by the Bankruptcy Court to prevent or delay the effect of the Secretary’s determination, including a Confirmation Order ordering the assumption of the provider agreements, constituted a breach of section 405(h)’s jurisdictional bar and was thus in excess of the Bankruptcy Court’s subject matter jurisdiction.

CONCLUSION

The Bankruptcy Court erred as a matter of law when it exercised subject matter jurisdiction over the treatment of the provider agreements after the Secretary had determined that the provider agreements would be terminated. The Bankruptcy Court was without

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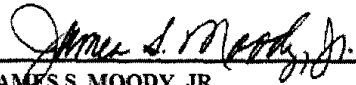
Case 8:14-bk-09521-MGW Doc 378 Filed 06/29/15 Page 13 of 13
Case 8:14-cv-02816-JSM Document 72 Filed 06/26/15 Page 13 of 13 PageID 5023

jurisdiction under the Medicare jurisdictional bar to issue the injunction that enjoined the Secretary's termination of the provider agreements and this error continued when the Bankruptcy Court subsequently authorized the Debtor to assume the provider agreements.

It is therefore **ORDERED AND ADJUDGED** that:

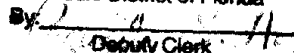
1. The September 5, 2014 Order and Confirmation Order are reversed to the extent explained herein.³
2. This appeal is remanded to the Bankruptcy Court for further proceedings.
3. The Clerk of Court is directed to close this case and terminate any pending motions as moot.

DONE and ORDERED in Tampa, Florida on June 26, 2015.


JAMES S. MOODY, JR.
UNITED STATES DISTRICT JUDGE

Copies furnished to:
Bankruptcy Judge Michael Williamson
Bankruptcy Clerk of Court
Counsel/Parties of Record

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I certify the foregoing to be a true
and correct copy of the original.
SHERYL L. LOESCH, Clerk
United States District Court
Middle District of Florida
By  Deputy Clerk

³ Notably, the reversal of the Confirmation Order is only with respect to the assumption of the Debtor's Medicare and Medicaid provider agreements.

No. 15-13731-FF
In The United States Court of Appeals
for the Eleventh Circuit

BAYOU SHORES, SNF, LLC,

Appellant

v.

FLORIDA AGENCY FOR HEALTH
CARE ADMINISTRATION and THE
UNITED STATES OF AMERICA, ON
BEHALF OF THE SECRETARY OF THE
UNITED STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES,

Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF FLORIDA, TAMPA DIVISION

Case No. 8:14-cv-02816-T-30 (Lead Case) as consolidated with
8:14-cv-02617-T-30; 8:15-cv-00103-T-30; 8:15-cv-00128-T-30

THE HONORABLE JAMES S. MOODY, JR.

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**CERTIFICATE OF INTERESTED PERSONS AND CORPORATE
DISCLOSURE STATEMENT BY COUNSEL FOR APPELLANT**

Appellant, Bayou Shores, SNF, LLC, (“Bayou”), by and through its undersigned counsel and pursuant to Rule 26.1 of the Federal Rules of Appellate Procedure and Eleventh Circuit Rule 26.1, hereby re-files its certificate of interested persons and corporate disclosure statement and identifies the following persons and entities:

CORPORATE DISCLOSURE STATEMENT

In accordance with Fed. R. App. P. 28(a)(1), 26.1(a) and Eleventh Circuit Rule 26.1-2, Bayou files this statement disclosing that no parent corporation or any publicly held corporation owns or has ever owned any stock in Bayou.

CERTIFICATE OF INTERESTED PERSONS

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MOODY, JR., HON. JAMES S.

MURPHY-DAVIS, COLLEEN

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PINELLAS COUNTY TAX COLLECTOR (NF)

SHEERAN, ANDREW T.

STREET, LESLIE G.

SYNOVUS BANK

TERZO, FRANK P.

THE UNITED STATES OF AMERICA, ON BEHALF OF THE SECRETARY
OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN
SERVICES

UNITED STATES TRUSTEE

VITALE, MICHAEL S.

WILLIAMS, STUART F.

WILLIAMSON, HON. MICHAEL G.

TABLE OF CONTENTS

CERTIFICATE OF INTERESTED PERSONS AND CORPORATE DISCLOSURE STATEMENT BY COUNSEL FOR APPELLANT	C1
CORPORATE DISCLOSURE STATEMENT	C1
CERTIFICATE OF INTERESTED PERSONS	C1
STATEMENT REGARDING ORAL ARGUMENT	1
JURISDICTIONAL STATEMENT	4
STATEMENT OF THE ISSUES PRESENTED FOR REVIEW	5
STATEMENT OF THE CASE AND FACTS	6
Nature of the case.	6
Statement of Facts, Course of Proceedings, and Disposition Below.	7
SUMMARY OF THE ARGUMENT	20
STANDARDS OF REVIEW APPLICABLE TO THE DISTRICT COURT’S (A) ORDERS DENYING BAYOU’S MOTIONS TO DISMISS AND (B) REVERSAL ORDER	22
ARGUMENT	24
I. Did the District Court err in concluding that 42 U.S.C. § 405(h) and/or (g) require administrative remedies to be exhausted before the Bankruptcy Court could exercise jurisdiction to consider whether Bayou Shores’ Medicare and Medicaid provider agreements had, or had not, terminated before the date Bayou Shores commenced its Chapter 11 case?	24
II. Did the District Court err by concluding that 42 U.S.C. § 405(h) and/or (g) deprived the Bankruptcy Court of jurisdiction to temporarily enjoin the termination of Bayou Shores’ Medicare and Medicaid provider agreements, after the Bankruptcy Court concluded Bayou Shores had made a prima facie showing that the agreements were property of the estate pursuant to 11 U.S.C. § 541(a) and that the police power exception to the automatic stay in 11 U.S.C. § 362(b)(4) did not apply?	34

III.	Did the District Court err by: (i) failing to interpret 42 U.S.C. § 405(h) according to its plain meaning and by (ii) concluding the Bankruptcy Court lacked jurisdiction to enter the (a) September 5, 2014 order; (b) Memorandum Opinion and Order on Confirmation, and (c) Confirmation Order providing for the assumption of its Medicare and Medicaid provider agreements?	42
IV.	Did the District Court err by denying Bayou Shores’ motion, and renewed motion, to dismiss the first appeals (as consolidated) filed by the United States of America, on behalf of the Secretary of the United States Department of Health and Human Services, and the Florida Agency for Health Care Administration, of the Bankruptcy Court’s order entered on September 5, 2014, when the issues in the first appeals had become both constitutionally and/or equitably moot?	51
V.	Did the District Court err by denying Bayou Shores’ motion to dismiss the appeal filed by the Florida Agency for Health Care Administration of the Bankruptcy Court’s Confirmation Order and the Memorandum Opinion and Order on Confirmation?.....	53
VI.	Did the District Court err by reversing the Bankruptcy Court’s Confirmation Order and the Memorandum Opinion and Order on Confirmation with respect to Bayou Shores’ assumption of its Medicare and Medicaid provider agreements after the Bankruptcy Court had concluded that Bayou Shores substantially consummated its Chapter 11 plan?	54
VII.	Did the District Court err by reversing the Bankruptcy Court’s: (i) September 5, 2014 order; (ii) the Memorandum Opinion and Order on Confirmation, and (iii) the Confirmation Order, when none of the Bankruptcy Court’s determinations with respect to Bayou Shores’ Medicare and Medicaid provider agreements involved an action “to recover on any claim arising under” the Medicare Act within the meaning of 42 U.S.C. § 405(h)?	56
	CERTIFICATE OF COMPLIANCE.....	60
	CERTIFICATE OF SERVICE.....	60

TABLE OF AUTHORITIES

	Page(s)
Cases	
<i>A.H. Robins Co., Inc. v. Piccinin</i> , 788 F.2d 994 (4th Cir.), cert. denied, 479 U.S. 876 (1986)	36
<i>Affil. Prof'l Home Health Care v. Shalala</i> , 164 F.3d 282 (5th Cir. 1999)	37
<i>Alanis-Bustamante v. Reno</i> , 201 F.3d 1303 (11th Cir. 2000)	45
<i>American Grain Ass'n v. Lee–Vac, Ltd.</i> , 630 F.2d 245 (5th Cir. Unit A 1980)	48
<i>Americana Healthcare Corp. v. Schweiker</i> , 688 F.2d 1072 (7th Cir. 1982)	37
<i>In re Baldwin–United Corp. Litig.</i> , 765 F.2d 343 (2d Cir.1985)	37
<i>Bank of Montreal v. Official Comm. of Unsecured Creditors</i> (<i>American Homepatient, Inc.</i>), 420 F.3d 559 (6th Cir. 2005)	52
<i>Bayou Shores SNF, LLC v. Burwell</i> , No. 8:14-cv-1849-T-33MPA, 2014 WL 4059900 (M.D. Fla. Aug. 15, 2014)	37
<i>Bayou Shores SNF LLC v. Sylvia Mathews Burwell, et al.</i> , Case No. 8:14-cv-1849-T-33-MAP . (Dist. Ct. Doc. No. 72, p. 4)	8
<i>BFP v. Resolution Trust Corp.</i> , 511 U.S. 531 (1994).....	45
<i>In re Bilzerian</i> , 153 F.3d 1278 (11th Cir.1998)	24
<i>In re BNW, Inc.</i> , 201 B.R. 838 (Bankr. S.D. Ala. 1996).....	55

<i>Bodimetric Health Services, Inc. v. Aetna Life & Cas.,</i> 903 F.2d 480 (7th Cir. 1990)	56, 57
<i>Matter of Boomgarden,</i> 780 F.2d 657 (7th Cir.1985)	39
<i>Brock v. Marysville Body Works,</i> 829 F.2d 383 (3rd Cir. 1987)	39
<i>In re Bryco Funding, Inc.,</i> No. 08-30173 TEC, 2009 WL 3271309 (Bankr. N.D. Cal. Oct. 9, 2009) .. Therefore, the Reversal Order	26
<i>Cannon v. University of Chicago,</i> 441 U.S. 677 (1979). Because the Reversal Order	47
<i>In re Carlton,</i> 309 B.R. 67 (Bankr. S.D. Fla. 2004)	29
<i>Carter v. Rodgers,</i> 220 F.3d 1249 (11th Cir. 2000). Civil	27, 36
<i>In re Castlerock Properties,</i> 781 F.2d 159 (9th Cir.1986)	39
<i>Cathedral Rock of North Coll. Hill v. Shalala,</i> 223 F.3d 354 (6th Cir. 2000)	37
<i>CBS Inc., v Primetime 24 JV,</i> 245 F.3d 1216 (11th Cir. 2001)	46
<i>In re Chateaugay Corp., Reomar, Inc.,</i> 93 B.R. 26 (S.D.N.Y.1988).....	37
<i>In re Citation Corp.,</i> 371 B.R. 518 (2007)	52, 53
<i>In re Club Assocs.,</i> 956 F.2d 1065 (11th Cir. 1992)	<i>passim</i>
<i>In re Coomer,</i> 375 B.R. 800 (Bankr. N.D. Ohio 2007).....	29

<i>In re Cox</i> , 338 F.3d 1238 (11th Cir.2003)	24
<i>In re Cox</i> , 433 B.R. 911 (Bankr.N.D.Ga.2010)	31
<i>In re Dolen</i> , 265 B.R. 471 (Bankr.M.D.Fla. 2001)	39
<i>In re Eastburg</i> , 447 B.R. 624 (B.A.P. 10th Cir. 2011)	39
<i>In re Ephedra Products Liab. Litig.</i> , 329 B.R. 1 (S.D.N.Y. 2005).....	28
<i>In re F.G. Metals, Inc.</i> , 390 B.R. 467 (Bankr. M.D. Fla. 2008)	50
<i>In re Fiber Optek Interconnect Corp.</i> , 2009 WL 3074605 (Bankr.S.D.N.Y. 2009).....	39
<i>In re Fin. Federated Title & Trust, Inc.</i> , 309 F.3d 1325 (11th Cir.2002)	24
<i>First American Health Care of Georgia, Inc., et al, v. U.S. Dept. of Health and Human Services</i> , 208 B.R. 985 (Bankr. S.D. Ga. 1996).....	43, 44
<i>FitzSimmons v. Walsh (In re FitzSimmons)</i> , 725 F.2d 1208 (9th Cir.1984)	30
<i>Forum Healthcare Grp., Inc. v. Ctrs. for Medicare & Medicaid Servs.</i> , 495 F. Supp. 2d 1321 (N.D. Ga. 2007).....	10, 13, 14, 37
<i>Friends of Everglades v. S. Fla. Water Mgmt. Dist.</i> , 570 F.3d 1210 (11th Cir.2009)	35
<i>In re Fundamental Long Term Care, Inc.</i> , 501 B.R. 770 (Bankr. M.D. Fla. 2013)	31
<i>In re Gardner</i> , 913 F.2d 1515 (10th Cir. 1990)	31

<i>Griffith v. United States</i> , 206 F.3d 1389 (11th Cir. 2000)	45
<i>In re GWI PCS I Inc.</i> , 230 F.3d 788 (5th Cir. 2000)	51
<i>Harris v. Garner</i> , 216 F.3d 970 (11th Cir. 2000) (en banc)	46
<i>Hicks, Muse & Co., Inc. v. Brandt (In re Healthco Inter'l, Inc.)</i> , 136 F.3d 45 (1st Cir. 1998).....	52
<i>Hillis Motors, Inc. v. Hawaii Auto. Dealers' Ass'n</i> , 997 F.2d 581 (9th Cir. 1993)	38
<i>In re Hillsborough Holdings Corp.</i> , 123 B.R. 1004 (1990)	36
<i>In re Holywell Corp.</i> , 911 F.2d 1539 (11th Cir. 1990), <i>overruled on other grounds</i> , 503 U.S. 47 (1992).....	51
<i>In re Hospital Staffing Services, Inc.</i> , 258 B.R. 53 (S.D. Fla. 2000)	56
<i>In re Int'l. Admin. Servs.</i> , 408 F.3d 689 (11th Cir.2005)	24
<i>In re Investment Company of the Southwest, Inc.</i> , 341 B.R. 298 (10th Cir. B.A.P. 2006)	49
<i>In re Jamko, Inc.</i> , 240 F.3d 1312 (11th Cir.2001)	25
<i>In re Justice Oaks II, Ltd.</i> , 898 F.2d 1544 (11th Cir. 1990)	5
<i>In re Kahihikolo</i> , 807 F.2d 1540 (11th Cir. 1987)	54
<i>Lindley v. F.D.I.C.</i> , 733 F.3d 1043 (11th Cir. 2013)	45

<i>Livingston Care Ctr., Inc. v. United States</i> , 934 F.2d 719 (6th Cir. 1991)	37
<i>In re Loop 76, LLC</i> , 465 B.R. 525 (B.A.P. 9th Cir. 2012) <i>aff'd</i> , 578 F. App'x 644 (9th Cir. 2014)	50
<i>Malowney v. Federal Collection Deposit Group</i> , 193 F.3d 1342 (11th Cir.1999)	35
<i>In re Manges</i> , 29 F.3d 1034 (5th Cir. 1994)	51
<i>McGahren v. First Citizens Bank & Trust (In re Weiss)</i> , 111 F.3d 1159 (4th Cir.1997)	29
<i>In re Menk</i> , 241 B.R. 896 (B.A.P. 9th Cir. 1999)	28
<i>Miami Center Ltd. Partnership v. Bank of New York</i> , 820 F.2d 376 (11th Cir.1987)	52
<i>Miles v. Apex MarineCorp.</i> , 498 U.S. 19 (1990).....	45, 47
<i>Miller v. Kemira, Inc. (In re Lemco Gypsum, Inc.)</i> , 910 F.2d 784 (11th Cir. 1990)	27
<i>Miller v. Meinhard–Commercial Corp.</i> , 462 F.2d 358 (5th Cir. 1972)	5
<i>In re Motors Liquidation Co.</i> , 462 B.R. 494 (Bankr. S.D.N.Y. 2012).....	55
<i>Northwest Healthcare, L.P. v. Sullivan</i> , 793 F. Supp. 724 (W.D. Tex. 1992)	37
<i>In re Nurses Registry and Home Health Corp.</i> , 533 B.R. 590 (Bankr. E.D. Ky. 2015)	45, 46
<i>Nyaga v. Ashcroft</i> , 323 F.3d 906 (11th Cir. 2003)	35

<i>Olympia & York Fla. Equity Corp. v. Bank of New York (In re Holywell Corp.),</i> 913 F.2d 873 (11th Cir.1990)	30
<i>Oncale v. Sundowner Offshore Servs., Inc.,</i> 523 U.S. 75 (1998).....	46
<i>Pacor, Inc. v. Higgins,</i> 743 F.2d 984 (3d Cir. 1984)	28
<i>In re Pegasus Gold Corp.,</i> 394 F.3d 1189 (9th Cir. 2005)	28
<i>Pension Benefit Guar. Corp. v. Cont'l Airlines, Inc. (In re Cont'l Airlines, Inc.),</i> 138 B.R. 442 (D.Del.1992).....	32
<i>Preiser v. Newkirk,</i> 422 U.S. 395, 95 S.Ct. 2330, 45 L.Ed.2d 272 (1975)	35
<i>Pursifull v. Eakin,</i> 814 F.2d 1501 (10th Cir. 1987)	39
<i>Schroeder v. New Century Holdings, Inc. (In re New Century Holdings, Inc.),</i> 387 B.R. 95 (Bankr.D.Del.2008).....	32
<i>In re Sea Garden Motel and Apartments,</i> 195 B.R. 294 (D.N.J.1996)	50
<i>In re Servico, Inc.,</i> 161 B.R. 297 (S.D. Fla. 1993)	35
<i>In re Sewanee Land, Coal & Cattle, Inc.,</i> 735 F.2d 1294 (11th Cir.1984)	48
<i>Soliman v. United States ex rel. INS,</i> 296 F.3d 1237 (11th Cir. 2002)	35
<i>In re St. Johns Home Health Agency, Inc.,</i> 173 B.R. 238 (Bankr. S.D. Fla. 1994)	56, 57

<i>In re St. Mary Hosp.,</i> 123 B.R. 14 (E.D. Pa. 1991)	56
<i>Stoll v. Gottlieb,</i> 305 U.S. 165 59 S.Ct. 134, 83 L.Ed. 104 (1938).....	5
<i>In re Strickland and Davis Intern., Inc.,</i> No. 14-13104, 2015 WL 2168348 (11th Cir. May 11, 2015)	55
<i>Sullivan v. Town & Country Home Nursing Svcs., Inc. (In re Town & Country Home Nursing Svcs., Inc.),</i> 963 F.2d 1146 (9th Cir.1992)	26, 45
<i>In re T–H New Orleans Limited Partnership,</i> 116 F.3d 790 (5th Cir.1997)	50
<i>In re Toledo,</i> 170 F.3d 1340 (11th Cir. 1999) . Civil	27
<i>Total Renal Laboratories v. Shalala,</i> 60 F. Supp.2d 1323 (N.D. Ga. 1999).....	56
<i>In re Town & Country Home Nursing Servs.,</i> 112 B.R. 329 (9th Cir. BAP 1990)	25
<i>Trade Around the World of PA v. Shalala,</i> 145 F. Supp. 2d 653 (W.D. Pa. 2001).....	37
<i>In re TXNB Internal Case,</i> 483 F.3d 292 (5th Cir. 2007)	28
<i>United States v. Gonzales,</i> 520 U.S. 1 (1997).....	46
<i>United States v. Johns,</i> 984 F.2d 1162 (11th Cir. 1993)	23
<i>United States v. McCranie,</i> 169 F.3d 723 (11th Cir. 1999)	23
<i>United States v. Veal,</i> 153 F.3d 1233 (11th Cir. 1998)	23

<i>United States v. Whiting Pools, Inc.</i> , 462 U.S. 198, 103 S.Ct. 2309, 76 L.Ed.2d 515 (1983).....	29, 30
<i>University Medical Center v. Sullivan (In re Medical Center)</i> , 973 F.2d 1065 (3d Cir.1992)	25
<i>In re UNR Indus., Inc.</i> , 20 F.3d 766 (7th Cir. 1994)	52
<i>In re Winn-Dixie Store, Inc.</i> , 286 Fed. App'x. 619 (11th Cir. 2008)	23
<i>In re Xonics, Inc.</i> , 813 F.2d 127 (7th Cir.1987)	32
Statutes	
5 U.S.C. § 705.....	8
11 U.S.C. § 105.....	12, 15, 36, 38
<i>11 U.S.C. § 105 and 362</i>	17, 49
11 U.S.C. § 105(a)	9, 36, 37, 38
11 U.S.C. §§ 105(a) and 362(a)	36
11 U.S.C. § 106.....	49
11 U.S.C. § 106(a)	37, 39
11 U.S.C. § 109.....	27
11 U.S.C. § 157(b)	8
11 U.S.C. § 362.....	35, 39
11 U.S.C. § 362(a)	9
11 U.S.C. § 362(a)(3).....	38
11 U.S.C. § 362(b)(4).....	<i>passim</i>
11 U.S.C. § 362(c)(1).....	35

11 U.S.C. § 365	48, 49, 58
11 U.S.C. § 541	25, 30, 31, 58
11 U.S.C. § 541(a)	<i>passim</i>
11 U.S.C. § 541(a)(1)	29, 30
11 U.S.C. § 541(a)(6)	30
11 U.S.C. § 1127(b)	55, 56
11 U.S.C. § 1129	49
11 U.S.C. § 1129(a)(11)	13, 49
11 U.S.C. § 1141	34, 49
11 U.S.C. §§ 1141 and 1142	49
11 U.S.C. § 1142	49
11 U.S.C. § 1144	55, 56
28 U.S.C. § 157	38
28 U.S.C. § 157(b)(2)	31, 33
28 U.S.C. § 157(b)(2)(G)	38
28 U.S.C. § 157(b)(2)(L)	48
28 U.S.C. § 157(b)(2)(M)	49
28 U.S.C. § 158(a)	4, 21
28 U.S.C. § 158(d)	4
28 U.S.C. § 405(g)	20, 22, 26, 46
28 U.S.C. § 405(g) and (h)	1
28 U.S.C. §§ 405(h) and (g)	23
28 U.S.C. § 1291	4

28 U.S.C. § 1331	<i>passim</i>
28 U.S.C. § 1334	<i>passim</i>
28 U.S.C. § 1334(b)	27, 28, 49
28 U.S.C. § 1334(e)	29, 30, 31, 33
28 U.S.C. § 1361	8
28 U.S.C. § 1651	8
42 U.S.C. § 405(h)	57
42 U.S.C. § 405	8
42 U.S.C. § 405(h)	<i>passim</i>
42 U.S.C. § 1395ii	8
Title 11 of the United States Code, Titles XVIII and XIX	<i>passim</i>
title 28, United States Code	43, 44, 47
Administrative Procedures Act	8
Federal Tort Claims Act	26
Medicare Act	<i>passim</i>

Rules

Bankruptcy Rule 3020(e)	15
Eleventh Circuit Rule 26.1	1
Eleventh Circuit Rule 26.1-2	1
Fed. R. App. P. 4(a)(1)(B)	5
Fed. R. App. P. 28(a)(1), 26.1(a)	1
Fed. R. Bankr. P. 3020(e)	18
Rule 25, Federal Rule of Appellate Procedure	60

Rule 26.1 of the Federal Rules of Appellate Procedure	1
Rule 9014	28
Other Authorities	
42 C.F.R. § 488.456(c).....	11
<i>Opinion vacated and superseded sub nom. First Am. Health Care of Georgia, Inc. v. U.S. Dep't of Health & Human Servs.</i> , No. 96-2007, 1996 WL 282149	44
Article III of the U.S. Constitution	<i>passim</i>
Article III, Section 2, of the U.S. Constitution	4, 22, 35, 51

STATEMENT REGARDING ORAL ARGUMENT

Appellant, Bayou Shores, SNF, LLC (“Bayou”), requests oral argument. The decisional process will be aided by oral argument in this appeal in which Bayou seeks the reversal of an order entered by the Honorable James S. Moody, Jr., of the United States District Court for the Middle District of Florida, Tampa Division (hereinafter, the “District Court”) on June 26, 2015 (hereinafter, the “Reversal Order”) in which the District Court reversed several orders entered during Bayou’s Chapter 11 case by the Honorable Michael G. Williamson of the Bankruptcy Court for the Middle District of Florida, Tampa Division (hereinafter, the “Bankruptcy Court”), including orders confirming Bayou’s Chapter 11 plan, on the basis that the Bankruptcy Court lacked jurisdiction to enter the orders. Bayou challenges the District Court’s conclusion that the Bankruptcy Court lacked jurisdiction to enter its orders and the District Court’s conclusion that it possessed jurisdiction to enter the Reversal Order at the time of its entry. Bayou also challenges the District Court’s conclusions regarding and interpreting 28 U.S.C. § 405(g) and (h).

The case on appeal is procedurally complex. The District Court consolidated four appeals filed by two parties in connection with orders entered by the Bankruptcy Court at the very beginning, and at the very end, of Bayou’s Chapter 11 case. Because appellees herein, the Florida Agency for Health Care Administration (hereinafter, “ACHA”) and the United States of America, on behalf

of the Secretary of the United States Department of Health and Human Services (hereinafter, “HHS”) failed to seek a stay pending their appeals of the very first orders the Bankruptcy court entered, Bayou’s Chapter 11 case progressed. At the conclusion of Bayou’s Chapter 11 case, the Bankruptcy Court entered two orders confirming Bayou’s Chapter 11 plan and authorizing Bayou to assume its Medicare and Medicaid provider agreements (collectively, “Provider Agreements”), and HHS and AHCA likewise appealed these orders to the District Court. AHCA did not request a stay of these subsequent orders pending appeal; HHS did request a stay but both the Bankruptcy Court and the District Court denied the request following hearings.

Subsequently, after Bayou substantially consummated its Chapter 11 plan, Bayou filed motions to dismiss the appeals of HHS and AHCA of the first orders entered by the Bankruptcy Court, and of AHCA’s appeal of the confirmation orders, which motions the District Court summarily denied. Next, the District Court combined the two prior appeals by HHS and AHCA of the first orders entered by the Bankruptcy Court with the two appeals by HHS and AHCA of the confirmation orders, and thereafter issued the Reversal Order.

In addition to being procedurally complex, the case on appeal is also legally complex. Certain issues presented are of first impression before this Court and upon which the authorities are divided. As such, Bayou believes oral argument will

facilitate this Court's consideration of the jurisdictional issues involved in this appeal as well as the interplay between the relevant statutory provisions contained in Title 11 of the United States Code, Titles XVIII and XIX of the Social Security Act, and case law arising under these federal statutes.

JURISDICTIONAL STATEMENT

Pursuant to 28 U.S.C. § 158(a), the District Court had jurisdiction to review the orders entered by the Bankruptcy Court as such constituted final orders of the Bankruptcy Court at the time HHS and AHCA commenced their appeals. However, the District Court did not have jurisdiction to enter the Reversal Order on June 26, 2015 because, by that date, most all of the issues on appeal had become constitutionally moot for failure to present any live case or controversy within the meaning of Article III, Section 2, of the U.S. Constitution. Any remaining issues that were not constitutionally moot when the District Court entered the Reversal Order had become equitably moot pursuant to *In re Club Assocs.*, 956 F.2d 1065, 1069 (11th Cir. 1992), because Bayou had substantially consummated its Chapter 11 plan. As such, the District Court erred as a matter of law by entering the Reversal Order reversing the Bankruptcy Court's orders, including orders confirmation orders, after Bayou had substantially consummated its Chapter 11 plan.

Jurisdiction in this Court is based upon 28 U.S.C. § 1291 as this is an appeal from a final decision of the District Court disposing of all of the parties' claims in that tribunal. Furthermore, this Court has jurisdiction to review the Reversal Order pursuant to 28 U.S.C. § 158(d) as a final order reversing the Bankruptcy Court's orders which orders ended all litigation between Bayou, HHS, and AHCA on the

merits in Bayou's Chapter 11 case. *In re Justice Oaks II, Ltd.*, 898 F.2d 1544, 1550 (11th Cir. 1990) (bankruptcy court order confirming a plan of reorganization constitutes a final judgment on the merits) *citing Stoll v. Gottlieb*, 305 U.S. 165, 170–71 59 S.Ct. 134, 137, 83 L.Ed. 104 (1938); *Miller v. Meinhard–Commercial Corp.*, 462 F.2d 358, 360 (5th Cir. 1972).

On August 19, 2015, Bayou filed its notice of appeal from the Reversal Order entered on June 26, 2015. Fed. R. App. P. 4(a)(1)(B) governs the time for filing a notice of appeal and provides that such notice may be filed by any party within 60 days after entry of the judgment or order appealed from if one of the parties is the United States or an agency of the United States. Because HHS is an agency of the United States, this appeal was timely filed pursuant to Fed. R. App. P. 4(a)(1)(B).

STATEMENT OF THE ISSUES PRESENTED FOR REVIEW

1. Did the District Court err in concluding that 42 U.S.C. § 405(h) and/or (g) require administrative remedies to be exhausted before the Bankruptcy Court could exercise jurisdiction to consider whether Bayou Shores' Medicare and Medicaid provider agreements had, or had not, terminated before the date Bayou Shores commenced its Chapter 11 case?
2. Did the District Court err by concluding that 42 U.S.C. § 405(h) and/or (g) deprived the Bankruptcy Court of jurisdiction to temporarily enjoin the termination of Bayou Shores' Medicare and Medicaid provider agreements, after the Bankruptcy Court concluded Bayou Shores had made a prima facie showing that the agreements were property of the estate pursuant to 11 U.S.C. § 541(a) and that the police power exception to the automatic stay in 11 U.S.C. § 362(b)(4) did not apply?

3. Did the District Court err by: (i) failing to interpret 42 U.S.C. § 405(h) according to its plain meaning and by (ii) concluding the Bankruptcy Court lacked jurisdiction to enter the (a) September 5, 2014 order; (b) Memorandum Opinion and Order on Confirmation, and (c) Confirmation Order providing for the assumption of its Medicare and Medicaid provider agreements?
4. Did the District Court err by denying Bayou Shores' motion, and renewed motion, to dismiss the first appeals (as consolidated) filed by the United States of America, on behalf of the Secretary of the United States Department of Health and Human Services, and the Florida Agency for Health Care Administration, of the Bankruptcy Court's order entered on September 5, 2014, when the issues in the first appeals had become both constitutionally and/or equitably moot?
5. Did the District Court err by denying Bayou Shores' motion to dismiss the appeal filed by the Florida Agency for Health Care Administration of the Bankruptcy Court's Confirmation Order and the Memorandum Opinion and Order on Confirmation?
6. Did the District Court err by reversing the Bankruptcy Court's Confirmation Order and the Memorandum Opinion and Order on Confirmation with respect to Bayou Shores' assumption of its Medicare and Medicaid provider agreements after the Bankruptcy Court had concluded that Bayou Shores substantially consummated its Chapter 11 plan?
7. Did the District Court err by reversing the Bankruptcy Court's: (i) September 5, 2014 order; (ii) the Memorandum Opinion and Order on Confirmation, and (iii) the Confirmation Order, when none of the Bankruptcy Court's determinations with respect to Bayou Shores' Medicare and Medicaid provider agreements involved an action "to recover on any claim arising under" the Medicare Act within the meaning of 42 U.S.C. § 405(h)?

STATEMENT OF THE CASE AND FACTS

NATURE OF THE CASE.

This is an appeal of three [3] orders entered by the District Court exercising appellate jurisdiction over four consolidated appeals of orders entered by the

Bankruptcy Court following extensive evidentiary hearings conducted in the very beginning, and at the very end, of Bayou's Chapter 11 case. (District Court Docket ["Dist. Ct."], Case No. 8:14-cv-02816-T-30, Doc. Nos. 31, 65, 72). Two of the orders on appeal are the District Court's orders denying Bayou's motions to dismiss the consolidated appeals on the grounds of mootness, which the District Court denied after failing to analyze the "case" and "controversy" requirement in Article III of the U.S. Constitution or the factors in *In re Club Assocs.*, 956 F.2d 1065, 1069 (11th Cir. 1992). (Dist. Ct. Doc. Nos. 31, p. 2; 65, p. 1). The third order on appeal is the Reversal Order in which the District Court *partially* reversed two confirmation orders *after* the Bankruptcy Court had made factual findings that Bayou substantially consummated the confirmed Plan and after AHCA and HHS waived or otherwise failed to obtain any stay of the confirmation orders. (Dist. Ct. Doc. No. 72, pp. 12-13). In the Reversal Order, the District Court concluded the Bankruptcy Court was without jurisdiction to enter either the confirmation orders or the order it entered at the beginning of Bayou's Chapter 11 case. (Dist. Ct. Doc. No. 72, pp. 9, 12). The relevant facts and procedural history are as follows.

STATEMENT OF FACTS, COURSE OF PROCEEDINGS, AND DISPOSITION BELOW.

After receiving a notice from HHS on July 22, 2014 that its Medicare provider agreement was slated for termination, Bayou obtained an *ex parte* temporary restraining order ("TRO") enjoining termination through August 15,

2014, in a civil action styled *Bayou Shores SNF LLC v. Sylvia Mathews Burwell, et al.*, Case No. 8:14-cv-1849-T-33-MAP (the “Civil Action”). (Dist. Ct. Doc. No. 72, p. 4). Bayou filed the Civil Action in same District Court issuing the orders appealed from herein, but a different judge presided over the Civil Action. Ultimately, the District Court dismissed the Civil Action for lack of jurisdiction and dissolved the TRO, concluding that 42 U.S.C. § 405(h) precluded it from exercising jurisdiction prior to the exhaustion of administrative remedies.¹ (Dist. Ct. Doc. No. 72, p. 4). One hour later, Bayou commenced its Chapter 11 case seeking to reorganize, which invoked the Bankruptcy Court’s jurisdiction pursuant to 11 U.S.C. § 1334 and 11 U.S.C. § 157(b). (Bankruptcy Court Docket [“Bk. Ct.”], Case No. 8:14-bk-09521-MGW, Doc. No. 1).

Seven [7] days after Bayou filed its Chapter 11 case (the “Petition Date”), approximately fourteen [14] AHCA representatives arrived at Bayou and delivered

¹ The Civil Action was based on the district court’s jurisdiction under 28 U.S.C. § 1331 (Federal question), 28 U.S.C. § 1361 (Action to compel an officer of the United States to perform his duty), 28 U.S.C. § 1651 (Writs), 42 U.S.C. § 405 (Evidence, procedure, and certification for payments), 42 U.S.C. § 1395ii (Prohibition against Federal interference), the district court’s general equity powers, and 5 U.S.C. § 705 (the Administrative Procedures Act). *See* Civil Action, Doc. No. 1 at ¶ 15. By contrast, the Bankruptcy Court’s jurisdiction was based upon 11 U.S.C. § 157(b) and 28 U.S.C. § 1334.

letters directly to Bayou's residents informing them that their Medicare and Medicaid benefits would be terminated on September 15, 2014, but that they could remain at Bayou and pay for their own care (the "Patient Letter"). (Bk. Ct. Doc. No. 25, Exh. C). (Nearly all of Bayou's residents are indigent, suffer from Alzheimer's or dementia, and have serious psychiatric conditions such as schizophrenia or bi-polar disorder). (Bk. Ct. Doc. No. 25, Exh. E, p. 2, ¶ 3). In response, to protect the patients and its chance to reorganize in Chapter 11, Bayou filed an emergency motion with the Bankruptcy Court requesting protection of the automatic stay provided in 11 U.S.C. § 362(a) and/or entering a temporary injunction to prevent the termination of the Provider Agreements and the termination of benefits to Bayou's residents during the Chapter 11 case ("Emergency Motion"). (Bk. Ct. Doc. No. 25). The Bankruptcy Court conducted an emergency hearing on August 22, 2014 and thereafter preliminarily granted the Emergency Motion concluding that because Bayou made a prima facie showing that the Provider Agreements had not terminated by the Petition Date they were property of the estate pursuant to 11 U.S.C. § 541(a) protected by the automatic stay in 11 U.S.C. § 362(a). (Bk. Ct. Doc. No. 35, ¶¶ 4, 7). The Bankruptcy Court further temporarily enjoined the removal of patients pursuant to 11 U.S.C. § 105(a) and prohibited termination of the Provider Agreements and the denial of patient claims (the "Preliminary Order"). (Bk. Ct. Doc. No. 35, ¶¶ 8-7).

AHCA did not file a response to the Emergency Motion. However, HHS filed a response arguing that: (i) the *Medicare* provider agreement terminated before the Petition Date, thus, the *Medicaid* provider agreement terminated “by operation of law”; (ii) the Bankruptcy Court lacked subject matter jurisdiction over the Provider Agreements; and (iii) the police power exception to the automatic stay in 11 U.S.C. § 362(b)(4) applied (“HHS’s Response”). (Bk. Ct. Doc. No. 42, pp. 2, 6-16). The Bankruptcy Court scheduled a final evidentiary hearing on the Emergency Motion and HHS’s Response on August 26, 2014 (“FEH”). (Bk. Ct. Doc. No. 35).

During the FEH, Bayou admitted twelve [12] exhibits and introduced testimony from six [6] witnesses, including testimony from a resident of Bayou who is blind, a guardian to several of Bayou’s residents, Bayou’s past and current administrators, an expert in administrative law, and an expert in patient care and regulatory compliance. (Bk. Ct. Doc. No. 80, pp. 4-5, 9, 13, 18, 65, 44, 60; Doc. No. 237). AHCA, attending the hearing only telephonically, supplied no evidence or witness testimony at all. (Bk. Ct. Doc. No. 80, pp. 4-6, 68). HHS introduced six [6] exhibits (Bk. Ct. Doc. Nos. 49, 50, 51, 52), but offered no witnesses to rebut the testimony of Bayou’s witnesses who testified regarding patient care at Bayou (Bk. Ct. Doc. No. 80, pp. 4, 9-11, 32-34), Bayou’s regulatory compliance efforts (Bk. Ct. Doc. No. 80, pp. 4, 19-34, 44-55), the critical value of the Provider

Agreements to Bayou's reorganization (Bk. Ct. Doc. No. 80, pp. 4, 28-30), "transfer trauma" and the possible impacts of such upon Bayou's infirm residents if forced to relocate (Bk. Ct. Doc. No. 80, pp. 4, 9-11, 13-16, 29-30, 52-55), and why, as a matter of law and fact, Bayou's Provider Agreements had not terminated on the Petition Date (Bk. Ct. Doc. No. 80, pp. 4, 60-67). Bayou's blind resident also testified that his depression would worsen if he was forced to move from his home, and that the local program to assist the blind in new surroundings no longer existed. (Bk. Ct. Doc. No. 80, pp. 10-11).

HHS offered no rebuttal testimony. HHS's evidence supplied only the reasons HHS elected to terminate, (Bk. Ct. Doc. Nos. 42-1, 42-2, 42-3), which reasons the Bankruptcy Court accepted and did not question (Bk. Ct. Doc. No. 80, p. 71, *ll.* 9-25; p. 72, *ll.* 1-8). Rather, the Bankruptcy Court limited its analysis to whether or not termination had, or had not, already occurred on the Petition Date. . (Bk. Ct. Doc. No. 80, pp. 112-19). Further, HHS offered no evidence of at least one important condition precedent to termination of the Medicare provider agreement into evidence at the FEH, or at any subsequent hearing in the Bankruptcy Court—notice to the public of termination pursuant to 42 C.F.R. § 488.456(c). As such, the Bankruptcy Court lacked any record evidence that at least one condition precedent to termination was satisfied.

Following the FEH, on September 5, 2014, the Bankruptcy Court issued an order confirming and extending the relief awarded in the Preliminary Order (Preliminary Order, together with order entered on September 5, 2014, collectively referred to herein as “September 5 Order”). (Bk. Ct. Doc. No. 78). AHCA and HHS separately appealed the September 5 Order to the District Court but, critically, neither sought a stay pending appeal (collectively, “First Appeals”). (Bk. Ct. Doc. Nos. 88, 156).² As a result, Bayou Shores was entitled to treat the Bankruptcy Court’s conclusions as final.

² HHS and AHCA each identified the same four issues on appeal in the First Appeals:

1. Whether the Bankruptcy Court erred in treating Bayou Shores SNF’s Medicare and Medicaid provider agreements as though they were still in effect at the time of the bankruptcy filing.
2. Whether the Bankruptcy Court erred in finding it had subject matter jurisdiction to enjoin the termination of the Medicare and Medicaid provider agreements
3. Whether the Bankruptcy Court erred in finding that the police and regulatory exception to the automatic stay, 11 U.S.C. § 362(b)(4), did not apply to the termination of the Medicare and Medicaid provider agreements.
4. Whether the Bankruptcy Court erred by invoking 11 U.S.C. § 105 to enjoin the termination of the Medicare and Medicaid provider agreements.

See, e.g., Dist. Ct. Doc. No. 1-3, Pg. 2.

As the First Appeals were pending, Bayou's Chapter 11 case progressed. On November 21, 2014, Bayou filed its First Amended Disclosure Statement and First Amended Chapter 11 Plan ("Plan") with the Bankruptcy Court. (Bk. Ct. Doc. Nos. 185, 186). Article VI of the Plan provided that Bayou would assume all of its executory contracts including: (i) the *Medicaid* provider agreement with AHCA (Bk. Ct. Doc. No. 186, p. 29); and (ii) the *Medicare* provider agreement with HHS (Bk. Ct. Doc. No. 186, p. 30). The Bankruptcy Court then entered an order establishing the deadline to object to confirmation of the Plan and setting the evidentiary hearing on confirmation for December 22, 2014 ("Scheduling Order") (Bk. Ct. Doc. No. 188), and providing that "timely filed objections to confirmation" would be heard on that date (Bk. Ct. Doc. No. 188, p. 1, ¶ 2). Timely objections were those filed no later than seven (7) days before the date of the hearing, December 15, 2014. (Bk. Ct. Doc. No. 188, p. 1, ¶ 5).

AHCA did not file an objection to the Plan, or to Bayou's assumption of the Medicaid provider agreement. (AHCA did file a Motion for Clarification/Relief from Stay on December 16, 2014, (Bk. Ct. Doc. No. 246), which was granted as to AHCA's licensing authority, (Bk. Ct. Doc. No. 282)). HHS filed a very limited objection to the Plan arguing *only* that: (i) the Plan was not feasible pursuant to 11 U.S.C. § 1129(a)(11) because it depended upon income from the Provider Agreements and (ii) because the future of the Provider Agreements and Bayou

Shores' license was uncertain, confirmation should be denied ("HHS's Feasibility Objection"). (Bk. Ct. Doc. No. 242, pp. 4-6). HHS also filed an objection to Bayou's assumption of the Medicare provider agreement (Bk. Ct. Doc. No. 255) ("HHS's Objection to Assumption"), arguing that assumption should be denied "because there is no executory contract—the Provider Agreement—the Debtor can assume or reject." (Bk. Ct. Doc. No. 255, p. 1). As such, no objection was filed in connection with Bayou's proposed assumption of the Medicaid provider agreement. Further, HHS's argument that there was no Medicare provider agreement was already before the District Court in the First Appeals, although the effect of the Bankruptcy Court's conclusion on that point was not stayed.

After evidence closed (Bk. Ct. Doc. No. 281, 12/22/14 TR. p. 58, *ll.* 16-17) at the hearing to consider confirmation of the Plan, HHS's Feasibility Objection, and HHS's Objection to Assumption, and after counsel for HHS argued HHS's Feasibility Objection, counsel for AHCA stated its "agreement with" and that it was "joining with" HHS's Feasibility Objection. (Bk. Ct. Doc. No. 281, 12/22/14 TR. p. 65, *ll.* 20-23). However, because HHS's Feasibility Objection pertained only to Medicare and not Medicaid, there was no objection to Bayou's Plan proposing to assume the Medicaid provider agreement pursuant to the deadline in the Scheduling Order. In addition, counsel for AHCA made no formal motion for *ore tenus* joinder, nor does the transcript from the confirmation hearing reflect that

joinder was granted. After AHCA's counsel spoke, the Bankruptcy Court simply thanked him for his comment. (Bk. Ct. Doc. No. 281, 12/22/14 TR. p. 65, *ll.* 24-25; p. 66, *l.* 1).

On December 31, 2014 the Bankruptcy Court entered an order concluding that: (i) it had jurisdiction over the parties' Medicare-related dispute (Bk. Ct. Doc. No. 282, pp. 8-11); (ii) Bayou could assume its Medicare provider agreement (Bk. Ct. Doc. No. 282, pp. 1-2); (iii) the Plan was feasible (Bk. Ct. Doc. No. 282, pp. 1-2, 17-22) (the "December Confirmation Order"). The December Confirmation Order also directed Bayou to submit an order confirming the Plan (Bk. Ct. Doc. No. 282, p. 22, ¶ 2) which order the Bankruptcy Court entered on January 7, 2015 (the "January Confirmation Order") (Bk. Ct. Doc. No. 285) and which provided for the assumption of the Provider Agreements (Bk. Ct. Doc. No. 285, p. 9, ¶ 2; p. 15, ¶ 19). The January Confirmation Order provided:

Unless otherwise provided in the Amended Plan or this Confirmation Order, all injunctions and stays previously provided for in this case pursuant to sections 105 and/or 362 of the Bankruptcy Code shall remain in full force and effect until the Effective Date.

[. . .]

The fourteen (14) day stay of Bankruptcy Rule 3020(e) shall not apply and this Confirmation Order shall become effective immediately upon its entry.

(Bk. Ct. Doc. No. 285, p. 13, ¶ 10; p. 17, ¶ 26).

On January 9, 2015, Bayou filed its “Notice of Effective Date” with the Bankruptcy Court. (Bk. Ct. Doc. No. 288). The term “Effective Date” was defined in the Plan to mean “a date within thirty (30) days after the Bankruptcy Court has entered the Confirmation Order; *provided, however*, that the Effective Date shall not occur until any preconditions to the occurrence of the Effective Date set forth in the Plan have been met unless waived by the Debtor. ***In the event that an appeal of the Confirmation Order is pending, the Effective Date may still occur at any time within thirty (30) days after the entry of the Confirmation Order provided that Debtor files a notice setting forth the Effective Date with the Bankruptcy Court.***” (Bk. Ct. Doc. No. 186, p. 7) (emphasis added). The Plan was served upon all creditors and parties in interest including counsel for Appellees *approximately one month before the scheduled hearing to consider confirmation of the Plan*, (Bk. Ct. Doc. No. 190), but neither Appellee nor any other party objected to the timing of the occurrence of the Effective Date.

On the Effective Date, nine [9] days after the December Confirmation Order was entered, and as specifically contemplated by the Plan, Bayou paid, in full, sixty-five [65] creditors and all of its administrative expenses. (Bk. Ct. Doc. No. 339, pp. 1-3, ¶ 3). To do this, Bayou borrowed \$700,000 from a \$1,000,000 revolving line of credit from a third-party lender which loan was secured by the filing of a UCC-1 in Florida’s secured transaction registry maintained by the

Florida Secretary of State securing repayment per the Plan. (Bk. Ct. Doc. No. 339, p. 3, ¶ 4). In addition, Bayou assumed fifty-eight [58] contracts,³ including its lease of the nursing home facility from its landlord, 42nd Ave. South LLC, committing itself to a term of three additional years (until December, 31, 2017) and payments totaling over \$4.5 million. (Bk. Ct. Doc. No. 339, p. 3, ¶ 5). Further, Bayou obtained an order discharging the patient care ombudsman (Bk. Ct. Doc. No. 296), and hired consultants in the area of patient care and regulatory compliance to advise it on an ongoing basis. (Bk. Ct. Doc. No. 339-1, p. 4 ¶ 7). Also, per the January Confirmation Order, *all injunctions and stays previously provided for in Bayou's Chapter 11 case pursuant to 11 U.S.C. § 105 and 362 ceased to be in effect upon the occurrence of the Effective Date*. (Bk. Ct. Doc. No. 285, p. 13, ¶ 10).

Thereafter, on January 13, 2015, HHS appealed the Confirmation Orders and on January 15, 2015, AHCA did so too. (Bk. Ct. Doc. Nos. 289, 330). AHCA did not seek a stay pending appeal, but HHS did seek a stay, on January 15, 2015 (Bk.

³ Bayou assumed approximately 28 contracts in the Plan. The other leases and contracts were assumed pursuant to separate order entered by the Bankruptcy Court. *See* Bk. Ct. Doc. Nos. 297, 298, 299, 300, 301, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, and 328.

Ct. Doc. No. 329) but only *after* Bayou had filed its Notice of Effective Date. (Bk. Ct. Doc. No. 288). Bayou opposed HHS's motion for stay. (Bk. Ct. Doc. No. 339). At a hearing conducted by the Bankruptcy Court on January 20, 2015, to consider HHS's request for a stay pending appeal and Bayou's opposition, after considering the facts and circumstances of Bayou's Chapter 11 case, the Bankruptcy Court concluded that Bayou had substantially consummated the Plan. (Bk. Ct. Doc. Nos. 342; 349, p. 22, *ll.* 19-25; p. 23 *ll.* 1-12). The Bankruptcy Court's oral ruling contained findings supporting its conclusion that the Plan was substantially consummated:

If I were to grant a stay in this case, I would have to undo the substantial consummation of this plan, all the actions taken. And you may argue that, "Well, it looked like the Debtor really rushed to get all that done." Well, the Debtor had the right to do that because there was not -- the 3020 stay wasn't in effect.⁴ Usually the Debtor would have to wait until after that to implement the plan. Here, it was all done.

And if at this point I were to stay things, we've got -- I think there were 65 executory contracts that were assumed. There was hundreds of thousands of dollars borrowed on the line of credit that was paid out. There were professionals that were employed. And not to

⁴ The Bankruptcy Court found that the provision in Fed. R. Bankr. P. 3020(e), which provides 14 days for an order to become final, had been waived by AHCA and HHS. *See* Bk. Ct. Doc. No. 281, 12/22/14 TR. p. 21, *ll.* 13-16 ("we have an unusual situation here because we had a waiver of the 3020(e) provision" which "exists to give an objecting party the opportunity to request a stay pending appeal before the plan is implemented.").

mention, the patients would have to be -- would be not on the street because they'd find somewhere to put the patients, I'm sure, I hope. But they're not going to be in Pinellas County because, as we all recall, the evidence was that there aren't however many beds, 60 to 80 beds in Pinellas County that can handle psychiatric patients.

(Bk. Ct. Doc. No. 349, p. 22, *ll.* 19-25; p. 23 *ll.* 1-12). Because the Bankruptcy Court concluded that Bayou had already substantially consummated the Plan, it denied HHS's request for a stay pending appeal. (Bk. Ct. Doc. No. 349, p. 25, *ll.* 19-20). The District Court likewise denied the stay when HHS filed the request in that forum. (Dist. Ct. Doc. No. 31, p. 1, ¶ 2).

Thereafter, based upon the Plan's substantial consummation and the dissolution of all previous injunctions and stays, on January 30, 2015, Bayou filed a motion to dismiss the consolidated First Appeals as moot ("First Motion to Dismiss") in the District Court. (Dist. Ct. Doc. No. 21). On February 3, 2015, the District Court denied the First Motion to Dismiss with no analysis of the law on point including whether the issues on appeal had become "actually" moot pursuant to Article III of the Constitution because the injunctions and stays of the September 5 Order had dissolved, and also "equitably moot" pursuant to *In re Club Assoc.* 956 F.2d 1065, 1069 (11th Cir. 1992), due to substantial consummation of the Plan. (Dist. Ct. Doc. No. 31, p. 2, ¶ 3). Then, on February 5, 2015 the District Court consolidated the appeals of the Confirmation Orders with the First Appeals. (Dist. Ct. Doc. No. 38, p. 1).

On April 27, 2015, Bayou filed a subsequent motion to dismiss AHCA's (but not HHS's) appeal of the Confirmation Orders on the basis that, *inter alia*, AHCA failed to file an objection to the Plan assuming the Provider Agreements within the time ordered by the Bankruptcy Court, failed to seek a stay pending appeal of the Confirmation Orders, and therefore that its appeal of the Confirmation Orders should be dismissed as equitably moot pursuant to *In re Club Associates*, 956 F.2d 1065, 1069, 1070 (11th Cir. 1992). (Dist. Ct. Doc. No. 54, pp. 2, 20-24). On May 19, 2015 the District Court denied Bayou's motion to dismiss AHCA's appeal of the Confirmation Orders, and also denied a renewed motion to dismiss the First Appeals (also based upon mootness) that Bayou filed on May 7, 2015. (Dist. Ct. Doc. Nos. 61 and 65). Thereafter, the District Court issued the Reversal Order (Dist. Ct. Doc. No. 72) concluding that the Bankruptcy Court lacked jurisdiction to enter the September 5 Order and the Confirmation Orders pursuant to the "jurisdictional bar" in 28 U.S.C. § 405(h) because administrative remedies must be exhausted first pursuant to 28 U.S.C. § 405(g). (Dist. Ct. Doc. No. 72, pp. 6-7, 9-10). Bayou's appeal to this Court ensued. (Dist. Ct. Doc. No. 84).

SUMMARY OF THE ARGUMENT

The Reversal Order was an advisory opinion and impermissible pursuant to the "case" and "controversy" requirement in Article III of the U.S. Constitution.

Although the District Court had jurisdiction at the time HHS and AHCA filed their appeals of the September 5 Order, it did *not* have jurisdiction at the time it entered the Reversal Order reversing the Bankruptcy Court's September 5 Order and partially reversing the Confirmation Orders because, at that time, the issues on appeal failed to present any live case or controversy and had also become equitably moot pursuant to *In re Club Assoc.* 956 F.2d 1065, 1069 (11th Cir. 1992), once Bayou substantially consummated its Chapter 11 Plan. Regarding the September 5 Order, the only ruling that possibly remained "live" after the January Confirmation Order was entered was the Bankruptcy Court's (unstayed) conclusion that the Provider Agreements had not terminated as of the Petition Date. *All other relief awarded by the Bankruptcy Court in the September 5 Order expired five [5] months before the District Court ruled; by mid-January, 2015, neither the temporary injunction nor the automatic stay any longer applied.* (Bk. Ct. Doc. No. 285, pp. 12-13, ¶ 10). Therefore, although the District Court had jurisdiction at the outset of the consolidated appeals pursuant to 28 U.S.C. § 158(a), events subsequent to the filing of the appeals deprived the District Court of jurisdiction to enter the Reversal Order on June 26, 2015.

Further, the District Court erred as a matter of law in concluding that the Bankruptcy Court lacked jurisdiction to enter the September 5 Order and the Confirmation Orders pursuant to the "jurisdictional bar" in 28 U.S.C. § 405(h) and

that administrative remedies must first be exhausted pursuant to 28 U.S.C. § 405(g). The District Court further erred by interpreting 28 U.S.C. § 405(h) in a manner that violates longstanding rules of statutory construction mandating that clear and unambiguous statutory language be interpreted in accordance with its plain meaning. Here, the District Court interpreted 28 U.S.C. § 405(h) to include reference to 28 U.S.C. § 1334, when the plain and unambiguous language of 28 U.S.C. § 405(h) does not. The District Court also wrongly concluded that the Bankruptcy Court's determinations in the September 5 Order and the Confirmation Orders involved claims "arising under" Medicare within the meaning of 28 U.S.C. § 405(h) when in fact the claims arose under Title 11.

**STANDARDS OF REVIEW APPLICABLE TO THE DISTRICT COURT'S
(A) ORDERS DENYING BAYOU'S MOTIONS TO DISMISS AND (B)
REVERSAL ORDER**

The exact rulings of the District Court presented to this Court for review are as follows. First, Bayou seeks the Court's review of the District Court's Orders Denying Bayou's Motions to Dismiss entered on May 19, 2015 (Dist. Ct. Doc. No. 65, denying Dist. Ct. Doc. Nos. 54 and 61) and on February 3, 2015 (Dist. Ct. Doc. No. 31, denying Dist. Ct. Doc. No. 20). The District Court plainly erred by failing to analyze whether the issues on appeal had become moot pursuant to U.S. Const. Art. III, § 2 and *In re Club Assoc.* 956 F.2d 1065, 1069 (11th Cir. 1992). Second, Bayou seeks the Court's review of the Reversal Order which reversed the

September 5 Order and partially reversed the Confirmation Orders. (Dist. Ct. Doc. No. 72). The District Court erred in concluding it had jurisdiction to enter the Reversal Order, and further erred in its legal conclusions regarding and interpreting 28 U.S.C. §§ 405(h) and (g).

The District Court's denial of Bayou's Motions to Dismiss involved determinations of law and therefore are reviewed *de novo*. See *In re Winn-Dixie Store, Inc.*, 286 Fed. App'x. 619 (11th Cir. 2008) rejecting "abuse of discretion standard" of review on appeal of district court order dismissing an appeal on equitable mootness grounds, and affirming district court's dismissal of consolidated appeal on the grounds that the appeal had been equitably mooted). The *de novo* standard of review also applies to this Court's review of the District Court's ruling in the Reversal Opinion that the Bankruptcy Court erred as a matter of law in entering the September 5 Order and the Confirmation Orders, concluding that 42 U.S.C. § 405(h) precluded the Bankruptcy Court from exercising jurisdiction over the Provider Agreements until administrative remedies were exhausted pursuant to 42 U.S.C. § 405(h). *United States v. McCranie*, 169 F.3d 723, 726 (11th Cir. 1999) ("The jurisdiction issue presents a question of law; accordingly, the *de novo* standard of review is applicable.") citing *United States v. Johns*, 984 F.2d 1162, 1163 (11th Cir. 1993); *United States v. Veal*, 153 F.3d 1233,

1245 (11th Cir. 1998) (issues of statutory interpretation are reviewed *de novo*). A *de novo* review affords no deference to the lower court's legal conclusions.

Further, this Court examines the Bankruptcy Court's findings of fact independently of the District Court. *In re Bilzerian*, 153 F.3d 1278, 1281 (11th Cir.1998). The Bankruptcy Court's findings of fact are reviewed for clear error. *In re Int'l. Admin. Servs.*, 408 F.3d 689, 699 (11th Cir. 2005); *In re Fin. Federated Title & Trust, Inc.*, 309 F.3d 1325, 1328-29 (11th Cir. 2002). The Bankruptcy Court's findings of fact are not clearly erroneous unless, in light of all the evidence, this Court is left with the definite and firm conviction that a mistake has been made. *In re Cox*, 338 F.3d 1238, 1241 (11th Cir. 2003).

ARGUMENT

I. Did the District Court err in concluding that 42 U.S.C. § 405(h) and/or (g) require administrative remedies to be exhausted before the Bankruptcy Court could exercise jurisdiction to consider whether Bayou Shores' Medicare and Medicaid provider agreements had, or had not, terminated before the date Bayou Shores commenced its Chapter 11 case?

The District Court broadly concluded that “the Bankruptcy Court’s Orders violated the Medicare jurisdictional bar set forth in 42 U.S.C. § 405(h)” and that such “moots any remaining arguments on appeal.” Dist. Ct. Doc. No. 72, Page ID 5012. As such, the District Court declared all of Bayou’s arguments “moot” and determined that the Bankruptcy Court lacked jurisdiction to enter the September 5 Order and Confirmation Orders *without ever analyzing the Bankruptcy Court’s*

jurisdiction to begin with. The District Court erred as a matter of law in failing to evaluate the scope of the Bankruptcy Court's statutory jurisdictional grants and to recognize that "[w]hen a petition for Chapter 11 relief is filed, a bankruptcy estate is created." *In re Jamko, Inc.*, 240 F.3d 1312, 1313 (11th Cir. 2001) *citing* 11 U.S.C. § 541.

The District Court, relying solely on courts that engrafted language onto 42 U.S.C. § 405(h) that did not exist after the statute was amended in 1984 (see discussion, *infra*), failed to engage in *any* analysis as to why those courts were right and the Bankruptcy Court was wrong. In other words, why does 42 U.S.C. § 405(h) require exhaustion of administrative remedies and deprive the Bankruptcy Court of jurisdiction to evaluate, *inter alia*, whether or not the Provider Agreements had, or had not been, terminated on or before the Petition Date? The existence of an administrative remedy, not yet exhausted, does not defeat the Bankruptcy Court's exclusive jurisdiction to assess the extent of a debtor's interests in property. *See, e.g., In re Town & Country Home Nursing Servs.*, 112 B.R. 329, 334 (9th Cir. BAP 1990) ("where there is an independent basis for bankruptcy court jurisdiction, exhaustion of administrative remedies pursuant to other jurisdictional statutes is not required"); *University Medical Center v. Sullivan (In re Medical Center)*, 973 F.2d 1065, 1073–74 (3d Cir. 1992) (where an independent basis for bankruptcy court jurisdiction exists, exhaustion of administrative

remedies pursuant to other jurisdictional statutes is not required); *Sullivan v. Town & Country Home Nursing Svcs., Inc. (In re Town & Country Home Nursing Svcs., Inc.)*, 963 F.2d 1146 (9th Cir. 1992) (failure to exhaust administrative remedy under Medicare Act and Federal Tort Claims Act did not divest bankruptcy court of jurisdiction over state-law claims); *In re Bryco Funding, Inc.*, No. 08-30173 TEC, 2009 WL 3271309, at *2 (Bankr. N.D. Cal. Oct. 9, 2009) (“Trustee's failure to exhaust state-law administrative remedies does not divest this court of jurisdiction to adjudicate the fraudulent transfer claims against the FTB, because the bankruptcy court has an independent basis for jurisdiction over the claims”). Therefore, the Reversal Order must be reversed.

The plain language of 42 U.S.C. § 405(h) does not deprive a bankruptcy court of jurisdiction to determine whether or not a contract has terminated prior to a bankruptcy filing. Rather, 42 U.S.C. § 405(h) details the binding nature of certain post-hearing findings and decisions and precludes the bringing of actions to recover on claims “arising under” Medicare pursuant to 28 U.S.C. §§ 1331 (Federal question) and 1346 (governing United States as defendant). Next, the plain language of 42 U.S.C. § 405(g) simply details procedures for judicial review of the decisions contemplated in 42 U.S.C. § 405(h). Neither statute precludes a bankruptcy court from evaluating the extent of a debtor’s property interests. Neither statute requires administrative exhaustion before a bankruptcy court can

assess whether or not provider agreements have, or have not, fully terminated, nor do they preclude a skilled nursing facility from filing a Chapter 11 case to protect the full extent of its property interests in its provider agreements.⁵

As argued by Bayou below (*e.g.*, Dist. Ct. Doc. No. 60, Page ID 11), when Bayou filed its Chapter 11 petition it invoked the District Court's original jurisdiction pursuant to 28 U.S.C. § 1334(b) over any civil proceeding that arises under, arises in, or that is related to a title 11 case. *Carter v. Rodgers*, 220 F.3d 1249, 1253 (11th Cir. 2000). Civil proceedings "arising under" are "matters invoking a substantive right created by the Bankruptcy Code." 220 F.3d at 1253. Civil proceedings "arising in" are "matters that could arise only in bankruptcy." *Id.* quoting *In re Toledo*, 170 F.3d 1340, 1345 (11th Cir. 1999) (citations omitted). Civil proceedings "related to" bankruptcy are those where the outcome "could conceivably have an effect" on the bankruptcy estate, 220 F.3d at 1253 citing *Miller v. Kemira, Inc. (In re Lemco Gypsum, Inc.)*, 910 F.2d 784, 788 (11th Cir. 1990), and/or where the outcome "could alter a debtor's rights, liabilities, options,

⁵ Eligibility for Title 11 relief is governed by 11 U.S.C. § 109, and contains a list of ineligible entities; skilled nursing facilities are *not* among them. Therefore, Bayou, a skilled nursing facility ("SNF"), was entitled to file its Chapter 11 petition on August 15, 2014. Appelles did not dispute that Bayou was eligible to file its Chapter 11 case.

or freedom of action either positively or negatively.” *In re TXNB Internal Case*, 483 F.3d 292, 298 (5th Cir. 2007); *In re Pegasus Gold Corp.*, 394 F.3d 1189, 1193 (9th Cir. 2005); *Pacor, Inc. v. Higgins*, 743 F.2d 984, 994 (3d Cir. 1984). Section 1334(b) “is, and was meant to be, expansive and to encompass all contested matters[.]”⁶*In re Menk*, 241 B.R. 896, 908-09 (B.A.P. 9th Cir. 1999). “In short, virtually every act a bankruptcy judge is called upon to perform in a judicial capacity is a ‘civil proceeding’ within § 1334(b).” *Id.* *Here, the relief requested in the Emergency Motion concerning whether the Provider Agreements had, or had not, terminated on the Petition Date constituted a civil proceeding involving a contested matter in Bayou’s Chapter 11 case pursuant to 28 U.S.C. § 1334(b) within the Bankruptcy Court’s original jurisdiction.*

In addition to a bankruptcy court’s expansive jurisdiction to consider civil proceedings related to a Title 11 case, a bankruptcy court has “exclusive

⁶ “Although ‘contested matter’ is not defined in the Code or text of the Rules, the Notes of the Advisory Committee to the 1983 amendment to Rule 9014 explain: ‘Whenever there is an actual dispute, other than an adversary proceeding, before the bankruptcy court, the litigation to resolve that dispute is a contested matter.’” *In re Ephedra Products Liab. Litig.*, 329 B.R. 1, 6-7 (S.D.N.Y. 2005). Here, there was an actual dispute between Bayou and Appellees on the Petition Date regarding whether or not the Provider Agreements had terminated.

jurisdiction... of all the property... of the debtor as of the commencement of such case, and of property of the estate.” 28 U.S.C. § 1334(e).⁷ The term “property of the estate” is defined in 11 U.S.C. § 541(a)(1). Such property includes “all legal or equitable interests of the debtor in property as of the commencement of the case.” 11 U.S.C. § 541(a)(1); *United States v. Whiting Pools, Inc.*, 462 U.S. 198, 204–05, 103 S.Ct. 2309, 2313, 76 L.Ed.2d 515, 521–22 (1983) (“Congress intended a broad range of property to be included in the estate” because “reorganization ... would have small chance of success ... if property essential to running the business were excluded ...”); *In re Coomer*, 375 B.R. 800, 804 (Bankr. N.D. Ohio 2007) (The definition of property of the estate is “intentionally broad” and includes “every conceivable interest that the debtor may have...”); *McGahren v. First Citizens Bank & Trust (In re Weiss)*, 111 F.3d 1159, 1166 (4th Cir. 1997) (noting broad definition of property); *In re Carlton*, 309 B.R. 67, 72 (Bankr. S.D. Fla. 2004) (debtor's contract rights, whether accrued or contingent, constitute property

⁷ As relevant, 28 U.S.C. § 1334(e) provides:

(e) The district court in which a case under title 11 is commenced or is pending shall have exclusive jurisdiction—

(1) of all the property, wherever located, of the debtor as of the commencement of such case, and of property of the estate...

of the estate under 11 U.S.C. § 541(a)(1) on the petition date); 462 U.S. at 205-205; *Olympia & York Fla. Equity Corp. v. Bank of New York (In re Holywell Corp.)*, 913 F.2d 873, 881 (11th Cir. 1990) (“Section 541 is construed broadly, so as to effectuate Congressional intent that a wide range of property be included in the estate.”). Ergo, the District Court’s conclusion that the Bankruptcy Court lacked jurisdiction over any aspect of the Provider Agreements is contrary to 28 U.S.C. § 1334(e), and ignores binding authority from the United States Supreme Court and the Eleventh Circuit defining the vast scope of property falling within 11 U.S.C. § 541. 462 U.S. at 204–05; 913 F.2d at 881. Here, the Bankruptcy Court’s⁸ legal conclusions that it had jurisdiction to consider the Emergency Motion and the issues raised therein concerning the Provider Agreements was entirely correct.⁹

⁸ The District Court for the Middle District of Florida has referred to the bankruptcy judges in its district all Title 11 cases and proceedings arising under, in, or related to a Title 11 case (6-12-MC-26-ORL-22) (“Order of Reference”). Accordingly, when Bayou filed its Chapter 11 petition, 28 U.S.C. § 1334 and the Order of Reference vested the Bankruptcy Court with jurisdiction over Bayou’s Chapter 11 case, civil proceedings arising in, under, or related to the case, and property of the estate.

⁹ In addition, the revenue and proceeds from the Provider Agreements are property of the estate pursuant to 11 U.S.C. § 541(a)(6) (property of the estate includes “proceeds, product, offspring, rents, or profits of or from property of the estate...”). See *FitzSimmons v. Walsh (In re FitzSimmons)*, 725 F.2d 1208, 1211

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The District Court plainly erred by failing to consider the federal statutes or controlling authority on this issue as argued by Bayou (*e.g.*, Dist. Ct. Doc. No. 60, Pg. ID11).

Shortly after Bayou filed its Chapter 11 case— after AHCA delivered the Patient Letter and Bayou filed the Emergency Motion in response— and prior to awarding any relief requested in the Emergency Motion, the Bankruptcy Court was required to determine the extent of Bayou’s property interests in the Provider Agreements and whether or not the Provider Agreements had terminated as of the Petition Date. Assessing the existence and extent of a debtor’s property interests are “core” determinations within the Bankruptcy Court’s exclusive jurisdiction. 28 U.S.C. § 157(b)(2). *See e.g., In re Fundamental Long Term Care, Inc.*, 501 B.R. 770, 781-782, n.37 (Bankr. M.D. Fla. 2013) (bankruptcy court possesses “exclusive jurisdiction over property of the estate and is best suited to determine whether property is, in fact, property of the estate.”) *citing* 28 U.S.C. § 1334(e); 11 U.S.C. § 541; *In re Cox*, 433 B.R. 911, 920 (Bankr.N.D.Ga.2010); *In re Gardner*, 913 F.2d 1515, 1518 (10th Cir. 1990) (the determination of whether property is

...continued from previous page

(9th Cir. 1984) (earnings attributable to accounts receivable constitute property of the estate).

part of the bankruptcy estate constitutes a core proceeding subject to the bankruptcy court's exclusive jurisdiction); *In re Xonics, Inc.*, 813 F.2d 127, 131 (7th Cir. 1987) (A bankruptcy court has jurisdiction over disputes regarding alleged property of the bankruptcy estate at the outset of the case); *Pension Benefit Guar. Corp. v. Cont'l Airlines, Inc. (In re Cont'l Airlines, Inc.)*, 138 B.R. 442, 445 (D.Del.1992) (determinations regarding property of the estate are core); *Schroeder v. New Century Holdings, Inc. (In re New Century Holdings, Inc.)*, 387 B.R. 95, 105 (Bankr.D.Del.2008) (same).

During the Emergency Hearing, Appellees argued that Bayou's Provider Agreements had already terminated, but based upon the evidence and testimony, the Bankruptcy Court disagreed. Appellees made an insufficient showing to support their conclusions that the Medicare provider agreement had terminated, and that, therefore, the Medicaid provider agreement also terminated, on its own, by operation of law. Sufficient evidence and testimony were admitted at the FEH to demonstrate that termination had not occurred.

In addition, during the FEH, Bayou admitted an exhibit (Exhibit 8) and introduced testimony detailing how, under AHCA's procedures, a healthcare provider requests a formal administrative hearing regarding termination issues (Dist. Ct. Doc. 10-2, p. 32) which results in an assignment of the matter to an administrative law judge to conduct proceedings and to submit a recommendation

to AHCA (Dist. Ct. Doc. 10-2, p. 26). Bayou's exhibit reflected that a final order was eventually entered explaining that the provider received a favorable HHS decision *and that the revocation of the provider's participation in Florida Medicaid had become either moot or overturned.* (Dist. Ct. Doc. 10-2, p. 29, ¶ 5). Thereafter, AHCA rescinded the contemplated termination of the provider's participation in the Florida Medicaid program. (Dist. Ct. Doc. 10-2, p. 29, ¶ 6). Certainly, this supported the Bankruptcy Court's conclusion that Bayou had a viable property interest in its Provider Agreements worthy of protection because, based on other evidence and testimony introduced at the FEH, Bayou was in substantial compliance prior to the Petition Date and was providing good patient care. In circumstances where trauma transfer is a concern, and where Bayou had invested substantial time and energy in bringing itself into compliance, the Bankruptcy Court reasonably concluded that HHS may reconsider its termination decision. *Particularly since Bayou went to the expense of retaining a national expert in regulatory compliance, why would it not?*

The Bankruptcy Court clearly had both core, 28 U.S.C. § 157(b)(2), and exclusive, 28 U.S.C. § 1334(e), jurisdiction to evaluate Bayou's interests in its Provider Agreements on the Petition Date. The District Court erred by disregarding applicable and controlling authority on this point and by characterizing such as

“moot.” Dist. Ct. Doc. No. 72, Pg. 2. Therefore, the Reversal Order must be reversed.

II. Did the District Court err by concluding that 42 U.S.C. § 405(h) and/or (g) deprived the Bankruptcy Court of jurisdiction to temporarily enjoin the termination of Bayou Shores’ Medicare and Medicaid provider agreements, after the Bankruptcy Court concluded Bayou Shores had made a prima facie showing that the agreements were property of the estate pursuant to 11 U.S.C. § 541(a) and that the police power exception to the automatic stay in 11 U.S.C. § 362(b)(4) did not apply?

The District Court erred in concluding that 42 U.S.C. § 405(h) and/or (g) deprived the Bankruptcy Court of jurisdiction to enter a temporary injunction and stay to protect the Provider Agreements during Bayou’s reorganization. *Moreover, when the District Court entered the Reversal Order, the temporary injunction and automatic stay had dissolved five [5] months earlier and were no longer in effect.* (Dist. Ct. Doc. No. 285, pp. 12-13, ¶ 10) (“this Confirmation Order, all injunctions and stays previously provided for in this case pursuant to sections 105 and/or 362 of the Bankruptcy Code shall remain in full force and effect *until the Effective Date.*”) (*emphasis added*)¹⁰. Bayou filed its Notice of Effective Date on January 9,

¹⁰ In addition to the automatic stay (362) terminating pursuant to the plain language of the January Confirmation Order, the automatic stay also terminates by operation of certain bankruptcy statutes due to plan confirmation. 11 U.S.C. § 1141 details the effects of confirming a Chapter 11 plan and provides that confirmation of a plan vests all “property of the estate” in the debtor. (Property of the estate is broadly defined in 11 U.S.C. § 541(a) to include “all legal and equitable interests of the debtor in property” and,

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2015. Bk. Ct. Doc. No. 288. As such, the Reversal Order constituted an impermissible advisory opinion with respect to its ruling on the Bankruptcy Court's injunctive powers and the applicability of the automatic stay. *Nyaga v. Ashcroft*, 323 F.3d 906, 913 (11th Cir. 2003) *citing* *Soliman v. United States ex rel. INS*, 296 F.3d 1237, 1242 (11th Cir. 2002); *Malowney v. Federal Collection Deposit Group*, 193 F.3d 1342, 1348 (11th Cir. 1999) (injury in the past “does not support a finding of an Article III case or controversy.”). Because critical aspects of the issues on appeal were moot pursuant to Article 3, § 2 of the U.S. Constitution, the District Court erred when it entered the Reversal Order. *Nyaga*, 323 F.3d at 913 (internal citations omitted). An “actual controversy must be extant at all stages of review,” not merely at the time an action is filed. *In re Servico, Inc.*, 161 B.R. 297, 300 (S.D. Fla. 1993) *citing* *Preiser v. Newkirk*, 422 U.S. 395, 401-02, 95 S.Ct. 2330, 2334, 45 L.Ed.2d 272 (1975); *Friends of Everglades v. S. Fla. Water Mgmt. Dist.*, 570 F.3d 1210, 1216 (11th Cir. 2009) (“To decide a moot issue

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here, includes the Agreements, as Bayou's most valuable assets). Pursuant to 11 U.S.C. § 362(c)(1), the stay of an act against “property of the estate” continues until such property is no longer “property of the estate.” Here, the January Confirmation Order vested all “property of the estate” in Bayou, thus removing it from 11 U.S.C. § 362 protection as “property of the estate.” Bk. Ct. Doc. No. 285, pg.14.

is to issue an advisory opinion, one unnecessary to the judicial business at hand and outside the authority of Article III courts.”).

In the event this Court concludes that the Reversal Order is not merely an advisory opinion and that these particular issues remained “live” even after the Effective Date, the Bankruptcy Court had ample authority pursuant to 11 U.S.C. §§ 105(a) and 362(a) to enter the temporary injunction and enforce the automatic stay after it concluded that the Provider Agreements had not terminated and were property of the estate. The relief sought in the Emergency Motion arose under, in, and was related to Bayou’s Chapter 11 case, within the meaning of those terms and as explained in *Carter v. Rodgers*, 220 F.3d 1249, 1253 (11th Cir. 2000). With respect to injunctive relief, bankruptcy courts are empowered to issue “any order, process, or judgment that is necessary or appropriate to carry out the provisions of [the Bankruptcy Code].” 11 U.S.C. § 105(a). Because the Bankruptcy Court had jurisdiction over the controversy concerning the Provider Agreements as explained above (i.e., whether they had terminated before the Petition Date or whether they were viable property of the estate), it also had the power and jurisdiction to protect this property and preserve the status quo during Bayou’s reorganization. *In re Hillsborough Holdings Corp.*, 123 B.R. 1004, 1017 (1990) (injunctive powers of Section 105 can be used where necessary to protect the integrity of the reorganization process) *citing A.H. Robins Co., Inc. v. Piccinin*, 788 F.2d 994,

1003, 1008 (4th Cir.), *cert. denied*, 479 U.S. 876 (1986); *In re Baldwin–United Corp. Litig.*, 765 F.2d 343, 348 (2d Cir. 1985); *In re Chateaugay Corp., Reomar, Inc.*, 93 B.R. 26, 29 (S.D.N.Y.1988). Furthermore, sovereign immunity is specifically abrogated as to governmental units (such as Appellees) with respect to 11 U.S.C. § 105(a) pursuant to 11 U.S.C. § 106(a) and plainly authorized the Bankruptcy Court to “hear and determine any issue arising with respect to the application of [105] to governmental units” and to “issue against a governmental unit an order... under [105] or the Federal Rules of Bankruptcy Procedure...”. The District Court compounded its errors of law with respect to its conclusion that the Bankruptcy Court lacked authority to temporarily enjoin termination of the Provider Agreements by relying upon eight [8] non-bankruptcy cases to reach this result.¹¹ Here, the Bankruptcy Court was acting under specific jurisdictional grants

¹¹ The District Court relied upon *Bayou Shores SNF, LLC v. Burwell*, No. 8:14-cv-1849-T-33MPA, 2014 WL 4059900 (M.D. Fla. Aug. 15, 2014) (holding that the district court was without jurisdiction to enjoin the termination of the provider agreements prior to exhaustion of administrative remedies); *Cathedral Rock of North Coll. Hill v. Shalala*, 223 F.3d 354 (6th Cir. 2000) (same); *Affil. Prof'l Home Health Care v. Shalala*, 164 F.3d 282 (5th Cir. 1999) (same); *Livingston Care Ctr., Inc. v. United States*, 934 F.2d 719 (6th Cir. 1991) (same); *Americana Healthcare Corp. v. Schweiker*, 688 F.2d 1072 (7th Cir. 1982) (same); *Forum Healthcare Grp., Inc. v. Ctrs. for Medicare & Medicaid Servs.*, 495 F. Supp. 2d 1321 (N.D. Ga. 2007) (same); *Trade Around the World of PA v. Shalala*, 145 F. Supp. 2d 653 (W.D. Pa. 2001) (same); *Northwest Healthcare, L.P. v. Sullivan*, 793 F. Supp. 724

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of authority and powers (28 U.S.C. §157, 28 U.S.C. §1334, 11 U.S.C. §105) which grants and powers were simply inapplicable in any of the cases upon which the District Court relied in support of its conclusions.

Next, issues pertaining to the automatic stay are within the Bankruptcy Court's core jurisdiction pursuant to 28 U.S.C. § 157(b)(2)(G). The automatic stay, which is self-effectuating, prohibits "any act to obtain possession of property of the estate or of property from the estate or to exercise control over property of the estate[.]" 11 U.S.C. § 362(a)(3). By its plain language, 11 U.S.C. § 362(a)(3) prevented any act by Appellees to exercise control over the Provider Agreements or to interfere with Bayou's interests under the Provider Agreements.

There is, however, an exception to the automatic stay for governmental acts taken in connection with police and regulatory powers. 11 U.S.C. § 362(b)(4). The phrase "police or regulatory power" in 11 U.S.C. § 362(b)(4) refers to the enforcement of laws affecting health, welfare, morals and safety, *but not to regulatory laws that directly conflict with the control of property by the bankruptcy court. Hillis Motors, Inc. v. Hawaii Auto. Dealers' Ass'n*, 997 F.2d 581, 591 (9th

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(W.D. Tex. 1992) (same). However, none of these cases are bankruptcy cases, so 28 U.S.C. § 1334 was not in play, nor was either 11 U.S.C. §§ 105(a) or 106(a).

Cir. 1993). The exception in 11 U.S.C. § 362(b)(4) is construed to balance the government's need to enforce its police or regulatory power with the estate's need to preserve its assets for the reorganization of the debtor. *Brock v. Marysville Body Works*, 829 F.2d 383 (3rd Cir. 1987). If a government is found to be acting in a pecuniary capacity, the 11 U.S.C. § 362(b)(4) exception to the automatic stay will not apply. *In re Dolen*, 265 B.R. 471, 485-486 (Bankr.M.D.Fla. 2001). Sovereign immunity is likewise abrogated as to Appellees with respect to 11 U.S.C. § 362 pursuant to 11 U.S.C. § 106(a).

A bankruptcy court's decision on issues arising pursuant to 11 U.S.C. § 362 is reviewed for abuse of discretion. *In re Eastburg*, 447 B.R. 624, 630-31 (B.A.P. 10th Cir. 2011); *Pursifull v. Eakin*, 814 F.2d 1501, 1504 (10th Cir. 1987); *Matter of Boomgarden*, 780 F.2d 657, 660 (7th Cir. 1985); *In re Castlerock Properties*, 781 F.2d 159, 163 (9th Cir. 1986). The government bears the burden of proving that the 11 U.S.C. § 362(b)(4) exception to the automatic stay applies. *In re Fiber Optek Interconnect Corp.*, 2009 WL 3074605 *8 (Bankr.S.D.N.Y. 2009). Appellees did not come close to meeting that burden in attempting to demonstrate they were not acting in their pecuniary interests and that they were acting in the best interests of Bayou's residents at the FEH on the Emergency Motion. Indeed, although Bayou bore no burden of proof on the issue, Bayou's exhibits and witnesses proved overwhelmingly that the stay must apply. Bayou's blind resident

testified that his depression would worsen if he had to relocate, and that a local program to train the blind on navigating a new environment no longer existed. (Bk. Ct. Doc. No. 80, pp. 10-11). The guardian to numerous patients testified that his patients at Bayou were happy, their needs were being met, and that if the patients on his roster were scattered to other facilities around the state he would be unable to visit as frequently. (Bk. Ct. Doc. No. 80, pp. 13-17). A prior administrator testified that Bayou retained an expert in the field of health care compliance to evaluate the facility to assure it was in substantial compliance and to make any necessary recommendations for improvement. (Bk. Ct. Doc. No. 80, p. 26, *ll.* 6-9; p. 27, *ll.* 11-23). He also testified that, without the payments under the Provider Agreements Bayou would close, employees would be terminated, and creditors would go unpaid. (Bk. Ct. Doc. No. 80, p. 29, *ll.* 18-25; p. 30, *ll.* 1-2). The present administrator testified that continuity of care was particularly important to Bayou's fragile resident population, and that AHCA had not visited Bayou to assess patient care since she had begun working at Bayou. (Bk. Ct. Doc. No. 80, p. 36, *ll.* 4-6; p. 37, *ll.* 1-4; p. 39, *ll.* 23-25; p. 40, *ll.* 1-2). The healthcare compliance expert — a former federal monitor and federal prosecutor— testified that he met with staff and management, visited every floor of the facility, examined treatment records, reviewed Bayou's new procedures and determined that Bayou was in substantial compliance with applicable regulations. (Bk. Ct. Doc. No. 80, p. 43, *ll.* 14-24; p.

44, *ll.* 7-15, 17-25; pp. 45-48). He also testified that the decision to terminate Bayou was unusual in the circumstances presented, and that transfer trauma could result in death. (Bk. Ct. Doc. No. 80, p. 48, *ll.* 16-25; p. 49, *ll.* 1-13; p. 53, *ll.* 11-25; p. 54, *ll.* 1-25; p. 55, *ll.* 1-11). Another witness— board certified in state and federal administrative law and former general counsel to AHCA— testified that the Medicaid provider agreements do not terminate by operation of law, and discussed examples to illustrate this point. (Bk. Ct. Doc. No. 80, pp. 57-58; p. 61, *ll.* 3-6; p. 62, *ll.* 12-25; p. 63, *ll.* 1-7).

By contrast, AHCA made no attempt to meet its burden and admitted no evidence or testimony. HHS introduced no live witness testimony, and its evidence was insufficient to carry the burden of proving Appellees were not acting in a pecuniary capacity by terminating benefits to indigent residents being cared for by Bayou. Because the evidence demonstrated that AHCA was permitting Bayou's patients to remain at Bayou at their own expense and had not visited Bayou to evaluate resident health, safety and welfare in some time, and because Bayou retained an expert in regulatory compliance who concluded Bayou's new procedures put it in substantial compliance, the Bankruptcy Court's conclusion that the police power exception of 11 U.S.C. § 362(b)(4) did *not* apply was soundly supported. Permitting residents, most of whom are indigent and plagued by serious psychological illnesses and many of whom are quite elderly, to remain indefinitely

at a facility which allegedly poses a safety problem is inconsistent with a concern for resident health and welfare. Terminating benefits to a facility whose residents are happy and whose needs are met is clearly a decision in respect of pecuniary interests. Weighing all of the evidence, the Bankruptcy Court correctly concluded that the police and regulatory power exception did not apply. The Bankruptcy Court's decision was clearly not an abuse of discretion given the evidence presented. Nevertheless, the District Court, in entering its advisory Reversal Order, failed to analyze any aspect of the law or the evidence which resulted in the Bankruptcy Court's ruling on the Emergency Motion. As such, the Reversal Order must be reversed.

III. Did the District Court err by: (i) failing to interpret 42 U.S.C. § 405(h) according to its plain meaning and by (ii) concluding the Bankruptcy Court lacked jurisdiction to enter the (a) September 5, 2014 order; (b) Memorandum Opinion and Order on Confirmation, and (c) Confirmation Order providing for the assumption of its Medicare and Medicaid provider agreements?

The District Court's Reversal Order concluded that the Bankruptcy Court erred as a matter of law because 42 U.S.C. § 405(h) precluded the Bankruptcy Court from exercising jurisdiction over the controversies concerning the Provider Agreements. To reach this result, the District Court ignored the plain language of an unambiguous thirty year old statute. However, absent an absurd result, this Court requires a clear and unambiguous statute to be interpreted in accordance with its plain meaning. Here, 42 U.S.C. § 405(h) is clear and unambiguous and no

absurdity results from an application of the statute according to its plain language. Nevertheless, the District Court did *not* construe 42 U.S.C. § 405(h) by its plain meaning, instead reaching outside of the statute and using selective legislative history to conclude it prohibited bankruptcy courts from taking any action related to Medicare or Medicaid provider agreements barring the exhaustion of administrative remedies. This is *not* what 42 U.S.C. § 405(h) says.

Although the plain language of 42 U.S.C. § 405(h) *did* prohibit bankruptcy jurisdiction 30 years ago, it has *not* precluded jurisdiction since Congress amended the statute in 1984, just eight (8) days after Congress affirmatively expanded bankruptcy court jurisdiction by enacting 28 U.S.C. § 1334. 42 U.S.C. § 405(h) provides as follows:

The findings and decision of the Commissioner of Social Security after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Commissioner of Social Security shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Commissioner of Social Security, or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28 to recover on any claim arising under this subchapter.

Clearly, 42 U.S.C. § 405(h) does not reference 11 U.S.C. § 1334.

As best explained in *First American Health Care of Georgia, Inc., et al, v.*

U.S. Dept. of Health and Human Services, 208 B.R. 985 (Bankr. S.D. Ga. 1996):

[I]n 1984, in an effort to completely revise and expand the scope of bankruptcy jurisdiction, Congress enacted 28 U.S.C. Section 1334

which took effect on July 10, 1984. When enacting Section 1334 Congress had the opportunity to exclude actions covered by 405(h), but instead omitted any reference to the Medicare jurisdictional preclusion provisions and, therefore, granted concurrent jurisdiction of Section 405(h) matters to bankruptcy courts[...]. Moreover, effective July 18, 1984, *only eight days subsequent to the enacting of Section 1334*, Congress revised Section 405(h) and substituted “section 1331 or 1346 of title 28, United States Code,” for Section 24 of the Judicial Code of the United States[...]. **Obviously, the language of Section 405(h) omits any reference to the preclusion of Medicare claim jurisdiction from cases arising under 28 U.S.C. Section 1334.** Although the possibility exists that the exclusion was unintentional, when considering the proximity of the enactment of both statutes along with the significant changes in bankruptcy jurisdiction that Section 1334 established, I hold that the plain meaning of Section 405(h) should be enforced, and clearly, this Court’s jurisdiction under Section 1334 was not circumscribed [...]. **[W]ithin a period of eight days, Congress, when presented with two opportunities, failed to exclude from the jurisdiction of the bankruptcy courts all actions arising under the Medicare program.** *Id.* at 988-89 (internal citations omitted, bold emphasis added).¹²

The thoughtful analysis of the *First American* opinion above, combined with the fact that 42 U.S.C. § 405(h) and 28 U.S.C. § 1334 have been *in effect for over thirty (30) years and Congress has never revised 42 U.S.C. § 405(h) to include*

¹² *Opinion vacated and superseded sub nom. First Am. Health Care of Georgia, Inc. v. U.S. Dep't of Health & Human Servs.*, No. 96-2007, 1996 WL 282149 (Bankr. S.D. Ga. Mar. 11, 1996).

Section 1334, demonstrates that Congress’ omission of 28 U.S.C. § 1334 from 42 U.S.C. § 405(h) was not inadvertent. “Congress is presumed to know the content of existing, relevant law, and where Congress knows how to say something but chooses not to, its silence is controlling.” *Lindley v. F.D.I.C.*, 733 F.3d 1043, 1055-56 (11th Cir. 2013) *citing Griffith v. United States*, 206 F.3d 1389, 1394 (11th Cir. 2000) (internal marks omitted); *Alanis-Bustamante v. Reno*, 201 F.3d 1303, 1311 (11th Cir. 2000) *citing BFP v. Resolution Trust Corp.*, 511 U.S. 531, 537 (1994); *Miles v. Apex Marine Corp.*, 498 U.S. 19, 32 (1990). Here, Congress’ silence is both clear and controlling. 28 U.S.C. § 1334 was enacted first, and 42 U.S.C. § 405(h) was enacted days later. Therefore, there can be no question that Congress was aware of 28 U.S.C. § 1334 at the time and certainly could have included it in 42 U.S.C. § 405(h), but did not. Furthermore, applying 42 U.S.C. § 405(h) as written yields no absurdity; indeed, affording bankruptcy courts concurrent jurisdiction over 42 U.S.C. § 405(h) matters is directly aligned with Congress’s broad jurisdictional grant in 28 U.S.C. § 1334 and the intent of Congress to bring all bankruptcy-related litigation within the umbrella of the bankruptcy courts. *In re Town & Country Home Nursing Services, Inc.*, 963 F.2d 1146, 1155 (9th Cir. 1992).

Recent case law supports Bayou’s analysis. In *In re Nurses Registry and Home Health Corp.*, 533 B.R. 590 (Bankr. E.D. Ky. 2015), the court denied the

government's motion for a stay pending appeal of an order enjoining the government from suspending Medicare payments to a nursing facility. In so doing, the court suggested that other courts which have ruled against Bayou's interpretation of Section 405(g), including the District Court, went against the plain language of the statute, the weight of authority on this issue, ignored other legislative history, and issued opinions which result in the judiciary undertaking the prohibited act of rewriting a congressional statute. *See id.* at pp. 593-96.

As such, the District Court's conclusion that the Bankruptcy Court exceeded its jurisdiction must be reversed. This Court has repeatedly urged that proper statutory interpretation should begin, and almost always end, with the plain language of the statute. When the words of a statute are unambiguous, "judicial inquiry is complete." *E.g., CBS Inc., v Primetime 24 JV*, 245 F.3d 1216, 1222 (11th Cir. 2001); *see also United States v. Gonzales*, 520 U.S. 1, 6 (1997); *Harris v. Garner*, 216 F.3d 970, 976 (11th Cir. 2000) (en banc) ("When the import of the words Congress has used is clear, ... we need not resort to legislative history, and we certainly should not do so to undermine the plain meaning of the statutory language."). "[I]t is ultimately the provisions of our laws rather than the principal concerns of our legislators by which we are governed." *CBS Inc.*, 245 F.3d at 1228 *citing Oncale v. Sundowner Offshore Servs., Inc.*, 523 U.S. 75, 79 (1998). Resorting to legislative history "only muddies the waters." *Gonzales*, 520 U.S. at 6.

42 U.S.C. § 405(h) is clear, and Congress' silence in amending the statute controls. Congress was aware of existing law when it enacted 42 U.S.C. § 405(h) in 1984, and plainly omitted 28 U.S.C. § 1334. *See Miles*, 498 U.S. at 32 (1990) (courts must assume "Congress is aware of existing law when it passes legislation") *citing Cannon v. University of Chicago*, 441 U.S. 677, 696–697 (1979). Because the Reversal Order construed 42 U.S.C. § 405(h) to contain language omitted by Congress thirty years ago, the Reversal Order must be overturned.

Further, even assuming, *arguendo*, that 42 U.S.C. § 405(h) *does* proscribe 28 U.S.C. § 1334 jurisdiction, the Bankruptcy Court did not cross any "jurisdictional bar" in 42 U.S.C. § 405(h) because neither the relief sought nor the relief ordered concerned any claim arising under Medicare. The third sentence of 42 U.S.C. § 405(h), often referred to as the Medicare "jurisdictional bar," provides that "[n]o action against the United States, the Commissioner of Social Security, or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28 to recover on any claim arising under this subchapter." Assuming 28 U.S.C. § 1334 *had* been inserted into the statute (which it was not), this *might* prohibit Bayou from bringing an action in the Bankruptcy Court "against the United States, the Commissioner of Social Security, or any officer or employee thereof ... to recover on any claim arising under" the laws of Medicare. Here, however, Bayou did nothing of the sort. Rather, all relief requested, and ordered, was based upon

specific grants of authority arising under the Bankruptcy Code, following evidentiary hearings.¹³

As explained above, the District Court clearly erred by entering the Reversal Order concluding that the Bankruptcy Court lacked jurisdiction to enter the September 5 Order, as all relief awarded fell squarely within the Bankruptcy Court's exclusive, original, and core jurisdictional grants. Neither Appellee requested a stay pending appeal of the September 5 Order, so Bayou was entitled to treat the order as final and to move forward in its Chapter 11 case. *In re Sewanee Land, Coal & Cattle, Inc.*, 735 F.2d 1294, 1295 (11th Cir. 1984) (a consequence of failing to obtain a stay is that the prevailing party may treat a judgment as final) *quoting American Grain Ass'n v. Lee-Vac, Ltd.*, 630 F.2d 245, 247 (5th Cir. Unit A 1980). Therefore, Bayou filed the Plan and the Bankruptcy Court issued the Scheduling Order (to which AHCA failed to timely object).

The Plan proposed to assume the Provider Agreements pursuant to 11 U.S.C. § 365 (Executory contracts and unexpired leases). Plan confirmation is clearly within the Bankruptcy Court's core jurisdiction pursuant to 28 U.S.C. § 157(b)(2)(L), and assumption of executory contracts also falls within the

¹³ All references to the "Bankruptcy Code" herein refer to Title 11 of the United States Code.

Bankruptcy Court's core jurisdiction provided in 28 U.S.C. § 157(b)(2)(M). The effect of confirmation of a Chapter 11 plan is governed by 11 U.S.C. § 1141, and plan implementation is governed by 11 U.S.C. § 1142. Each of these matters concern claims "arising under" the Bankruptcy Code within the meaning of 28 U.S.C. § 1334(b).

After Bayou demonstrated all factual and other requirements necessary to assume the Provider Agreements pursuant to 11 U.S.C. § 365 and the elements necessary to confirm a Chapter 11 plan pursuant to 11 U.S.C. § 1129, including that the Plan was feasible, the Bankruptcy Court entered the second orders on appeal—the Confirmation Orders. All relief awarded in the Confirmation Orders pertained to matters arising under, arising in, or related to the bankruptcy case and did not concern claims "arising under" Medicare within the meaning of 42 U.S.C. § 405(h). Further, as is the case with 11 U.S.C. § 105 and 362, sovereign immunity is also abrogated with respect to 11 U.S.C. §§ 1141 and 1142 pursuant to 11 U.S.C. § 106.

The most significant issue regarding confirmation was whether Bayou's Plan was "feasible" within the meaning of 11 U.S.C. § 1129(a)(11). In the December Confirmation Order, the Bankruptcy Court drafted over twenty [20] pages of analysis on the facts and the law on this issue. Although feasibility determinations must be "firmly rooted in predictions based on objective fact, *In re Investment*

Company of the Southwest, Inc., 341 B.R. 298, 310 (10th Cir. B.A.P. 2006), a finding of feasibility requires only a relatively low threshold of proof. *In re F.G. Metals, Inc.*, 390 B.R. 467, 475-76 (Bankr. M.D. Fla. 2008) citing *In re Sea Garden Motel and Apartments*, 195 B.R. 294, 304 (D.N.J.1996). A plan can be confirmed even if it does “not view all business prospects in the worst possible light.” *F.G. Metals*, 390 B.R. at 475-76 citing *In re T–H New Orleans Limited Partnership*, 116 F.3d 790, 801–02 (5th Cir. 1997). The Bankruptcy Court’s findings of fact on feasibility are subject to the “clearly erroneous” standard of review. *In re Loop 76, LLC*, 465 B.R. 525, 544-45 (B.A.P. 9th Cir. 2012) *aff’d*, 578 F. App’x 644 (9th Cir. 2014). Other than HHS, no party objected to the Plan’s feasibility. The Bankruptcy Court considered HHS’s Feasibility Objection in great detail, but disagreed with HHS’s position.

The District Court erred both in its interpretation of 42 U.S.C. § 405(h) and by concluding the Bankruptcy Court lacked jurisdiction to enter the September 5 Order and the Confirmation Orders permitting Bayou to assume its Medicare and Medicaid provider agreements. The Bankruptcy Court’s detailed factual findings and analysis on the issue of feasibility are not clearly erroneous. For each of these reasons, the Reversal Order must be reversed.

IV. Did the District Court err by denying Bayou Shores' motion, and renewed motion, to dismiss the first appeals (as consolidated) filed by the United States of America, on behalf of the Secretary of the United States Department of Health and Human Services, and the Florida Agency for Health Care Administration, of the Bankruptcy Court's order entered on September 5, 2014, when the issues in the first appeals had become both constitutionally and/or equitably moot?

The District Court should have granted Bayou's motion, and renewed motion, to dismiss (Dist. Ct. Doc. Nos. 20 and 61) and it erred by not dismissing the First Appeals of the September Order. As explained in detail above, at least three of the issues in Appellee's appeal of the September 5 Order were moot within the meaning of Article III, Section 2 of the U.S. Constitution. The remaining issue was moot pursuant to the doctrine of equitable mootness as applicable in Chapter 11 cases in the Eleventh Circuit, and many others. *See*, Fn. 14.

Equitable mootness "is not an Article III inquiry as to whether a live controversy is presented; rather, it is a recognition by the appellate courts that there is a point beyond which they cannot order fundamental changes in reorganization actions." *In re GWI PCS I Inc.*, 230 F.3d 788, 800 (5th Cir. 2000) *citing In re Manges*, 29 F.3d 1034, 1038-39 (5th Cir. 1994) (citation omitted); *In re Holywell Corp.*, 911 F.2d 1539, 1543 (11th Cir. 1990), *overruled on other grounds*, 503 U.S. 47 (1992) ("The mootness doctrine, as applied in a bankruptcy proceeding, permits the court[] to dismiss an appeal based on its lack of power to rescind certain transactions."). To determine whether an issue has become equitably moot in the

Chapter 11 context, a court “must determine whether the reorganization plan has been so substantially consummated that effective relief is no longer available.” *In re Citation Corp.*, 371 B.R. 518, 523-524 (2007) citing *In re Club Associates*, 956 F.2d 1065, 1069 (11th Cir. 1992) quoting *Miami Center Ltd. Partnership v. Bank of New York*, 820 F.2d 376, 379 (11th Cir. 1987) (internal quotations omitted).¹⁴

In the Eleventh Circuit, the following questions must be considered when evaluating whether issues on appeal have become equitably moot:

The mootness inquiry necessarily involves many subsidiary questions: Has a stay pending appeal been obtained? If not, then why not? Has the plan been substantially consummated? If so, what kind of transactions have been consummated? What type of relief does the appellant seek on appeal? What effect would granting relief have on the interests of third parties not before the court? And, would relief

¹⁴ Similar considerations have been adopted by the United States Courts of Appeal for the First, Sixth, and Seventh Circuits. See, e.g., *Hicks, Muse & Co., Inc. v. Brandt (In re Healthco Inter'l, Inc.)*, 136 F.3d 45, 49 (1st Cir. 1998) (examining (i) whether a “repeated failure to request a stay enabled developments to evolve in reliance on the bankruptcy court order to the degree that their remediation has become impracticable”; and (ii) whether an “order has been implemented to the degree that meaningful appellate relief is no longer practicable even though the appellant may have sought a stay with all due diligence.”); *Bank of Montreal v. Official Comm. of Unsecured Creditors (American Homepatient, Inc.)*, 420 F.3d 559, 563 (6th Cir. 2005) (examining whether (1) a stay has been obtained, (2) a plan has been substantially consummated, and (3) the relief requested would affect the rights of parties not before the court or the success of the plan); *In re UNR Indus., Inc.*, 20 F.3d 766, 769 (7th Cir. 1994) (equitable mootness “asks whether it is prudent to upset the plan of reorganization”).

affect the reemergence of the debtor as a revitalized entity? The answers to these questions provide the reviewing court with the backdrop to evaluate the ultimate issue of whether a [confirmed] plan has progressed to the point where effective judicial relief is no longer a viable option.

371 B.R. at 524 *quoting Club Associates*, 956 F.2d at 1069, n. 11. Critically, the District Court failed to engage in *any analysis* of the equitable mootness doctrine despite Bayou's detailed pleadings supplying the law and the facts on that exact issue. *See, e.g.*, Dist. Ct. Doc. No. 20, pgs. 9 – 18. As such, the District Court erred as a matter of law in denying Bayou's motion, and renewed motion, to dismiss the First Appeals. The Reversal Order must be reversed.

V. Did the District Court err by denying Bayou Shores' motion to dismiss the appeal filed by the Florida Agency for Health Care Administration of the Bankruptcy Court's Confirmation Order and the Memorandum Opinion and Order on Confirmation?

The District Court erred by failing to dismiss AHCA's appeal of the Confirmation Orders. As detailed to the District Court (Dist. Ct. Doc. No. 54) and as also detailed above, AHCA failed to preserve any right to attack the Confirmation Orders on appeal. AHCA filed no timely objection to the Plan pursuant to the Scheduling Order, filed no objection to Bayou's assumption of the Medicaid provider agreement, and attended the confirmation hearing at which all of Bayou's evidence was considered, only by phone. Dist. Ct. Doc. No. pgs. 46-37, p. 5. For each of these reasons, the District Court erred in denying Bayou's motion

to dismiss AHCA's appeal of the Confirmation Orders. AHCA should not be permitted to pursue an appeal the Confirmation Orders where it took no timely action to object to Plan or to the assumption of the Medicaid provider agreement to which it is a party. In addition, as detailed above, Bayou had already substantially consummated its Plan by the time AHCA commenced its appeal of the Confirmation Orders after AHCA waived and/or otherwise failed to obtain a stay of the Confirmation Orders pending appeal. On these facts, the District Court should have dismissed AHCA's appeal of the Confirmation Orders, and the District Court must be reversed on this issue.

VI. Did the District Court err by reversing the Bankruptcy Court's Confirmation Order and the Memorandum Opinion and Order on Confirmation with respect to Bayou Shores' assumption of its Medicare and Medicaid provider agreements after the Bankruptcy Court had concluded that Bayou Shores substantially consummated its Chapter 11 plan?

The District Court erred as a matter of law by entering the Reversal Order which "partially reversed" the Confirmation Orders stripping Bayou of the primary assets upon which its entire reorganization was premised, and *after* the Bankruptcy Court concluded the Plan was substantially consummated. According to *In re Kahihikolo*, 807 F.2d 1540, 1542 (11th Cir. 1987), the District Court was powerless to order such relief. 807 F.2d at 1542 (explaining that where no stay pending appeal has been obtained, "the court of appeals is powerless to grant relief, and the appeal must be dismissed as moot.").

Furthermore, pursuant to *In re Club Associates*, 956 F.2d 1065, 1069 (11th Cir 1992), an order confirming a chapter 11 plan cannot be reversed after the plan is substantially consummated because the issues on appeal become moot under prudential considerations. The “most significant consideration for a court” in considering whether an appeal of a confirmation order is equitably moot is whether a chapter 11 plan has been substantially consummated. *In re Strickland and Davis Intern., Inc.*, No. 14-13104, 2015 WL 2168348, at *7 (11th Cir. May 11, 2015) (affirming District Court’s decision to dismiss appeals as equitably moot). Here, the Bankruptcy Court ruled that Bayou substantially consummated its Chapter 11 plan and neither Appellee appealed this conclusion. Furthermore, a confirmation order—regardless of substantial consummation or any of the other factors in *Club Associates*, cannot be “partially reversed.” A court has the power only to fully, and not to partially, revoke a Chapter 11 plan confirmation order. *In re Motors Liquidation Co.*, 462 B.R. 494 (Bankr. S.D.N.Y. 2012) (courts cannot “cherry pick, or otherwise choose, components of plan confirmation that it desires to revoke”, discussing plan revocation pursuant to 11 U.S.C. § 1144). After a plan is substantially consummated, it cannot be modified pursuant to 11 U.S.C. § 1127(b), *In re BNW, Inc.*, 201 B.R. 838, 845-46 (Bankr. S.D. Ala. 1996), nor can it be revoked pursuant to 11 U.S.C. § 1144, absent fraud. Here, the partial reversal of the Confirmation Orders was either an impermissible post-substantial

consummation modification in violation of 11 U.S.C. § 1127(b) or a full out revocation of Bayou's Plan in violation of 11 U.S.C. § 1144 (permitting a confirmation order to be revoked only if such was procured by fraud). Neither is permissible and the District Court plainly erred. The success of a Chapter 11 reorganization demands finality to the order of confirmation. The Reversal Order must be reversed.

VII. Did the District Court err by reversing the Bankruptcy Court's: (i) September 5, 2014 order; (ii) the Memorandum Opinion and Order on Confirmation, and (iii) the Confirmation Order, when none of the Bankruptcy Court's determinations with respect to Bayou Shores' Medicare and Medicaid provider agreements involved an action "to recover on any claim arising under" the Medicare Act within the meaning of 42 U.S.C. § 405(h)?

Even if this Court aligned itself with the courts endorsing the expansive reading of 42 U.S.C. § 405(h) because of essentially a scrivener's error,¹⁵ then this Court would conclude that bankruptcy jurisdiction is not available in instances where a debtor is attempting to recover on a claim arising under the Medicare Act. Interestingly, all cases cited for what the Reversal Order referred to as the

¹⁵ See *In re Hospital Staffing Services, Inc.*, 258 B.R. 53 (S.D. Fla. 2000); *Bodimetric Health Services, Inc. v. Aetna Life & Cas.*, 903 F.2d 480 (7th Cir. 1990); *Total Renal Laboratories v. Shalala*, 60 F. Supp.2d 1323 (N.D. Ga. 1999); *In re St. Johns Home Health Agency, Inc.*, 173 B.R. 238 (Bankr. S.D. Fla. 1994); *In re St. Mary Hosp.*, 123 B.R. 14 (E.D. Pa. 1991).

“majority view” reached their conclusions where there have been claims arising under the Medicare Act. Notably, the case of *In re St. Johns Home Health Agency, Inc.*, 173 B.R. 238 (Bankr. S.D. Fla. 1994) is instructive. In *St. Johns*, the Bankruptcy Court for the Southern District of Florida determined that it could not take jurisdiction over an action to assume the Medicare provider agreement because in order to assume the agreement the debtor had to cure the *monetary default*. The court noted that taking jurisdiction upon a *monetary claim* (i.e., a right to payment) was not within the jurisdictional ambit of the bankruptcy court in this limited circumstance, where the right to payment arose under the Medicare Act. In the case of *Bodimetric Health Services, Inc. v. Aetna Life & Cas.*, 903 F.2d 480 (7th Cir. 1990), Medicare providers brought an action against a fiscal intermediary for improperly denying reimbursement claims made under the Medicare Act. The fiscal intermediary moved to dismiss the bankruptcy court action for lack of subject matter jurisdiction alleging that the exclusive review mechanisms of the Medicare Act barred Bodimetric from pursuing its challenge in federal court. The district court granted the motion to dismiss and the Seventh Circuit affirmed. The Seventh Circuit determined that the bankruptcy court was precluded by 42 U.S.C. § 405(h)’s jurisdictional bar from exercising jurisdiction over Bodimetric’s claims because, as in *St. John’s*, Bodimetric’s action was an action to recover on a claim arising under the Medicare Act.

Here, however, there was no monetary claim at issue in the Bankruptcy Court. Neither the September 5 Order nor the Confirmation Orders had anything to do with recovering a claim (a right to payment) arising under the Medicare Act. Rather, these orders determined whether the Provider Agreements had been terminated, or were viable contract rights and a property interest pursuant to 11 U.S.C. § 541, and, thereafter, whether they could be assumed pursuant to 11 U.S.C. § 365. Therefore, even if this Court aligns itself with the courts that engraft 28 U.S.C. § 1334 into the “jurisdictional bar” of 42 U.S.C. § 405(h), it still does not preclude a bankruptcy court from determining a debtor’s property interests pursuant to 28 U.S.C. § 1334, or from confirming a plan providing for the assumption of provider agreements with Medicare and Medicaid.

CONCLUSION

For each reason stated herein, the District Court erred in entering the Reversal Order. Each of Bayou’s motions to dismiss should have been granted, and the Reversal Order must be reversed.

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CERTIFICATE OF COMPLIANCE

This is to certify that this brief complies with Federal Rules of Appellate Procedures 32(a)(7). This brief is submitted in 14-point Times New Roman font, and it contains 13,551 words.

/s/ Tiffany D. Payne

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on October 16, 2015, the foregoing *Appellant Bayou Shores, SNF, LLC's Initial Brief* was electronically filed via the Court's Electronic Case Files System. I FURTHER CERTIFY, in compliance with Rule 25, Federal Rule of Appellate Procedure, Eleventh Circuit General Order 37, that the foregoing was sent by the Court's ECF system, via a "Notice of Docket Activity" e-mail to the following:

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IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 15-13731

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

AND

UNITED STATES ON BEHALF OF SECRETARY, UNITED STATES
DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Plaintiffs-Appellees,

v.

BAYOU SHORES SNF, LLC,

Defendant-Appellant.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF FLORIDA

BRIEF FOR THE FEDERAL APPELLEES

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No. 15-13731-FF

**Amended Certificate of Interested Persons
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C-3 of 3

STATEMENT REGARDING ORAL ARGUMENT

The United States and Secretary of Health and Human Services respectfully request oral argument. The case presents important and recurring issues concerning a bankruptcy court's jurisdiction and authority to enjoin the termination of a substandard nursing home from the Medicare program. Oral argument will illuminate the position of the parties and aid the Court in reaching a decision.

TABLE OF CONTENTS

CERTIFICATE OF INTERESTED PERSONS AND CORPORATE DISCLOSURE STATEMENT.	C-1
STATEMENT REGARDING ORAL ARGUMENT.	i
JURISDICTIONAL STATEMENT	2
STATEMENT OF ISSUES PRESENTED FOR REVIEW	5
STATEMENT OF THE CASE	5
A. Statutory and Regulatory Scheme	5
1. Federal Standards for the Health and Safety of Nursing Home Residents	5
2. Remedies and Enforcement	9
3. Administrative Appeal and Judicial Review	11
B. Statements of Facts and Course of Proceedings	14
1. Bayou Shores' History Of Substandard Care And Termination From the Medicare Program	14
2. Bayou's District Court Action for A Temporary Restraining Order.....	17
3. Bayou's Bankruptcy Petition and Bankruptcy Court Rulings	18
a. Preliminary Injunction.....	18
b. Confirmation Order and Denial of Stay Pending Appeal.....	19
4. District Court Decision	22

5. Appeal and Stay	23
STATEMENT OF THE STANDARD OF REVIEW.....	25
SUMMARY OF THE ARGUMENT	25
ARGUMENT	30
I. The Medicare Statute Establishes The Exclusive Avenue For Obtaining Judicial Review Of A Decision To Terminate A Nursing Home From Participation In Medicare And Bars Bankruptcy Courts From Interfering With The Secretary’s Determination To Terminate A Substandard Provider From The Program	30
II. Even Assuming Jurisdiction, Bankruptcy Courts Have No Authority To Disregard Statutory Provisions Regulating Participation In Medicare.....	47
III. The Case Presents A Live Controversy	57
IV. The Secretary’s Appeal To The District Court Was Not Equitably Mooted By Implementation Of The Plan Of Reorganization	58
CONCLUSION.....	65
FRAP 32(a)(7) CERTIFICATE OF COMPLIANCE	
CERTIFICATE OF SERVICE	

TABLE OF AUTHORITIES

Cases:	<u>Page</u>
<i>Affiliated Prof'l Home Health Care v. Shalala</i> , 164 F.3d 282 (5th Cir. 1999).....	35
<i>Americana Healthcare Corp. v. Schweiker</i> , 688 F.2d 1072 (7th Cir. 1982).....	35
<i>Bayou Shores v. Burwell</i> , No. 145-849, 2014 WL 4059900 (M.D. Fla. Aug. 15, 2014)	17-18
* <i>Bodimetric Health Services, Inc. v. Aetna Life & Cas.</i> , 903 F.2d 480 (7th Cir. 1990).....	42
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* <i>Butz v. Glover Livestock Comm'n Co., Inc.</i> , 411 U.S. 182, 93 S. Ct. 1455 (1973).....	56
<i>Cathedral Rock of North Coll. Hill v. Shalala</i> , 223 F.3d 354 (6th Cir. 2000).....	35
<i>Federal Crop Ins. Corp. v. Merrill</i> , 332 U.S. 380, (1947)	49
<i>First American Health Care, Inc. v. HHS</i> , 208 B.R. 985 (Bankr. S.D. Ga. 1996)	43
* <i>Florida Power & Light Co. v. Lorion</i> , 470 U.S. 729, 105 S. Ct. 1598 (1985)	52
<i>Fourco Glass Co. v. Transmirra Products Corp.</i> , 353 U.S. 222, 77 S. Ct. 787 (1957).....	43
<i>Geriatrics, Inc. v. Harris</i> , 640 F.2d 262 (10th Cir. 1981).....	35

* Cases primarily relied upon are marked with an asterisk

<i>Heckler v. Ringer</i> , 466 U.S. 602, 104 S.Ct. 2013 (1984)	44
<i>In re Bricker</i> , 43 B.R. 344 (Bankr. D. Ariz. 1984)	50
<i>In re Club Associates</i> , 956 F.2d 1065 (11 th Cir. 1992).....	59
<i>In re Fontainebleau Hotel Corp.</i> , 515 F.2d 913 (5th Cir.1975).....	49
<i>In Re Lett</i> , 632 F.3d 116 (11 th Cir. 2011).....	59
<i>In re St. John’s Home Health Agency, Inc.</i> , 173 B.R. 238 (Bankr. S.D. Fla. 1994).....	43
<i>In re St. Mary Hosp.</i> , 123 B.R. 14 (E.D. Pa. 1991)	
<i>In re Town & Country Nursing Home Servs., Inc.</i> , 963 F.2d 1146 (1992).....	44
<i>In re University Medical Center</i> , 973 F.2d 1065 (3d Cir. 1992)	44, 45
<i>Jackson v. Astrue</i> , 506 F.3d 1349 (11th Cir. 2007).....	23
<i>Jackson v. United States</i> , 573 F.2d 1189 (Ct. Cl.1978)	49
<i>Lifestar Ambulance Service, Inc. v. United States</i> , 365 F.3d 1293 (11th Cir. 2004).....	33
<i>Livingston Care Ctr. v. United States</i> , 934 F.2d 719 (6th Cir. 1991).....	9
<i>Lucas v. W.W. Grainger, Inc.</i> , 257 F.3d 1249 (11th Cir. 2001)	47
<i>MCorp Financial, Inc. v. Board of Governors of the Federal Reserve System</i> , 502 U.S. 32, 112 S. Ct. 459 (1991)	44
<i>Merck & Co. v. Reynolds</i> , 559 U.S. 663, 130 S. Ct. 1784 (2010)	44
<i>Midland Psychiatric Assocs., Inc. v. United States</i> , 145 F.2d 1000 (8th Cir. 1998).....	42

<i>Midlantic Nat'l Bank v. New Jersey Dep't of Env'tl. Protection</i> , 474 U.S. 494, 106 S.Ct. 755 (1986).....	47
<i>Moody v. Amoco Oil Co.</i> , 734 F.2d 1200 (7th Cir. 1984).....	49, 50
<i>Nichole Med. Equip. v. Tricenturion, Inc.</i> , 694 F.3d 340 (3d Cir. 2012).....	42-43
<i>Northlake Cmty. Hosp. v. United States</i> , 654 F.2d 1234 (7 th Cir. 1981)	35
* <i>Shalala v. Illinois Council on Long Term Care, Inc.</i> , 529 U.S. 1 (2000).....	3, 26, 33, 45
<i>V.N.A. of Greater Tift County v. Heckler</i> , 711 F.2d 1020 (11th Cir. 1983).....	27, 37, 38
<i>Weinberger v. Salfi</i> , 422 U.S. 749, 95 S. Ct. 2457 (1975).....	32

Statutes:

Omnibus Reconciliation Act of 1987, Pub L. No. 100-203, title IV, subtitle C, 101 Stat. 1330-160	5
Pub L. No. 76-379, § 205(h), 53 Stat. 1360 (1939).	40
Pub. L. No. 80-773, § 1, 62 Stat. 869, 930 (1948)	41
Pub L. No. 98-369, § 2663(a)(4)(D), 98 Stat. 1162 (1984).....	42, 43
Pub. L. No. 109-8, §§ 1104-1106, 119 Stat. 191 (2005)	54
36 Stat. 1091, 1093 (1911).....	40
2 U.S.C. 285b(1)	41
11 U.S.C. 333	54
11 U.S.C. 362(a)	50
11 U.S.C. 362(a)(2).....	18
11 U.S.C. 362(b)(28)	54

11 U.S.C. 362(b)(4).....	19, 50
11 U.S.C. 365(a)	49
28 U.S.C. 41(19) (1934)	40, 42
28 U.S.C. 1331.....	30, 41, 42
28 U.S.C. 1334.....	19, 30, 35, 40
28 U.S.C. 1334(a)	2, 35
28 U.S.C. 1334(b).....	35
28 U.S.C. 1334(e)	36
28 U.S.C. 1346.....	30, 40, 41, 42
28 U.S.C. 157.....	2, 19
28 U.S.C. 158(a)	3
28 U.S.C. 158(d)(1)	4
42 U.S.C. 1320a-7a(e)	13
42 U.S.C. 1395cc(b)(2).....	30
42 U.S.C. 1395cc(b)(2)(A)	36
42 U.S.C. 1395cc(C)(I) (i).....	34
42 U.S.C. 1395cc(h)	14
42 U.S.C. 1395cc(h)(1).....	13, 22
42 U.S.C. 1395cc(h)(1)(A)	31, 34
42 U.S.C. 1395cc(h)(1)(B)	13, 34
42 U.S.C. 1395f(a).....	58
42 U.S.C. 1395i-3	13
42 U.S.C. 1395i-3(a)-(d).....	5
42 U.S.C. 1395i-3(b)(2).....	7
42 U.S.C. 1395i-3(g)(1)(A)	8
42 U.S.C. 1395i-3(g)(2)(A)(i)	55
42 U.S.C. 1395i-3(g)(2)(A)(i)&(iii)	7
42 U.S.C. 1395-i(g)(2)(B).....	8
42 U.S.C. 1395i-3(g)(2)(C).....	8
42 U.S.C. 1395i-3(g)(2)(ii)	8
42 U.S.C. 1395i-3(g)(5).....	8
42 U.S.C. 1395i-3(h).....	9
42 U.S.C. 1395i-3(h)(1).....	9
42 U.S.C. 1395i-3(h)(2).....	13
42 U.S.C. 1395i-3(h)(2)(A)(i).....	48
42 U.S.C. 1395i-3(h)(4).....	33, 48
42 U.S.C. 1395ii	13, 14, 31
42 U.S.C. 1396a(a)(39).....	9

42 U.S.C. 1396i-3(h)(2).....	9
42 U.S.C. 1396r(a)-(d).....	5
42 U.S.C. 1396r(b)(2).....	7
42 U.S.C. 1396r(g)(2)(A)(i) &(iii)	7
42 U.S.C. 1396r(g)(2)(A)(ii).....	8
42 U.S.C. 1395r(g)(2)(B).....	8
42 U.S.C. 1396r(g)(2)(C).....	8
42 U.S.C. 1396r(g)(1)(A)	8
42 U.S.C. 1396r(g)(5).....	8
42 U.S.C. 1396r(h).....	9
42 U.S.C. 1396r(h)(1).....	9
42 U.S.C. 1396r(h)(2).....	9
42 U.S.C. 405(b).....	14, 31
42 U.S.C. 405(g).....	13, 14, 22, 23, 31
42 U.S.C. 405(h).....	passim

Regulations:

42 C.F.R. 431.153(g).....	12
42 C.F.R. 431.153(i)	12
42 C.F.R. 431.153(i)(2).....	12
42 C.F.R. 483.1-483.75	7
42 C.F.R. 483.25	7
42 C.F.R. 488.26.....	8, 56
42 C.F.R. 488.301	11
42 C.F.R. 488.305	8
42 C.F.R. 488.307	55
42 C.F.R. 488.314	8
42 C.F.R. 488.325	8
42 C.F.R. 488.330(c).....	11
42 C.F.R. 488.404	10
42 C.F.R. 488.406	10
42 C.F.R. 488.488.408	10
42 C.F.R. 488.408(e).....	11
42 C.F.R. 488.408 (d).....	11
42 C.F.R. 488.402 (f)	11
42 C.F.R. 488.408(f)(2).....	11
42 C.F.R. 489.13, 489.57	53

42 C.F.R. 498.2	12
42 C.F.R. 498.3(b).....	12
42 C.F.R. 498.40-498.66	12
42 C.F.R. 498.5	12
42 C.F.R. 498.5(c).....	12-13
42 C.F.R. 498.74	12
42 C.F.R. 498.85-498.86	13
42 C.F.R. 498.88	13
42 C.F.R.488.408(d).....	11
42 C.F.R.498.80	12
42 C.F.R. 498.95	13
59 Fed. Reg. 56116 (1994)	5

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Rule:

Bankruptcy Rule 3020(e).....	3, 5, 22, 29, 60, 61,62, 65

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This case arises out of the Secretary's termination of a substandard nursing home from the Medicare program. It raises important issues concerning a bankruptcy court's jurisdiction to review the Secretary's action before exhaustion of administrative remedies as well as a bankruptcy court's authority to make its own, *de novo* determination of whether a facility satisfies Medicare health and safety standards.

The Secretary terminated appellant Bayou Shores from Medicare after three consecutive health and safety inspections revealed that Bayou chronically placed its residents in immediate jeopardy of serious bodily harm. The Secretary's action came after twice imposing lesser alternative remedies, which failed to motivate Bayou to comply with the minimum health and safety requirements of the Medicare program. That decision was consistent with Congress's intent to eliminate from Medicare chronically substandard nursing homes that temporarily correct deficiencies, only to quickly lapse into noncompliance until the next inspection.

The bankruptcy court nonetheless reversed the Secretary's decision in order to facilitate Bayou's reorganization under Chapter 11. In so doing, it violated express statutory limitations on its jurisdiction, congressional policies requiring substandard nursing home to be eliminated from Medicare, and fundamental principles of administrative law requiring

agency action to be reviewed on the basis of an administrative record rather than a newly-created evidentiary record. The district court correctly reversed the bankruptcy court's decision, and its judgment should be affirmed.

JURISDICTIONAL STATEMENT

1. Appellant Bayou Shores operates a skilled nursing facility. On July 22, 2014, the Centers for Medicare & Medicaid Services ("CMS") terminated Bayou Shores from the Medicare program, effective August 3, 2014, after determining that a state survey had found that the facility was not in substantial compliance with Medicare requirements, and that substandard conditions at the facility placed the health and safety of its residents in immediate jeopardy.

On August 15, 2015, Bayou petitioned to reorganize in bankruptcy and subsequently obtained bankruptcy court orders barring Medicare's termination notice from taking effect. The bankruptcy court had jurisdiction over the reorganization proceedings pursuant to 28 U.S.C. 1334(a) and 28 U.S.C. 157. The bankruptcy court, however, had no jurisdiction to enjoin or review Medicare's termination order. Rather, as we will explain more fully below, Congress has expressly barred the federal courts from assuming jurisdiction over all claims arising under the Medicare statute prior to

exhaustion of administrative remedies—a requirement that has not been met here. 42 U.S.C. 405(h), 1395ii; *see generally Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 120 S. Ct. 1084 (2000).

2. The two pertinent bankruptcy court orders are an injunction prohibiting any action to terminate Bayou’s Medicare and Medicaid provider agreements, issued September 5, 2014, and a subsequent order confirming Bayou’s plan of reorganization, which was entered on January 7, 2015, and which enjoined Medicare from enforcing the notice terminating Bayou from Medicare. The Secretary filed timely appeals of these two orders to the district court on September 9, 2014, and January 13, 2015, respectively. CR. (Clerk’s Record No.) 88; 289. The district court had jurisdiction over the Secretary’s appeals from the bankruptcy court orders under 28 U.S.C. 158(a).

3. The district court consolidated the two appeals and, on June 26, 2015, reversed the bankruptcy court’s orders and remanded for further proceedings consistent with the court’s opinion. CR. 72. As explained in the Secretary’s response to this Court’s jurisdictional question (filed October 1, 2015), the district court’s order is a final judgment, notwithstanding the remand, because it conclusively determines that the bankruptcy court has no

jurisdiction to enjoin or otherwise review the Secretary's termination of Bayou's Medicare provider agreement.

Bayou filed a timely notice of appeal to this Court on August 19, 2015. CR. 84. This Court therefore has appellate jurisdiction under 28 U.S.C. 158(d)(1).

STATEMENT OF ISSUES PRESENTED FOR REVIEW

1. Whether 42 U.S.C. 405(h), as incorporated into Medicare by 42 U.S.C. 1395ii, precludes a bankruptcy court from exercising jurisdiction over an order terminating a skilled nursing facility from the Medicare program before the facility has exhausted its administrative remedies.

2. Whether, assuming jurisdiction, a bankruptcy court may overturn the Secretary's exercise of enforcement discretion on the basis of the court's *de novo* determination that post-termination improvements have remedied conditions threatening the residents' health and safety.

3. Whether the government's appeal to the district court of a bankruptcy court order that continues to bar the Secretary from terminating a substandard nursing home from Medicare participation is constitutionally moot.

4. Whether appeal of the order confirming Bayou's plan of reorganization is "equitably moot" where there has been only a minimal

distribution of estate assets to the debtor's creditors, and where the bankruptcy court's order overriding Bankruptcy Rule 3020(e)'s automatic stay of plan implementation is unsupported by any findings that immediate consummation of the plan is necessary or appropriate.

STATEMENT OF THE CASE

A. Statutory and Regulatory Scheme.¹

1. Federal Standards for the Health and Safety of Nursing Home Residents.

To participate in Medicare and Medicaid, a nursing home must comply with standards for each resident's health and safety. 42 U.S.C. 1395i-3(a)-(d) (Medicare); 42 U.S.C. 1396r(a)-(d) (Medicaid). The standards and compliance provisions now in effect were principally established by the Omnibus Budget Reconciliation Act of 1987, Pub L. No. 100-203, title IV, subtitle C, 101 Stat. 1330-160, and by implementing regulations that took effect on July 1, 1995. *See* 59 Fed. Reg. 56116 (Nov. 10, 1994).

Congress concluded that the prior enforcement program had not adequately protected nursing home residents. It noted that a 1986 survey by the Institute of Medicine of had found that, in many "government certified

¹ Pertinent statutes are reprinted in the addendum.

nursing homes, individuals * * * receive very inadequate —sometimes shockingly deficient —care that is likely to hasten the deterioration of their physical, mental, and emotional health.” H.R. Rep. No. 100-391(pt. I), at 452 (1987), *reprinted in* 1987 U.S.C.C.A.N. 2313-1, 2313-272. Testimony before Congress confirmed disturbingly common instances of unsanitary conditions, pervasive neglect, and serious resident abuse. *See generally Nursing Home Care Vol I: The Unfinished Agenda: Hearing before the Senate Special Comm. on Aging*, 99th Cong., 1082 (1986) (“1986 Hearing”).²

In 1987, Congress responded by amending the statute to focus on the adequacy of care delivered to individual residents, and to expand the enforcement remedies available to state and federal officials. H.R. Rep. No. 391 at 486-477. The current regulatory scheme requires that “[e]ach resident must receive and the facility must provide the necessary care and

² Surveyors and others had found nursing home residents lying in their own feces or urine for extended periods of time, covered with flies and dried food, and ridden with bedsores, despite complaints from visiting relatives. *1986 Hearing* 8 -9, 61, 64, 800. There were reports of residents dying when facilities failed to pay attention to their medical needs. *See, e.g., id.* at 110 (resident died of starvation after facility failed to ensure feeding tube provided sufficient calories); *id.* at 73 -74 (resident died from absence of medical attention for severe cramps and vomiting). And there were frequent reports of brain-impaired and comatose patients being raped and sexually abused. *Id.* at 105-106.

services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with [a] comprehensive assessment and plan of care.” 42 C.F.R. 483.25; *see* 42 U.S.C. 1395i-3(b)(2); 42 U.S.C. 1396r(b)(2).

The statute and implementing regulations set forth detailed requirements for resident admission, transfer, and discharge, the protection of resident rights, the scope and quality of health care and other services, the qualifications of the facility’s staff and health care professionals, and the facility’s physical environment. 42 C.F.R. 483.1-483.75.

Moreover, to ensure that residents receive quality care in practice, the statute also sets forth detailed procedures for the inspection of nursing homes and the enforcement of health and safety standards. Each skilled nursing facility is subject to a standard survey that must be conducted without prior notice. The surveys are, on average, to be conducted on an annual basis and must be performed at each facility at intervals of no longer than 15 months. 42 U.S.C. 1395i-3(g)(2)(A)(i), (iii); 42 U.S.C. 1396r(g)(2)(A)(i), (iii). Each survey must examine, for a statistically meaningful sample of residents, the quality of care furnished individual patients as well as the facility’s compliance with statutory provisions protecting each resident’s right to choose his or her attending physician, to

be free from physical or chemical restraint, and to exercise other individual rights guaranteed by statute. 42 U.S.C. 1395i-3(g)(2)(ii); 42 U.S.C. 1396r(g)(2)(A)(ii); 42 C.F.R. 488.305.

Surveys for both the Medicare and Medicaid programs are generally conducted by a single state agency. 42 U.S.C. 1395i-3(g)(1)(A); 42 U.S.C. 1396r(g)(1)(A). They must be conducted by a multidisciplinary team of professionals and conform to federally-prescribed methods, procedures, and forms. 42 U.S.C. 1395i-3(g)(2)(C); 42 U.S.C. 1396r(g)(2)(C); *see also* 42 C.F.R. 488.314, 488.26(c). If the survey agency finds that a nursing facility has provided substandard care, it must conduct a more extensive evaluation of the facility's operations to further assess compliance with statutory requirements and to identify the policies and procedures that resulted in the deficiency. 42 U.S.C. 1395-i(g)(2)(B); 42 U.S.C. 1395r(g)(2)(B).

Congress has required the Secretary and the States to make survey information publicly available. 42 U.S.C. 1395i-3(g)(5); 42 U.S.C. 1396r(g)(5). Statements of deficiencies, the nursing facility's comments in response to survey findings, remedial measures, and the results of any appeal taken by the provider must thus be made available to the general public on request. 42 C.F.R. 488.325. In addition, regulatory authorities must provide similar information to the facility's licensing board, the physician attending

any resident found to have received substandard care, and the state's long-term care ombudsman (a state advocate for nursing home residents). *Ibid.*

2. Remedies and Enforcement.

After completing a survey, the pertinent regulatory agency must determine what remedy or sanction, if any, is necessary to enforce the statutory requirements for resident care.³ 42 U.S.C. 1395i-3(h); 42 U.S.C. 1396r(h). Congress stated that it intended to improve the quality of care for nursing home residents by giving regulators the power “either to * * * bring substandard facilities into compliance with [federal] quality of care requirements or to exclude them from the program.” H. R. Rep. No. 100-391(I) at 452. The statute accordingly vests federal and state officials with authority to impose a broad range of remedies and sanctions to ensure compliance with nursing home standards. Regulatory officials are thus empowered to direct a plan for correcting statutory violations, to impose civil money penalties, to deny further reimbursement for services rendered after the deficiency is discovered, to appoint temporary management, to

³ In the federally-administered Medicare program, the state survey agency recommends an appropriate remedy and the Secretary makes the final decision on remedial action. 42 U.S.C. 1395i-(3)(h)(1). In Medicaid, these remedial powers are vested in the State. 42 U.S.C. 1396r(h)(1). If the provider is terminated from Medicare, however, it will automatically be terminated from Medicaid as well. 42 U.S.C. 1396a(a)(39); *Livingston Care Ctr., Inc. v. United States*, 934 F.2d 719, 720 (6th Cir. 1991)

terminate a facility's right to participate in Medicare or Medicaid, or to transfer residents and close the facility. 42 U.S.C. 1396i-3(h)(2); 42 U.S.C. 1396r(h)(2), 42 C.F.R. 488.406.

Congress also vested federal and state officials with the discretion to tailor these remedies to the violations found in the survey. Rather than dictate the selection of specific enforcement remedies in particular circumstances, the statute directs the Secretary to "specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these * * * remedies. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies." 42 U.S.C. 1395i-3(h)(2)(B)(iii); 42 U.S.C. 1396r(h)(2)(A).

The Secretary has accordingly promulgated regulations for calibrating the enforcement remedy to the scope and severity of the deficiencies found in the survey and inspection process. 42 C.F.R. 488.400-488.430. These regulations provide that the selection of an appropriate remedy will be based on the degree of actual or potential harm to resident health or safety, and the extent to which deficient care discovered in the survey reflects an isolated occurrence or pervasive problem. 42 C.F.R. 488.404, 488.408. For

example, regulators need not impose any remedy if they conclude that a nursing home's violation of a statutory requirement has not resulted in any actual harm to a resident and poses no more than a risk of minimal harm in the future. 42 C.F.R. 488.301 (defining substantial compliance with health and safety requirements); 42 C.F.R. 488.408(f)(2).

More serious violations, however, will result in progressively more substantial remedies. Thus, violations that have resulted in actual harm to a resident or that, though yet to cause harm, are widespread and have the potential to cause more than minimal harm, will result in significant sanctions, including civil money penalties or the denial of payment for new nursing home admissions. 42 C.F.R. 488.408(d). Similarly, violations that place the health or safety of residents in imminent jeopardy may result in even more stringent remedies, such as the appointment of new, temporary management, closure of the facility, or termination of the facility's participation in Medicare and/or Medicaid. 42 C.F.R. 488.408(e).

3. Administrative Appeal and Judicial Review.

Nursing homes must be given written notice of any deficiencies noted in the state survey, a statement of any remedies imposed, and a statement of the facility's right to appeal. 42 C.F.R. 488.330(c), 488.402(f). If a remedy or sanction is imposed, the provider may in most instances contest the

underlying survey findings through a formal evidentiary hearing. 42 C.F.R. 498.3(b), 498.5; 42 C.F.R. 431.153(i). The hearing must afford the provider an opportunity to appear before an administrative law judge or other impartial decisionmaker, to be represented by counsel, to call witnesses, and to present other evidence. 42 C.F.R. 498.40-498.66, 42 C.F.R. 431.153(i). Hearing decisions must be in writing and set forth the reasons for the enforcement action and the evidence on which it is based. 42 C.F.R. 498.74; 42 C.F.R. 431.153(i)(2).

Nursing homes participating in the Medicare program have a further right to appeal an adverse hearing decision to HHS's Departmental Appeals Board. 42 C.F.R. 498.80, 42 C.F.R. 431.153(g). The Appeals Board is established within the Office of the Secretary to provide impartial review of disputed agency decisions. 42 C.F.R. 498.2. A nursing home seeking review before the Appeals Board may present briefs and argument to the Appeals Board and may, in addition, introduce additional evidence not considered by the ALJ. 42 C.F.R. 498.85-498.86. The Board must issue a decision in writing and is empowered to modify, affirm, or reverse the ALJ's decision. 42 C.F.R. 498.88.

Medicare providers may then seek judicial review of a final decision of the Appeals Board by commencing a civil action within 60 days. 42

C.F.R. 498.5(c), 498.95. If the challenged decision results in imposition of a civil money penalty, the nursing home may seek review directly in the court of appeals. 42 U.S.C. 1395i-3(h)(2), incorporating by reference 42 U.S.C. 1320a-7a(e). Other final administrative decisions are reviewable in district court. *See* 42 U.S.C. 1395cc(h)(1), incorporating by reference 42 U.S.C. 405(g). Facilities that are terminated from Medicare have access to expedited administrative and judicial review. 42 U.S.C. 1395cc(h)(1)(B), (C). Congress, however, further provided that nothing in these expedited rights of review “shall be construed to affect the application of any remedy imposed under section 1395i–3 of this title [pertaining to enforcement of nursing home standards] during the pendency of an appeal under this subparagraph.” 42 U.S.C. 1395cc(h)(1)(B).

The statute provides that this avenue of administrative appeal and judicial review is the exclusive means of obtaining jurisdiction over claims arising under the Medicare Act, thereby making exhaustion of administrative remedies a prerequisite to obtaining judicial review of a nursing home enforcement sanction. 42 U.S.C. 405(h), as incorporated into Medicare by 42 U.S.C. 1395ii, thus states:

The findings and decision of the [Secretary] after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the [Secretary] shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the [Secretary], or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28, to recover on any claim arising under this subchapter.⁴

The central issue here is whether, notwithstanding these statutory provisions, a bankruptcy court can enjoin and conduct a *de novo* review of debtor nursing home's termination from the Medicare program—before the nursing home has exhausted its administrative remedies, and without regard to the procedures for administrative and judicial review established by Congress.

B. Statement of Facts and Course of Proceedings.

1. Bayou Shores' History Of Substandard Care And Termination

From the Medicare Program.

Appellant Bayou Shores operates a skilled nursing facility located in St. Petersburg, Florida. In February 2014, surveyors inspected Bayou and discovered rampant, serious problems, which the surveyors documented in a detailed, 124-page report. CR. 42-1, Exh. A. Multiple residents were

⁴ Although 42 U.S.C. 405(b), (g), and (h) refer to the “Commissioner of Social Security,” Congress directed that any reference to the Commissioner be construed as a reference to the Secretary where context so indicates. *See* 42 U.S.C. 1395cc(h), 1395ii.

observed to have very poor hygiene. *Id.* at. 73-77, 81-82 (one resident's fingernails long and encrusted with "brown matter," another's teeth "caked," another's incontinence brief "saturated" and foul-smelling). Medication carts from which drugs were dispensed were unattended, unlocked, and contained multiple expired medications. *Id.* at 85-88. Despite these deficiencies, the Secretary did not terminate Bayou from the Medicare program but instead afforded Bayou an opportunity to correct the substandard conditions. CR. 42-4, Exh. D ¶ 2.

In March 2014, surveyors returned to the facility and discovered serious and continuing deficiencies. Within days after the February inspection, the nursing home had admitted from a hospital a man whom the hospital had noted was a "prior sex offender." CR. 42-2, Exh. B at 15-18; 20. The man was placed in a room with another resident, who was paralyzed due to stroke. *Id.* at 17-18. The paralyzed resident was not informed of his roommate's history, and the roommate attempted to sexually molest the paralyzed resident. *Id.* In addition to these findings, the March survey found that medication carts still contained expired and/or undated medications. *Id.* at pp. 7-9. Medicare again afforded Bayou an opportunity to correct these deficiencies. CR. 42-4, Exh. D ¶ 2.

On July 11, 2014, the Florida Agency for Healthcare Administration—the single state agency that conducts nursing home compliance surveys for the Medicare and Medicaid—returned to the facility and conducted a detailed review of conditions at Bayou Shores. The survey agency once again found numerous instances in which Bayou Shores failed to comply with standards for patient health and safety, and seven instances of violations that placed Bayou’s residents in immediate jeopardy of serious harm or death. CR. 42-1, Exh. A; CR. 42-5, Exh. E. As summarized by the Medicare ALJ reviewing Bayou’s administrative appeal:

Immediate jeopardy represents the most serious level of deficiency, and this facility had a whopping number of them—seven—stemming largely from the facility’s failure to identify and protect residents who wandered or presented elopement risks. One mentally-impaired resident left the facility on a hot Florida day, wandered through traffic and was later found “at a bus stop.” * * * His departure was not documented, not investigated, and not reported to his physician. Nor were the non-jeopardy-level deficiencies trivial. Among other problems, kitchen personnel and nurse aides, as well a nurse supervisor did not follow adequate hand washing techniques, which poses a serious risk of infection among a vulnerable population.

CR. 261-1 at 4 n.2.⁵ Bayou did not contest the findings of immediate jeopardy.

⁵ Although Bayou has invoked its administrative appeal rights, the ALJ decision does not resolve all the issues raised by Bayou’s administrative

On July 22, 2014, CMS notified Bayou that its Medicare provider agreement authorizing Bayou's participation in the Medicare program would be terminated, effective 11:59 p.m. on August 3, 2014. CR. 42-5, Exh. E. at 2. The notice advised Bayou that Medicare payments for residents admitted before the effective date of the termination would continue to be made for up to 30 days to facilitate the orderly transfer or relocation of residents, but that Medicare would make no further payments for patients admitted after July 24, 2014. *Ibid.* Medicare also imposed a civil money penalty of \$3,050 per day for each day the facility failed to comply with standards for health and safety, effective June 21, 2014. *Ibid.* Finally, the notice advised Bayou of its right to an administrative hearing before HHS's Departmental Appeals Board to contest the findings of noncompliance underlying the termination order as well as the imposition of civil money penalties. *Id.* at 3.

2. Bayou's District Court Action for A Temporary Restraining Order.

On August 1, 2014, two days before the termination was to take effect, Bayou filed a district court action seeking to enjoin its termination from Medicare. It initially obtained an *ex parte* TRO enjoining CMS from terminating the Medicare and Medicaid provider agreements through August 15, 2014. *See Bayou Shores v. Burwell*, No. 145-849, 2014 WL 4059900

appeal. *See* CR. 261-1 at 6-7. Bayou's administrative appeal remains pending as of this writing.

(M.D. Fla. Aug. 15, 2014). The district court, however, subsequently dissolved the TRO and dismissed Bayou's action for lack of subject matter jurisdiction. *Ibid.* The district court concluded that Medicare's jurisdictional bar, 42 U.S.C. 405(h), precluded the court from exercising jurisdiction over the controversy prior to Bayou's exhaustion of its administrative remedies—a requirement that Bayou had not met.

3. Bayou's Bankruptcy Petition and Bankruptcy Court Rulings.

a. Preliminary Injunction.

Less than one hour later, Bayou filed a petition to reorganize under chapter 11 of the Bankruptcy Code and immediately renewed its request for emergency relief barring its termination from the Medicare program. CR. 1 at 25. On August 25, 2014, the bankruptcy court preliminarily enjoined Bayou's termination pending an evidentiary hearing. CR. 35. It reasoned that Bayou had made a *prima facie* showing that the provider agreement was still in effect and remained property of the estate, notwithstanding Medicare's express statement that the termination was effective August 3, 2015 – nearly two weeks before the commencement of the bankruptcy case-- and that any action to terminate the putative agreement would violate the Code's "automatic stay" of actions against the debtor. CR. 35; *see* 11 U.S.C. 362(a)(2).

The bankruptcy court held an evidentiary hearing on August 26, 2014. On September 5, 2014, it issued an order prohibiting termination of Bayou's Medicare provider agreement and barring Medicare from transferring or relocating Bayou's patients. CR. 78. The court found that it had jurisdiction under 28 U.S.C. 157 and 28 U.S.C. 1334 (CR. 80, Tr. 112-13), that the deficiencies found in the surveys of Bayou had been addressed and that the patients were no longer in jeopardy (*id.* at 116, 118), that terminating the facility would harm Bayou's patients, employees, customers, and creditors (*id.* at 117-18), and that the termination was not an exercise of the government's police power exempted from the Code's "automatic stay" by 11 U.S.C. 362(b)(4) (*id.* at 117).

b. Confirmation Order and Denial of Stay Pending Appeal.

In November 2014, Bayou submitted its Plan of Reorganization and First Amended Disclosure Statement. CR. 184, 185. The plan contemplated that Bayou would continue to participate in the Medicare and Medicaid programs, notwithstanding the prior termination of its provider agreement, that distributions under the plan would commence on the plan's effective date or 30 days after the pertinent claim is allowed, and that, if certain contingencies were met, the plan would be deemed effective

immediately, without order of the court. CR. 184 at 15, 19-20, CR. 185 at 8-15, 17, 28

The United States objected to confirmation of the plan. CR. 242. The government argued that the reorganization was not feasible absent authority to participate in the Medicare and Medicaid programs, and that Bayou's continued program participation depended entirely and exclusively on whether Bayou succeeded in overturning its termination from these programs in the pending administrative appeal or any subsequent action for judicial review after a final administrative decision. The United States also specifically objected to Bayou's request for judicial permission to assume its Medicare provider agreement, arguing that the agreement had been terminated before commencement of the bankruptcy proceedings, and that it thus could not be subject to the court's power to direct the assumption of executory contracts that remained in effect as of the date of the petition.

On January 7, 2015, the bankruptcy court confirmed Bayou's plan of reorganization. It overruled the United States' objection, directed that Bayou's "Medicare provider agreement shall be assumed upon entry of this order," and enjoined enforcement of claims against the debtor. CR. 285 at 9, 12-13. Shortly thereafter, Bayou filed a notice asserting that all conditions

had been satisfied and that the reorganization plan was effective as of January 9, 2015.

On January 15, 2015, the United States filed an emergency motion for an order staying consummation of the plan of reorganization pending appeal of the confirmation order. CR. 329. The government argued that the bankruptcy court had no jurisdiction over the termination of Bayou from Medicare, that the provider agreement had been terminated prepetition and thus was not subject to the bankruptcy court's authority over executory contracts in effect on the petition date, and that a stay was necessary to preserve the government's statutory right to appeal the confirmation order.

The bankruptcy court denied the United States emergency stay motion by order entered January 20, 2015. CR. 342. The court reasoned that evidence presented at earlier court hearings showed that "the patients were being well taken care of," that closure of the nursing home would cause "substantial harm to those patients who would be relocated," and that "[t]here was never any suggestion that the patients were ever in jeopardy." CR. 349, Tr. 20.

With respect to potential prejudice to the United States' rights to appeal if consummation were completed, the court found that the government had waived its right to the stay of consummation provided by

Bankruptcy Rule 3020(e). That rule provides that an order of confirmation is stayed for 14 days unless the court orders otherwise, *id.*, and is generally intended to safeguard an objecting party's appellate rights by providing sufficient time to request a stay. *See id.*, Advisory Comm. Notes on 1999 Amendment. The court, however, concluded that Bayou had authority to commence consummation of the plan immediately after confirmation because it had previously decreed that the Rule 3020(e) stay would not be in effect. CR. 349, Tr. 22; *see* CR. 285 at 17. It further concluded that ordering a stay at that juncture of the proceedings would be contrary to the interests of Bayou's creditors, patients, and contractual relationships. CR. 349 at 21-23.

4. District Court Decision.

The United States appealed the bankruptcy court's September 5 preliminary injunction and subsequent confirmation order to the district court. The court consolidated the two appeals and then reversed the bankruptcy court's orders, reasoning that the federal courts have no jurisdiction to enjoin or review a provider termination before exhaustion of administrative remedies. The court noted that 42 U.S.C. 1395cc(h)(1) provides that judicial review of a provider termination is available "*after such hearing as is provided in [42 U.S.C.] section 405(g),*" and that under

this Court’s precedent, judicial review under section 405(g) is the “exclusive source of federal court jurisdiction.” CR. 72 at 7-8, quoting *Jackson v. Astrue*, 506 F.3d 1349, 1353 (11th Cir. 2007).

The court explained that section 405(h) provides that the decisions of the Secretary may be reviewed only through the administrative and judicial remedies established within the Medicare statute. *Id.* at 8. The court held 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) *after* administrative remedies have been exhausted and the Secretary has issued a final agency decision.” *Id.* at 9 (emphasis in original). The court concluded that “any action by the Bankruptcy Court to prevent or delay the effect of the Secretary’s determination, including a Confirmation Order ordering the assumption of the provider agreements, constituted a breach of section 405(h)’s jurisdictional bar and was thus in excess of the Bankruptcy Court’s subject matter jurisdiction.” *Id.* at 12.

5. Appeal and Stay.

Though the district court’s reversal of the bankruptcy court’s order would have permitted Medicare to terminate Bayou Shores forthwith, the district court issued a 90-day stay so that Bayou could afford its residents

sufficient notice and opportunity to make arrangements for their transfer and care. CR. 83.

In the interim, Bayou appealed to this Court and moved for a stay pending appeal. The Court initially denied the stay but, on reconsideration, issued a stay until October 26, 2015, and granted Bayou leave “to present a renewed motion for a stay and any alleged new evidence to the district court that they believe may bear on the likelihood of success on the merits of the appeal of the jurisdiction issue and on the issues of any potential harm the parties or the public may sustain in relation to the request for a stay pending appeal.” Order of October 16, 2015.

Bayou renewed its stay application in district court. On October 27, 2015, the district court granted a stay until this Court rules on the merits of the appeal. The court found that Bayou’s patients, their families, and the public interest would be irreparably harmed if the facility was inappropriately terminated from Medicare and Medicaid, and that there was a significant divergence in judicial opinion on the jurisdictional issue that is the central question in this appeal. CR. 101. The district court, however, further directed that Bayou is barred from accepting any new Medicare and/or Medicaid patients for the duration of the stay. *Ibid.*

STATEMENT OF THE STANDARD OF REVIEW

The appeal's jurisdictional and statutory issues present questions of law subject to the Court's *de novo* review.

SUMMARY OF THE ARGUMENT

1. The bankruptcy court's orders barring the Secretary from terminating a substandard nursing home from the Medicare program violate express limitations on the court's jurisdiction and impair the Secretary's authority to protect the health and safety of nursing home residents. Congress responded to evidence of shockingly deficient care in skilled nursing facilities by vesting the Secretary with broad powers to inspect nursing home conditions, and to swiftly terminate from participation in Medicare those facilities whose conditions place residents in immediate jeopardy of serious injury or death. Nursing homes subject to such sanction have a right to a prompt evidentiary hearing and to expedited judicial review after a final agency decision. But the statute, consistent with the gravity of potential harm to the facility's residents, makes clear that a termination remedy should be imposed "immediately" and before administrative or judicial review.

The Medicare statute protects the integrity of this administrative process by barring any judicial review of the Secretary's enforcement

decisions prior to exhaustion of administrative remedies. Section 405(h) provides that the comprehensive blend of administrative and judicial review procedures established by the Medicare statute afford the sole and exclusive means of reviewing the Secretary's enforcement decisions. The Supreme Court, in the context of reviewing a challenge to Medicare's procedures for enforcing compliance with nursing home standards, has thus held that these judicial review provisions apply to all manner of claims arising under the Medicare statute, that they preclude resort to other avenues of federal jurisdiction, and that any action for judicial review is contingent on exhaustion of administrative remedies and issuance of a final agency decision. *Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 120 S. Ct. 1084 (2000). The bankruptcy court's orders exceed these limitations on its jurisdiction.

2. The bankruptcy court compounds these jurisdictional errors by making its own, *de novo* determination that conditions at Bayou are satisfactory and no longer require termination from the Medicare program.

This determination violates bedrock principles of administrative law. Evaluation of a facility's compliance with health and safety standards is entrusted to the Secretary, not a court of bankruptcy. Even where jurisdiction lies over the Secretary's decision, a reviewing court must

confine itself to reviewing the agency record and decisional rationale. It is not empowered to make a *de novo* determination of the matter on the basis of a new evidentiary record created in the reviewing court. *Florida Power & Light Co. v. Lorion*, 470 U.S. 729, 743-44, 105 S. Ct. 1598, 1606 (1985); *V.N.A. of Greater Tift County v. Heckler*, 711 F.2d 1020 (11th Cir. 1983). Nor is it empowered to second-guess the agency's choice among appropriate enforcement remedies. *Butz v. Glover Livestock Comm'n Co., Inc.*, 411 U.S. 182, 185-86, 93 S. Ct. 1455, 1458 (1973).

Moreover, the bankruptcy court's substantive evaluation of whether conditions at Bayou warrant its termination is contrary to the Medicare statute and congressional policy. Bayou has *conceded* that it was not in substantial compliance with Medicare standards for patient health and safety at the time of its last survey. The bankruptcy court concluded that Bayou had subsequently fixed these deficiencies and should therefore be allowed to remain in Medicare. Congress, however, intended to end the practice whereby chronically substandard facilities would be allowed to remain in Medicare if they remediated the cited deficiencies, only to lapse back into noncompliance when the threat of administrative sanction was removed. The Secretary found serious deficiencies at Bayou in *three* successive surveys. The bankruptcy court, in excusing this history of noncompliance

on the basis of *post hoc* efforts to redress substandard care, condones the very practice Congress sought to end.

The court similarly errs in concluding that termination must be enjoined because, in its view, the potential harm resulting from transfer of the residents to a different facility outweighs the risks of allowing them to remain in a facility with a history of substandard care. Congress recognized that the closure of a nursing home could be difficult for residents. It nonetheless concluded that the risk of such harm may be outweighed by the risk of allowing residents to remain in a facility where substandard conditions place them in immediate jeopardy of serious injury or death. The potential for so-called “transfer trauma” is present in any circumstance where residents must leave the facility. Congress nonetheless made clear that termination of the facility may be the best remedial option in some cases. It entrusted the task of balancing the relative harms and choosing an appropriate remedy to the Secretary’s informed discretion. The bankruptcy court erred in substituting its own judgment for Secretary’s considered choice of enforcement remedies.

3. Finally, Bayou errs in asserting that the case was constitutionally or equitably moot when the district court took up the Secretary’s appeal of the bankruptcy court’s orders. There is, and has been at each stage of this

appeal, a live, justiciable controversy as to whether Medicare's termination of Bayou could be put into effect during the pendency of the bankruptcy and thereafter. Bayou's contentions to the contrary are meritless.

Bayou further errs in asserting that, because it substantially consummated the plan of reorganization two days after the plan was confirmed, the Secretary's subsequent appeal to the district court was equitably moot and should have been dismissed. No party could reasonably expect that the Secretary would allow a substandard nursing facility to remain in the Medicare program. And as the plan contemplated full payment of *all* claimants, reversal of the confirmation order would not prejudice the reliance interests of other parties.

Application of the equitable mootness doctrine here would be particularly unfair because implementation of the plan should have been stayed pending appeal. Bankruptcy Rule 3020(e) automatically stays a confirmation order for 14 days to ensure that an objecting party has a reasonable opportunity to appeal. The bankruptcy court eliminated this safeguard by ordering that the Rule 3020(e) automatic stay would not apply. But it did so without any determination that immediate plan implementation was necessary, and without any consideration of the potential prejudice to the United States' appellate rights. Bayou urged this error on the court and

then rushed to implement the plan. It cannot now claim that it had a reasonable right to rely on the finality of the confirmation order.

ARGUMENT

I. The Medicare Statute Establishes The Exclusive Avenue For Obtaining Judicial Review Of A Decision To Terminate A Nursing Home From Participation In Medicare And Bars Bankruptcy Courts From Interfering With The Secretary's Determination To Terminate A Substandard Provider From The Program.

The avenues of administrative and judicial review established by the Medicare statute are the sole and exclusive means of reviewing the Secretary's decision to terminate a provider's participation in the Medicare program. These provisions channel any and all challenges to a nursing home termination through a set of special administrative hearing and judicial review procedures established by the Medicare statute, condition any action for judicial review on the exhaustion of these administrative remedies, and bar actions on Medicare claims based on any other source of jurisdiction, including federal question jurisdiction under 28 U.S.C. 1331, United States as defendant jurisdiction under 28 U.S.C. 1346, and bankruptcy jurisdiction under 28 U.S.C. 1334.

These jurisdictional limitations on review of nursing home terminations are imposed through a set of three interlocking statutory provisions. First, with an exception not relevant here, the statute provides

that an institution, including a skilled nursing facility, that is dissatisfied with the Secretary's determination under 42 U.S.C. 1395cc(b)(2) to terminate the facility's provider agreement (and thereby exclude the provider from the Medicare program) "shall be entitled to a hearing thereon by the Secretary (after reasonable notice) to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title * * *." 42 U.S.C. 1395cc(h)(1)(A).

Second, as noted above, these jurisdictional provisions incorporate by reference the judicial review provisions of 42 U.S.C. 405(g). This section in turn provides that a provider may obtain judicial review "after any final decision of the [Secretary] made after a hearing to which [the provider] was a party" by filing a civil action in district court within 60 days after notice of the decision. 42 U.S.C. 405(g).

Finally, 42 U.S.C. 405(h), which is incorporated by reference into Medicare [*see* 42 U.S.C. 1395ii], makes this the exclusive means of obtaining review of the Secretary's final decision by stating that the decisions of the Secretary may be reviewed only through the procedures specified in the Medicare statute, and by barring resort to other bases of federal jurisdiction.

The Supreme Court’s precedents make clear that these provisions channel all manner of claims that arise under the Medicare statute through the administrative and judicial review procedures established therein. The Court has characterized the section 405(h) bar to other avenues of review as “sweeping and direct,” *Weinberger v. Salfi*, 422 U.S. 749, 757, 95 S. Ct. 2457, 2463 (1975), and explained that it applies to “*all* ‘claim[s] arising under the’ the Medicare Act.” *Heckler v. Ringer*, 466 U.S. 602, 615, 104 S. Ct. 2013, 2022 (1984) (emphasis added). In *Illinois Council*, the Court’s most recent, comprehensive review of this line of authority, the Court stressed that, so long as the claim arises under Medicare, the nature of the claim has no bearing on whether it must be channeled through the exclusive judicial review provisions of the Medicare statute. The Court, specifically rejecting Bayou’s contention that section 405(h) is limited to actions on monetary claims (*see* Appellant Br. 56), stressed that its precedents:

foreclose distinctions based upon the “potential future” versus the “actual present” nature of the claim, the “general legal” versus the “fact specific” nature of the challenge, the “collateral” versus “noncollateral” nature of the issues, or the “declaratory” versus “injunctive” nature of the relief sought. Nor can we accept a distinction that limits the scope of § 405(h) to claims for monetary benefits. 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 or interrelated regulations or statutory provisions. There is no reason to distinguish among them in terms of the language or in terms of the purposes of § 405(h).

Illinois Council, 529 U.S. at 14, 120 S. Ct. at 1094; *accord Lifestar*

Ambulance Service, Inc. v. United States, 365 F.3d 1293, 1297 (11th Cir. 2004).

The specific statutory provisions governing nursing home terminations make clear that Congress focused on preventing premature judicial intrusion into Medicare's enforcement actions. The need for such protections is clearly illustrated by the facts of this case. The Secretary terminated Bayou after determining that conditions at the nursing home were so egregiously substandard as to threaten the lives and safety of its residents. The Chief of Field Operations for the state survey agency characterized Bayou as a "particularly problematic facility." CR. 42-4, Exh. D ¶ 2. She stated "unequivocally" that Bayou is a "substandard nursing home," and that her surveyors had found conditions that placed Bayou's "vulnerable residents in serious and immediate danger." *Ibid.*

It would make little sense for Congress to permit a court to preliminarily enjoin regulatory action taken to protect residents from the risk of serious injury or death during the months or perhaps years that may elapse during the pendency of administrative and judicial review. The statute

directs the Secretary to take “immediate action” if she finds substantial noncompliance placing the health or safety of residents in immediate jeopardy. 42 U.S.C. 1395i-3(h)(4). And in light of the gravity of such findings, Congress provided for judicial review *after* the administrative hearing is completed, not before. 42 U.S.C. 1395cc(h)(1)(A).

Congress recognized the potential financial impact on providers. But it addressed that concern by establishing procedures through which a terminated provider may obtain specially expedited administrative and judicial review. 42 U.S.C. 1395cc(h)(1)(B), (C)(I)(i). At the same time, it made clear that the remedies imposed by the Secretary were to remain in effect during any action for administrative or judicial review, thus providing that access to expedited review may not be “construed to affect the application of any remedy imposed under section 1395i-3 of this title during the pendency of an appeal.” 42 U.S.C. 1395cc(h)(1)(B).

Thus, Congress has already undertaken the kind of balancing of harms a court conducts in determining whether to grant preliminary equitable relief. It has plainly found that the potential risk to patients if remedies are stayed outweighs any potential harm to the provider if remedies remain in effect during administrative or judicial review. The statutory provisions barring pre-exhaustion equitable relief are an essential part of this statutory

scheme and crucial to the Secretary's ability to protect the health and safety of nursing home residents.

Every Circuit to consider the matter has held the Medicare statute establishes the exclusive means of reviewing termination decisions, and that the courts have no jurisdiction to enjoin or review a Medicare termination prior to exhaustion of administrative remedies.⁶ *See Cathedral Rock of North Coll. Hill, Inc. v. Shalala*, 223 F.3d 354 (6th Cir. 2000); *Affiliated Prof'l Home Health Care Agency v. Shalala*, 164 F.3d 282 (5th Cir. 1999); *Americana Healthcare Corp. v. Schweiker*, 688 F.2d 1072 (7th Cir. 1982). Bayou nonetheless argues that Congress has allowed bankruptcy courts to exercise a pre-exhaustion jurisdiction withheld from every other federal court, and to overturn the Secretary's considered determination that conditions at a nursing home pose so great a threat to its patients as to require its immediate termination from the Medicare program. It asserts that such jurisdiction is conferred by the general grants of bankruptcy jurisdiction set forth in 28 U.S.C. 1334. Jurisdiction under these provisions, however, is foreclosed by 42 U.S.C. 405(h).

⁶ For similar reasons, courts have held that providers have no constitutional right to pre-termination review. *See Cathedral Rock*, 223 F.3d at 365-66; *Geriatrics, Inc. v. Harris*, 640 F.2d 262, 265 (10th Cir. 1981); *Northlake Cmty. Hosp. v. United States*, 654 F.2d 1234, 1241-43 (7th Cir. 1981).

Section 405(h) expressly and explicitly states that “[n]o findings of fact or decision of the [Secretary] shall be reviewed by *any* person, tribunal, or governmental agency except as herein provided.” (emphasis added). A determination by the Secretary to terminate a provider from the Medicare program is incontrovertibly a “decision of the Secretary” within the meaning of this provision. The statute provides that “[t]he Secretary * * * may terminate such [provider] agreement after the Secretary * * * has determined that the provider fails to comply substantially with the provisions of the agreement [or] with the provisions of this subchapter and regulations thereunder.” *See* 42 U.S.C. 1395cc(b)(2)(A) . Termination is thus based on the Secretary’s finding of substantial noncompliance with health and safety standards, her assessment of the dangers posed by the nursing home’s deficiencies, and her exercise of discretion to select an appropriate remedy. It is, in every relevant sense, a “decision of the Secretary” that is not subject to review in *any* judicial forum prior to exhaustion of administrative remedies.

Bayou may argue that bankruptcy court orders that preliminarily enjoin the immediate termination of a provider are not actions to “review” the Secretary’s termination decision. This Court, however, rejected similar

contentions in *V.N.A. of Greater Tift County v. Heckler*, 711 F.2d 1020 (11th Cir. 1983).

There, a Medicare provider sought an injunction barring the collection of an alleged overpayment before it had exhausted its administrative remedies. The provider asserted that it was not requesting “review” of the agency decision within the meaning of section 405(h) because it merely wanted to preserve its solvency and ability to operate pending completion of administrative review proceedings. *Id.* at 1027. The Court squarely rejected such contentions:

The preclusion provision in the Medicare Act works in both directions: it avoids unnecessary and/or uninformed court decisions, and it protects the integrity of the administrative process. The agency would be substantially undermined by issuance of a status quo injunction. Where both parties engage in extensive discovery and presentation of their whole cases on the merits, the district court does *exactly* what the PRRB [*i.e.*, Medicare’s Provider Reimbursement Review Board] is expected to do. It is simply not realistic to say that the district court in such a case does not address and decide the merits of the case. Such plenary consideration violates not only the procedural structure of the Medicare Act, but it is in effect a *de novo* decision on the merits in direct contravention of the limited review mandated by statute.

Id. at 1032.

The Court’s analysis applies with full force here. The Secretary’s termination of Bayou from Medicare was intended to take effect on August 3, 2014. Under the Medicare statute, any administrative and judicial review

was to take place *after* termination. Indeed, postponing the effective date of the termination pending some administrative or judicial review would be manifestly inconsistent with the Secretary's underlying finding that patients were in *immediate* jeopardy of serious harm or death. When the bankruptcy court preliminarily enjoined the termination, it substituted its judgment for that of the Secretary on appropriate remedial action, contravened statutory provisions requiring the termination to take effect during, not after, any action for judicial review, and irretrievably reversed the Secretary's decision to put enforcement measures into effect *immediately*. As *V.N.A. of Greater Tift County* makes clear, that is a "review" of the Secretary action forbidden by the second sentence of section 405(h).

The bankruptcy court's confirmation order directing assumption of the provider agreement and enjoining Bayou's termination from Medicare is similarly a prohibited action to "review" the Secretary's termination decision. The bankruptcy court made this decision after conducting an evidentiary hearing and making its own determinations as to whether conditions at the nursing home and any costs associated with closing the facility and transferring its patients warranted terminating the facility or allowing it to continue in Medicare. Bayou adduced voluminous evidence intended to establish that post-termination conditions at the facility were

satisfactory. *See* Appellant Br. 10 (noting admission of 12 exhibits, testimony from six witnesses including a resident, a guardian, facility administrators, and experts in patient care). The bankruptcy court then reviewed this evidence and made its own findings as to whether conditions at the facility and the potential harm to patients if the facility were closed warranted termination from Medicare. Despite the undisputed survey findings that residents faced imminent risk of serious harm, the bankruptcy court concluded that “[t]here was never any suggestion that the patients were ever in jeopardy.” CR. 349, Tr. 20

We respectfully disagree with these findings in virtually every particular. But the salient point is that the bankruptcy court’s order overturns the Secretary’s uncontested findings of substandard conditions at the facility and reverses the Secretary’s decision to terminate Bayou from Medicare. The order is, in form and practical effect, a pre-exhaustion, *de novo* “review” and reversal of the Secretary’s decision to terminate Bayou from Medicare—a judicial action that is expressly and explicitly barred by the second sentence of section 405(h).

The third sentence of 405(h) confirms that Congress did not intend for bankruptcy courts to exercise pre-exhaustion jurisdiction over determinations to terminate a provider from the Medicare program. This

sentence states that, “No action against the United States, the [Secretary], or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28, United States Code, to recover on any claim arising under” the Medicare statute. As currently codified, the third sentence only expressly bars actions predicated on federal question or United States-as defendant jurisdiction; it does not expressly preclude bankruptcy jurisdiction under 28 U.S.C. 1334.

It is nonetheless clear that Congress intended to bar bankruptcy jurisdiction as well. The jurisdictional limitations now codified as 42 U.S.C. 405(h) were first enacted in 1939 as an amendment adding section 205(h) of the Social Security Act. Pub L. No. 76-379, § 205(h), 53 Stat. 1360, 1371 (1939). At that time, the third sentence of the statute barred actions brought “under section 24 of the Judicial Code.” *Ibid.* In 1939, section 24 of the Judicial Code (which was then codified at 28 U.S.C. 41 (1934)) specifically included the grant of federal bankruptcy jurisdiction. 36 Stat. 1091, 1093 (1911), 28 U.S.C. 41(19) (1934). The section 405(h) preclusion thus applied to bankruptcy jurisdiction when first enacted.

The express textual link between section 405(h) and the general grants of district court jurisdiction was severed by the 1948 reorganization of the Judicial Code. In that revision, Congress directed that the general grants

of jurisdiction formerly grouped in the catch-all provision of section 24 of the Judicial Code be codified in a series of separate sections of chapter 85 of Title 28 of the U.S. Code. *See* Pub. L. No. 80-773, § 1, 62 Stat. 869, 930 (1948), adding chapter 85 of title 28, U.S. Code. These provisions included a separate provision granting federal courts jurisdiction over bankruptcy cases. The reorganization of the Judicial Code, however, was technical in character and not intended to effect a substantive change in any limitation on the district courts jurisdiction. *See id.*, §§ 2(b), 33, 39, 62 Stat. 985, 991, 992 (1948).

In 1976, the Office of Law Revision Counsel revised the third sentence of section 405(h) to refer only to actions brought under 28 U.S.C.1331 or 1346. *See* 42 U.S.C. 405 codification note, at p. 661 (1982). Congress, however, has made clear that any such revision must preserve the intent of the original enactments. *See* 2 U.S.C. 285b(1) (directing Office of Law Revision to prepare “a complete compilation, restatement, and revision of the general and permanent laws of the United States *which conforms to the understood policy, intent, and purpose of the Congress in the original enactments.* . . .”) (emphasis added).

In 1984, Congress enacted the Office of Law Revision’s clarification of section 405(h) into positive law. Thus, in the Deficit Reduction Act of

1984, Congress amended the provision codified at 42 U.S.C. 405(h) 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 of the United States Code.’” Pub L. No. 98-369, § 2663(a)(4)(D), 98 Stat. 1162 (1984). At the same time, however, Congress cautioned that none of the amendments made by section 2663 [which included the amendment of section 405(h)] “shall be construed as changing or affecting any right, liability, status, or interpretation which existed before that date.” *Id.* § 2664(b).

Every court of appeals to consider the matter has held that: (1) the 1984 enactment of the Office of Law Revision’s clarifications of 42 U.S.C. 405(h) was not intended to effect any substantive change in the prior law, and (2) the third sentence of section 405(h) should, consistent with the original statute, be construed to bar jurisdiction over Medicare claims under *any* of the general grants of jurisdiction to the federal courts formerly codified at 28 U.S.C. 41, not just federal question or United States as defendant jurisdiction. *Bodimetric Health Services, Inc. v. Aetna Life & Cas.*, 903 F.2d 480, 488-89 (7th Cir. 1990); *Midland Psychiatric Assocs., Inc. v. United States*, 145 F.2d 1000, 1004 (8th Cir. 1998); *Nichole Med. Equip. v. Tricenturion, Inc.*, 694 F.3d 340, 346-47 (3d Cir. 2012); *see also In*

re St. Mary Hosp., 123 B.R. 14, 17-18 (E.D. Pa. 1991); *In re St. John's Home Health Agency, Inc.*, 173 B.R. 238, 244 (Bankr. S.D. Fla. 1994).

Citing *First American Health Care, Inc. v. HHS*, 208 B.R. 985 (Bankr. S.D. Ga. 1996), *vacated and superseded*, 1996 WL 282149 (Bankr. S.D. Ga. March 11, 1996), Bayou dismisses this authority, asserting that it relies on mere legislative history. But *Bodimetric* and the cases that follow it rest squarely on statutory text and firmly established principles for construing clarifying codifications of the law. The version of section 405(h) that was developed by the Office of Law Revision was, from the outset, intended to clarify not amend substantive law. And when Congress enacted the revised codification of section 405(h) into positive law, it expressly stated in the statutory text that nothing in the pertinent provision “shall be construed as changing or affecting any right, liability, status, or interpretation which existed before that date.” Pub L. No. 98-369, § 2664(b), 98 Stat. 1162 (1984).

The Supreme Court has held that “it will not be inferred that Congress, in revising and consolidating the laws, intended to change their effect unless such intention is clearly expressed.” *Fourco Glass Co. v. Transmirra Products Corp.*, 353 U.S. 222, 227, 77 S. Ct. 787, 791 (1957).

Here, Congress's intent to preserve section 405(h)'s prior limitations on bankruptcy jurisdiction is set forth in the plain language of the statute.

That Congress also amended the grants of bankruptcy jurisdiction in 1984 is of no moment. In May 1984, just months before the July enactment of the cited legislation, the Supreme Court, in *Heckler v. Ringer*, held that with respect to Medicare claims, section 405(g) and section 405(h) “require[e] that administrative remedies be exhausted before judicial review of the Secretary’s decisions takes place.” *Id.* 466 U.S. at 627, 104 S. Ct. at 2028. Congress must be presumed to have been aware of this recent authority. *Merck & Co. v. Reynolds*, 559 U.S. 663, 648, 130 S. Ct. 1784, 1795 (2010). If, in revisiting section 405(h) and bankruptcy law, it had intended to carve out an exception to Medicare review scheme permitting bankruptcy courts—alone among all courts—to assume pre-exhaustion jurisdiction of the Secretary’s decisions, it would have said so expressly. *Cf.* *MCorp Financial, Inc. v. Board of Governors of the Federal Reserve System*, 502 U.S. 32, 42, 112 S. Ct. 459, 465 (1991) (general grant of bankruptcy jurisdiction does not trump statute precluding judicial review before exhaustion of administrative remedies).

Bayou’s position draws no further support from *In re University Medical Center*, 973 F.2d 1065 (3d Cir. 1992) or *In re Town & Country*

Nursing Home Services, Inc., 963 F.2d 1146 (9th Cir. 1992). Both cases predate *Illinois Council*, and neither involves pre-exhaustion review of the termination of a provider from the Medicare program. They are, moreover, plainly distinguishable on their facts and decisional rationale.

University Medical Center involved Medicare's authority to recoup prepetition overpayments by offsetting them against reimbursement for post-petition payments due a hospital that was reorganizing in bankruptcy. The Court held that the provider's claim to bar this recoupment "arises under the Bankruptcy Code and not under the Medicare statute" and thus was outside the section 405(h) bar. 973 F.2d at 1073. That premise is incorrect but nonetheless shows that the court's holding has no application to claims that, like a provider's very right to participate in the program, *do* arise under Medicare statute.

Town & Country is distinguishable for similar reasons. There, as in *University Medical Center*, Medicare sought to recover prepetition overpayments by offsetting them against reimbursement due a provider for services rendered after it had petitioned for bankruptcy. The provider brought an adversary proceeding against Medicare that "asserted six claims for relief *arising under the Bankruptcy Code and state law*." 963 F.2d at 1148 (emphasis added). The case did not involve a claim challenging the

termination of a provider from the Medicare program, nor did the Court hold that claims that do “arise under” the Medicare statute may be heard under bankruptcy jurisdiction, without regard to exhaustion of administrative remedies.

At bottom, Bayou offers no persuasive explanation as to why Congress would except bankruptcy jurisdiction from this comprehensive scheme for judicial review. It asserts that bankruptcy jurisdiction would further Congress’s intent to centralize disputes with the debtor in one forum in order to efficiently administer the estate. But that would, at most, explain why Congress would permit a bankruptcy court, under a suitable reference from the district court, to exercise concurrent jurisdiction *after* exhaustion of administrative remedies. It cannot begin to explain why Congress would authorize bankruptcy courts—and bankruptcy courts alone—to intrude into the administrative process before its completion, to halt the termination of a provider deemed by the expert administrative agency entrusted with such decisions to pose an immediate threat to the health and safety of its patients, and to make a *de novo* determination of conditions at the facility instead of reviewing the administrative record supporting the facility’s termination.

II. Even Assuming Jurisdiction, Bankruptcy Courts Have No Authority To Disregard Statutory Provisions Regulating Participation In Medicare.

Even assuming the bankruptcy court had jurisdiction, it had no authority to disregard statutory and regulatory requirements for participating in Medicare. The Bankruptcy Code does not give bankruptcy courts *carte blanche* to ignore non-bankruptcy law. *Midlantic Nat'l Bank v. New Jersey Dep't of Env'tl. Protection*, 474 U.S. 494, 502, 106 S. Ct. 755, 760 (1986). Statutory health and safety requirements are not suspended because the provider is seeking to reorganize in bankruptcy. Nor does a bankruptcy petition give the court license to substitute its judgment for the Secretary's exercise of enforcement discretion.

The bankruptcy court violated these limitations on its authority. Accordingly, although the district court did not reach the merits, its judgment can be affirmed on the alternative grounds that the bankruptcy court violated substantive provisions of the Medicare statute and settled administrative law principles governing judicial review of agency action.⁷

To begin with, the court fashioned its own rules for determining whether Bayou remained a participating Medicare provider at the commencement of the case. The Secretary has express statutory authority to

⁷ A district court judgment can be affirmed on any ground apparent in the record. *Lucas v. W.W. Grainger, Inc.*, 257 F.3d 1249, 1256 (11th Cir. 2001).

terminate a provider agreement and to specify that termination will take effect “immediately.” 42 U.S.C. 1395i-3(h)(2)(A)(i); 42 U.S.C. 1395i-3(h)(4). Here, Medicare issued a termination notice to Bayou on July 22, 2014, published notice of the termination in the Tampa Bay Times and other papers of record on July 26, 2014 (*see, e.g.*, CR. 67-1), and made the termination effective August 3, 2014—a swift termination consistent with, indeed demanded by, the agency’s determination that the health and safety of Bayou’s residents was in immediate jeopardy. The termination was thus effective well before commencement of the bankruptcy case. By the time Bayou filed its bankruptcy petition, there was no longer any pending termination conceivably susceptible to the Bankruptcy Code’s “automatic stay,” no extant provider agreement with Medicare that could be considered property of the estate as of the date of the petition, and no extant contract with Medicare susceptible to the court’s power to direct the assumption or rejection of executory contracts.

The bankruptcy court nonetheless concluded that Bayou’s provider agreement remained in effect as of the commencement of the case, citing cases addressing when certain contracts may be deemed terminated under *state* law. CR. 282 at 13 n.60, citing *In re Fontainebleau Hotel Corp.*, 515 F.2d 913, 915 (5th Cir.1975) (termination of a lease under Louisiana law);

Moody v. Amoco Oil Co., 734 F.2d 1200, 1212 (7th Cir. 1984) (termination of a franchise agreement under Wisconsin law).

This holding was essential to all that followed. The court's initial injunction barring termination was predicated on the assumption that a valid provider agreement was in effect at the commencement of the case, and that Bayou had not already been terminated from the Medicare program prepetition. The court's confirmation order directing assumption of the provider agreement was likewise premised on the conclusion that Bayou remained in the Medicare program post-petition, and that its provider agreement remained subject to the court's authority under 11 U.S.C. 365(a) to approve or reject the assumption of executory contracts.

But the court's fundamental premise that the provider agreement was still in effect at the commencement of the case is incorrect. Medicare provider agreements, like all contracts with the federal government, are governed by federal statute and regulation, not state law. *Federal Crop Ins. Corp. v. Merrill*, 332 U.S. 380, 383-85, (1947); *see also Jackson v. United States*, 573 F.2d 1189, 1194 (Ct. Cl. 1978) ("The law in effect when a Government contract is made becomes a part of the contract"). State law contract principles have no bearing on whether or when a contract governed by federal law is terminated. The cases on which the bankruptcy court relied

are applicable here only insofar as they hold that the “filing of a Chapter 11 petition cannot resuscitate rights under a contract validly terminated pre-petition.” *In re Bricker*, 43 B.R. 344, 347 (Bankr. D. Ariz. 1984) (citing *Moody, supra*).⁸

The bankruptcy court compounded this error by ordering Bayou’s continued participation in Medicare on the basis of a *de novo* evidentiary determination that post-termination conditions at the facility had improved. This determination violates key substantive policies of the Medicare program as well as fundamental principles of administrative law.

When Congress overhauled the regulation of nursing home standards in 1987, it expressed particular concern with instances in which substandard providers had avoided termination from Medicare by claiming that they had cured serious violations of safety standards, only to lapse back into noncompliance after the threat of administrative sanction was removed. And it forcefully stated that it intended revised enforcement procedures to eliminate such providers from the program:

⁸ Moreover, even assuming its provider agreement were still in effect, Bayou errs in asserting that termination would be barred by the Code’s automatic stay, 11 U.S.C. 362(a). The stay does not apply in the absence of jurisdiction. And it would not, in any event, bar a governmental regulatory action to enforce the debtor’s compliance with health and safety standards. See 11 U.S.C. 362(b)(4); *Brock v. Rusco Industries, Inc.*, 842 F.2d 270, 273 (11th Cir. 1988).

In reviewing the enforcement experience under current law, the [Institute of Medicine] Committee identified as a serious problem “the large numbers of marginal or substandard nursing homes that are chronically out of compliance when surveyed, may or may not be subject to mild sanctions, temporarily correct their deficiencies under a plan of correction, and then quickly lapse into noncompliance until the next annual survey.” The IOM Committee traced this “yo/yo” or “roller coaster” phenomenon in part to a general enforcement attitude that substantial facilities should be encouraged to achieve compliance rather than be barred from the Medicaid program until they are in compliance. * * * Under the Committee amendment, the Secretary and the States are expected to eliminate substandard providers from the program and deter repeat violations, not to allow substandard providers to remain in the program through a policy or practice of consultation.

H. R. Rep. No. 100-391(I) at 471.

The Secretary terminated Bayou after finding that it had serious violations of health and safety standards in *three* successive surveys. As the ALJ reviewing Bayou’s administrative appeal found, the facility had a “whopping” number of serious violations, and “concede[d] that it was not in substantial compliance at the time of the survey.” CR. 261-1 at 2.

The bankruptcy court nonetheless excused this disturbing regulatory history by finding that conditions had improved *after* the Secretary’s action. But that approach would perpetuate precisely the type of chronically substandard care Congress intended to redress. A history of noncompliance is not erased by a *post hoc* demonstration that conditions have improved. Such history is instead a strong indication that the facility lacks the

managerial capacity, supervisory oversight, and dedication to resident health and safety needed to provide quality care for Medicare beneficiaries – not just at a single point in time, and not just when conditions are under active regulatory scrutiny – but on an on-going basis. Enjoining a termination order whenever a facility claims that conditions have improved would render the termination remedy an idle threat and rob it of deterrent value.

The bankruptcy court further compounds this error by making a *de novo* determination of post-termination conditions at the facility on the basis of an evidentiary record tendered by the nursing home. It is a bedrock principle of administrative law that agency action must be evaluated on the administrative record created by the agency, not a new evidentiary record created in the reviewing court. *Florida Power & Light Co. v. Lorion*, 470 U.S. 729, 743-44, 105 S. Ct. 1606 (1985). “The reviewing court is not generally empowered to conduct a *de novo* inquiry into the matter being reviewed and to reach its own conclusions based on such an inquiry.” *Id.* at 744. Even if post-termination conditions were relevant to whether the termination should be sustained – and they are not—the court had neither the authority nor expertise to make that determination itself.⁹ Matters pertaining

⁹ As the ALJ explained, longstanding agency policy holds that a provider’s efforts to bring itself into compliance after the survey have no bearing on the validity of the termination (CR. 261-1 at 5) – a policy fully consistent with

to conditions at a nursing home and its compliance with statutory standards are entrusted by statute to the Secretary in the first instance. The bankruptcy court committed reversible error by displacing the Secretary's enforcement authority and making its own *de novo* determination.

Medicare by no means discourages facilities from improving their conditions and seeking reinstatement in the program. It permits a terminated facility to be readmitted to Medicare if it can demonstrate, to the *Secretary's* satisfaction, substantial compliance with health and safety standards and "reasonable assurance" that it can maintain compliance going forward. 42 C.F.R. 489.13, 489.57; CR. 89-3 at 5. But that determination may be made *only* on the basis of two *unannounced* surveys conducted at the beginning and end of the "reasonable assurance" period. *Id.* Bayou, however, never sought reinstatement. It instead by-passed this administrative process entirely.

The bankruptcy court also cast this administrative scheme aside and made its own determination of whether conditions at the facility have sufficiently improved to permit continued participation in the Medicare program. Moreover, the court relied on evidence that is not reliable: a self-serving evidentiary record compiled by Bayou itself, and the reports of the

Congress's intent to exclude providers that continually cure deficiencies only to lapse back into noncompliance when the threat of termination is removed.

patient care ombudsman appointed pursuant to 11 U.S.C. 333.¹⁰ We do not question the ombudsman's impartiality or competence. But his reports were based on announced visits to the facility and thus cannot offer the kind of candid evaluation made possible by unannounced, expert inspection. CR. 252 at 2 (noting Ombudsman's "tours" of the facility preceded by entrance meeting with Bayou's administrator).

Congress placed special emphasis on ensuring that nursing home inspections would be *unannounced*, thus providing for the assessment of civil money penalties against anyone who notifies a nursing home of the time when a survey is scheduled and directing the Secretary to ensure that states have adequate procedures for ensuring that facilities do not have advance notice of an impending survey. 42 U.S.C. 1395i-3(g)(2)(A)(i); 42

¹⁰ Provisions authorizing the appointment of a patient care ombudsman were added as part of a package of amendments intended to bolster the bankruptcy court's power to ensure that conditions at a nursing facility do not deteriorate while the facility is reorganizing in bankruptcy or closing down. Pub. L. No. 109-8, §§ 1104-1106, 119 Stat. 191 (2005). There is no suggestion in this statute or its legislative history that Congress intended that ombudsman reports to serve as a "second opinion" on whether the facility should be terminated from Medicare. *See* H. R. Rep. No. 109-31, 109th Cong., 1st Sess. 138-140 (2005). Indeed, the set of amendments adding the ombudsman provision also included provisions, codified at 11 U.S.C. 362(b)(28), expressly exempting from the Code's automatic stay "the exclusion by the Secretary of Health and Human Services of the debtor from participation in the [M]edicare program" – further indication that Congress did not intend to afford bankruptcy courts any authority to enjoin Medicare enforcement determinations before exhaustion of administrative remedies.

C.F.R. 488.307. The ombudsman's reports and cherry-picked testimony from Bayou's administrators and staff are no substitute for these unannounced inspections and do not afford an adequate basis for determining whether a provider with a history of recurrent, serious problems should be permitted to rejoin in the Medicare program.

Finally, the bankruptcy court's concern that closure of the facility will harm residents and their families cannot support the court's intrusion into the Secretary's enforcement discretion. When Congress revamped Medicare's enforcement remedies, it recognized that "the transfer of residents, even from poor facilities, can be traumatic for the residents involved." H. R. Rep. No. 100-391(I) at 437. But it also made clear that a nursing home must be terminated if the Secretary concludes that the potential harm to residents from closure of the facility is outweighed by the risk that residents will be exposed to an immediate risk of serious injury or death. *Ibid.*

The risk of so-called "transfer trauma" is common to virtually any nursing home termination. If it were, standing alone, sufficient to bar enforcement action, then the Secretary would never be able to eliminate substandard providers from the program – a result that is plainly contrary to Congress's intent that the Secretary "either * * * bring substandard facilities

into compliance with [federal] quality of care requirements or to exclude them from the program.” *Id.* at 452.

The decision as to how balance potential “transfer trauma” against the risks of leaving residents in a substandard facility is entrusted to the Secretary’s informed discretion and may not be second-guessed by a bankruptcy court. An agency’s choice of enforcement remedies may not be overturned unless “unwarranted in law * * * or without justification in fact.” *Butz v. Glover Livestock Comm’n Co.*, 411 U.S. 182, 185-86 (1973). That highly deferential standard of review applies with particular force here, where Congress has taken care to leave the Secretary a range of enforcement choices up to and including termination and left the selection of an appropriate remedy to the Secretary’s considered judgment.

Federal regulations mitigate the risk of “transfer trauma” by *requiring* the state agency to “arrange for the safe and orderly transfer of [residents]” to nursing homes that meet minimum standards. 42 C.F.R. 488.426(b). Here, the Chief of Field Operations for the state survey agency explained that the agency had put in place procedures to insure that the residents were adequately counseled and assisted in making transfers to qualified nursing homes, that there were an ample number of qualified nursing homes in the St. Petersburg area capable of accommodating Bayou’s residents, and that,

contrary Bayou's implications, Bayou has no specialty designation rendering it uniquely suited to care for its residents. CR. 42-4, Exh. D, ¶¶ 3-5.

The bankruptcy court disregarded the Secretary's judgments in this regard entirely. It arrogated to itself the authority to make a *de novo* decision as to whether termination was necessary. And it ignored Congress's determination that even the prospect of "transfer trauma" will not warrant allowing a nursing home with a history of egregiously substandard care to remain in the Medicare program.

III. The Case Presents A Live Controversy.

Bayou errs in asserting that the issues presented here were constitutionally moot when the district court considered the Secretary's appeal. Bayou argues that the automatic stay and temporary injunction issued by the bankruptcy court dissolved upon the bankruptcy court's confirmation of a plan of reorganization and were no longer in effect by the time the district court undertook appellate review, thus rendering the Secretary's appeal to the district court moot and presumably requiring the district court's decision to be vacated. Appellant Br. 34.

Two key issues, however, presented a live controversy when the district court ruled, and they continue to do so here. First, the bankruptcy court's automatic stay and temporary injunction compelled Medicare to treat

Bayou's provider agreement as remaining in effect in the period between commencement of the case and confirmation of a plan of reorganization. As entitlement to Medicare reimbursement is contingent on having a provider agreement in effect (*see* 42 U.S.C.1395f(a), 1395cc(a)(1)), the validity of the orders barring Medicare from terminating Bayou during the pendency of the bankruptcy bears directly on whether Medicare is obligated to reimburse Bayou for care rendered during that period. That issue has not been mooted by confirmation of a reorganization plan.

Second, we construe the bankruptcy court's confirmation order as barring Medicare from giving effect to its prior termination order. CR. 285 at 9, 12-13. That issue thus also presented a live controversy at the time the district court considered the Secretary's appeal, and it continues to do so here.

IV. The Secretary's Appeal To The District Court Was Not Equitably Mooted By Implementation Of The Plan Of Reorganization.

Equitable mootness is a bankruptcy doctrine holding that, in some circumstances, the substantial consummation of a reorganization plan will render it infeasible for an appellate court to grant relief on an appeal of an order confirming a plan and therefore compel dismissal of the case. *In re Lett*, 632 F.3d 1216, 1225 (11th Cir. 2011). Though denominated as a principle of "mootness," it does not turn on whether there is a justiciable

controversy. It is instead an intensely practical inquiry that directs consideration of such factors as whether the reviewing court can effectively unwind the transactions authorized by confirmation if the appeal is meritorious, whether doing so would unreasonably interfere with the reasonable reliance interests the debtor, creditors, and third parties, and whether the party aggrieved by the confirmation order has sought a stay. *Ibid.*; *In re Club Assoc.*, 956 F.2d 1065, 1069 (11th Cir. 1992). The party asserting equitable mootness bears the burden of persuasion. *In re Lett*, 632 F.3d at 1226. And in evaluating these considerations, the court must “strike the proper balance between the equitable considerations of finality and good faith reliance on a judgment and the competing interests that underlie the right of a party to seek review of a bankruptcy court order adversely affecting him.” *Id.* at 1225-26 (internal quotation marks omitted).

Bayou argues that the Secretary’s appeal to the district court was equitably moot and should have been dismissed because the reorganization plan was substantially consummated by the time the district court undertook consideration of the case. Application of the equitable mootness doctrine, however, is inappropriate here.

First, the bankruptcy court stymied the Secretary’s timely efforts to stay consummation of the plan by extinguishing the automatic stay of plan

implementation provided by Bankruptcy Rule 3020(e) – without any findings supporting the need for immediate plan implementation, and without any consideration of potential prejudice to the Secretary’s appellate rights.

Rule 3020(e) provides that an order confirming a plan is automatically stayed for 14 days unless the court orders otherwise. As the Advisory Committee Notes explain, this provision is intended “to provide sufficient time for a party to request a stay pending appeal of an order confirming a plan under chapter 9 or chapter 11 of the Code before the plan is implemented and an appeal becomes moot.” Fed. R. Bankr. P. 3020(e), Advisory Comm. Notes on 1999 Amendment.

Here, the court confirmed Bayou’s plan on January 7, 2015, and included provisions stating that the confirmation order would be effective immediately upon entry, and that the Rule 3020(e) 14-day stay of implementation shall not apply. CR. 285 at 17. The Secretary accordingly sought an emergency stay pending appeal eight calendar days after entry of the confirmation order. CR. 329. Bayou, however, had implemented the plan on August 9, 2014 (CR. 288)—two days after confirmation – and argued that the Secretary’s stay motion was already too late. The bankruptcy court agreed and denied the stay (CR. 342), reasoning that the plan had

already been substantially consummated, and that Bayou had a right to proceed with plan implementation immediately because no Rule 3020(e) stay was in effect. CR. 349, Tr. 22.

Rule 3020(e) does provide that the 14-day automatic stay of plan implementation may be cut back or eliminated by court order. That the court has such power, however, does not mean that it can be exercised arbitrarily. Given the stated purposes of Rule 3020(e), the court cannot extinguish the stay without first considering the potential prejudice to the appellate rights of objecting parties, and without making specific findings as to why permitting the immediate consummation of the plan is necessary or appropriate.

Nothing of the kind is in evidence here. Nearly five months had elapsed between the petition and confirmation of the plan and Bayou did not demonstrate any sudden need for immediate implementation. There was no legitimate basis for shortening the Rule 3020(e) stay and no legitimate basis for suddenly consummating the plan before the Secretary could seek a stay pending appeal. That Bayou engineered improper permission to do so affords no basis for deeming the Secretary's appeal to be equitably moot.

Moreover, the bankruptcy court errs insofar as it suggests the Secretary waived the right to object to the Rule 3020(e) order. Neither the plan of reorganization nor the disclosure statement specifically proposed

eliminating the Rule 3020(e) stay. Bayou first requested such action in a proposed order of confirmation. The Secretary immediately objected to the proposed order and expressly reserved rights to appeal. CR. 29 at 11 & Exh. E.

Second, reversal of the confirmation order would not interfere with the reasonable reliance interests of the debtor, its creditors, or third parties. A nursing home operates in a highly regulated environment. No party can rely on a facility's continued participation in Medicare, especially if the facility, like Bayou, has a history of substantial noncompliance with the program's health and safety requirements. The Secretary terminated Bayou *before* commencement of bankruptcy, opposed the bankruptcy court's interference with the termination order at every stage of this case, vigorously pursued appeals of orders barring the termination from taking effect, objected to the plan of reorganization, and sought a stay of the confirmation order with dispatch. No party could reasonably expect that the confirmation order compelling Medicare to allow Bayou's continued participation in the Medicare program would go unchallenged on appeal.

Finally, this is not a circumstance in which this Court lacks the practical ability to unwind the principal transactions authorized by the plan without unreasonably prejudicing other parties. Under the plan, the

prepetition secured creditor retains its liens to the same extent, priority, and validity as existed prepetition. CR. 185 at 5. Reversal of the plan would merely return it to the *status quo ante*.

Unsecured creditors with claims of more than \$5,000 are to be paid in full over a three year period. *Id.* As no large immediate distribution to these creditors was contemplated, reversal of the plan would largely return them to the *status quo ante* as well. Immediate distributions were made to unsecured creditors with claims under \$5,000, *id.*, and it is possible that some of these payments could not be clawed back into the estate if the confirmation order were reversed. But these distributions constituted only two percent of the expected distribution under the plan—\$68,000 in payments out of \$3,426,700 in all claims against the estate. *Id.* at 4-5. And because the plan was a full payment plan as to *all* claimants, *ibid.*, the inability to recoup these small payments if the plan were reversed would not prejudice other parties.

One creditor lent Bayou substantial “exit” financing to fund Bayou’s operations after it emerged from bankruptcy. *Id.* at 21. But, as shown above, it could not reasonably rely on Bayou’s continued participation in Medicare. Indeed, it protected itself against that contingency by securing the indebtedness with a lien on the debtor’s personal property. *Ibid.* And while

the court, as part of the confirmation order, approved the assumption of a number of prepetition executory contracts, reversal of the confirmation order would largely return those parties to the *status quo ante* as well.

We cannot rule out the possibility that some parties may have changed their position in reliance on the confirmation order. But any resulting harm from reversal of the order would be dwarfed by the injury to the United States if fulfillment of its obligation to terminate a substandard nursing home from Medicare were stymied by extinguishing its right to appeal. Bayou's consummation of the plan was effected in the most dubious of circumstances – a rush to implementation over strenuous objection, without any demonstration of need for such urgency, and made possible only through the bankruptcy court's arbitrary decision to eliminate the automatic stay of plan implementation contemplated by Bankruptcy Rule 3020(e). Equitable mootness is an equitable doctrine. There is no equity in applying it here.

Finally, Bayou errs in asserting that sections 1127(b) and 1144 of the Bankruptcy Code bar an objecting party from appealing a confirmation order after substantial consummation of the plan. Section 1127 limits a plan *proponent's* right to modify a plan after substantial consummation, not an objecting party's right to appeal. As a leading treatise explains, “[w]hether a court can provide effective relief to a party appealing an order of

confirmation should not depend on whether the plan has been substantially consummated.” 7 Alan N. Resnick and Henry J. Sommer, *Collier on Bankruptcy* ¶ 1101.02 [1][c] (6th ed. 2015); *see also id.* n.6 (collecting cases holding that substantial consummation does not preclude appeal). Section 1144 is inapposite. It addresses rights to revoke a confirmation order for fraud and does not limit an objecting party’s right to appeal.

In sum, the district court had ample authority to consider the Secretary’s appeal from the bankruptcy court’s adverse orders. It did not err in reversing the bankruptcy court’s injunction and confirmation order.

CONCLUSION

The district court’s judgment should be affirmed.

Respectfully submitted,

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FRAP 32(a)(7) CERTIFICATE OF COMPLIANCE

I certify that this brief has been prepared in Microsoft Word using a 14-point, proportionally spaced font, and that based on word processing software, the brief contains 13,999 words.

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CERTIFICATE OF SERVICE

I certify that on November 16, 2015, I electronically filed the foregoing Brief for the Federal Appellee using the Court's CM/ECF system, which constitutes service under the Court's rules. The brief was served in this manner on:

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STATUTORY ADDENDUM

A. Jurisdictional Provisions.

42 U.S.C. 405(b)	
Administrative hearing.....	1a
42 U.S.C. 405(g)	
Judicial review.....	1a
42 U.S.C. 405(h)	
Finality of Decision	2a
42 U.S.C. 1395cc(b)(2)	
Termination or nonrenewal of agreements.	2a
42 U.S.C. 1395(cc)(h)	
Dissatisfaction with determination of Secretary; appeal by institutions or agencies.	3a
42 U.S.C. 1395ff(b) (F)	
Expedited proceedings.	4a
42 U.S.C. 1395ii.....	5a

B. Inspection and Enforcement Provisions

42 U.S.C. 1395i-3(g)	
Survey and certification process.....	6a
42 U.S.C. 1395i-3(h)	
Enforcement process.....	8a

42 U.S.C. 405(b)**(b) Administrative determination of entitlement to benefits; findings of fact; hearings; investigations; evidentiary hearings in reconsiderations of disability benefit terminations; subsequent applications****(1)**

The Commissioner of Social Security is directed to make findings of fact, and decisions as to the rights of any individual applying for a payment under this subchapter. Any such decision by the Commissioner of Social Security which involves a determination of disability and which is in whole or in part unfavorable to such individual shall contain a statement of the case, in understandable language, setting forth a discussion of the evidence, and stating the Commissioner's determination and the reason or reasons upon which it is based. Upon request by any such individual or upon request by a wife, divorced wife, widow, surviving divorced wife, surviving divorced mother, surviving divorced father, husband, divorced husband, widower, surviving divorced husband, child, or parent who makes a showing in writing that his or her rights may be prejudiced by any decision the Commissioner of Social Security has rendered, the Commissioner shall give such applicant and such other individual reasonable notice and opportunity for a hearing with respect to such decision, and, if a hearing is held, shall, on the basis of evidence adduced at the hearing, affirm, modify, or reverse the Commissioner's findings of fact and such decision. Any such request with respect to such a decision must be filed within sixty days after notice of such decision is received by the individual making such request. The Commissioner of Social Security is further authorized, on the Commissioner's own motion, to hold such hearings and to conduct such investigations and other proceedings as the Commissioner may deem necessary or proper for the administration of this subchapter. In the course of any hearing, investigation, or other proceeding, the Commissioner may administer oaths and affirmations, examine witnesses, and receive evidence. Evidence may be received at any hearing before the Commissioner of Social Security even though inadmissible under rules of evidence applicable to court procedure.

42 U.S.C. 405(g)**(g) Judicial review**

Any individual, after any final decision of the Commissioner of Social Security made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Commissioner of Social Security may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides, or has his principal place of business, or, if he does not reside or have his principal place of business within any such judicial district, in the United States District Court for the District of Columbia. As part of the Commissioner's answer the Commissioner of Social Security shall file a certified copy of the transcript of the record including the evidence upon which the findings and decision complained of are based. The court shall have power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Commissioner of Social Security, with or without remanding the cause for a rehearing. The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive, and where a claim has been denied by the Commissioner of Social Security or a decision is rendered under subsection (b) of this section which is adverse to an individual who was a party to the hearing before the Commissioner of Social Security, because of failure of the claimant or such individual to submit proof in conformity with any regulation prescribed under subsection (a) of this section, the court shall review only the question of conformity with such regulations and the validity of such regulations. The court may, on motion of the Commissioner of Social Security made for good cause shown before the Commissioner files the Commissioner's answer, remand the case to the Commissioner of Social Security for further action by the Commissioner of Social Security, and it may at any time order additional evidence

to be taken before the Commissioner of Social Security, but only upon a showing that there is new evidence which is material and that there is good cause for the failure to incorporate such evidence into the record in a prior proceeding; and the Commissioner of Social Security shall, after the case is remanded, and after hearing such additional evidence if so ordered, modify or affirm the Commissioner's findings of fact or the Commissioner's decision, or both, and shall file with the court any such additional and modified findings of fact and decision, and, in any case in which the Commissioner has not made a decision fully favorable to the individual, a transcript of the additional record and testimony upon which the Commissioner's action in modifying or affirming was based. Such additional or modified findings of fact and decision shall be reviewable only to the extent provided for review of the original findings of fact and decision. 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. Any action instituted in accordance with this subsection shall survive notwithstanding any change in the person occupying the office of Commissioner of Social Security or any vacancy in such office.

42 U.S.C. 405(h)

(h) Finality of Commissioner's decision

The findings and decision of the Commissioner of Social Security after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Commissioner of Social Security shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Commissioner of Social Security, or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28 to recover on any claim arising under this subchapter.

42 U.S.C. 1395cc(b)(2)

(b) Termination or nonrenewal of agreements

(1)

A provider of services may terminate an agreement with the Secretary under this section at such time and upon such notice to the Secretary and the public as may be provided in regulations, except that notice of more than six months shall not be required.

(2) The Secretary may refuse to enter into an agreement under this section or, upon such reasonable notice to the provider and the public as may be specified in regulations, may refuse to renew or may terminate such an agreement after the Secretary—

(A)

has determined that the provider fails to comply substantially with the provisions of the agreement, with the provisions of this subchapter and regulations thereunder, or with a corrective action required under section 1395ww(f)(2)(B) of this title,

(B)

has determined that the provider fails substantially to meet the applicable provisions of section 1395x of this title,

(C)

has excluded the provider from participation in a program under this subchapter pursuant to section 1320a-7 of this title or section 1320a-7a of this title, or

(D)

has ascertained that the provider has been convicted of a felony under Federal or State law for an offense which the Secretary determines is detrimental to the best interests of the program or program beneficiaries.

(3)

A termination of an agreement or a refusal to renew an agreement under this subsection shall become effective on the same date and in the same manner as an exclusion from participation

under the programs under this subchapter becomes effective under [section 1320a–7\(c\) of this title](#).

42 U.S.C. 1395(cc)(h)

(h) Dissatisfaction with determination of Secretary; appeal by institutions or agencies; single notice and hearing

(1)

(A)

Except as provided in paragraph (2), an institution or agency dissatisfied with a determination by the Secretary that it is not a provider of services or with a determination described in subsection (b)(2) of this section shall be entitled to a hearing thereon by the Secretary (after reasonable notice) to the same extent as is provided in [section 405\(b\) of this title](#), and to judicial review of the Secretary's final decision after such hearing as is provided in [section 405\(g\) of this title](#), except that, in so applying such sections and in applying section 405(l) of this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

(B)

An institution or agency described in subparagraph (A) that has filed for a hearing under subparagraph (A) shall have expedited access to judicial review under this subparagraph in the same manner as providers of services, suppliers, and individuals entitled to benefits under part A of this subchapter or enrolled under part B of this subchapter, or both, may obtain expedited access to judicial review under the process established under [section 1395ff\(b\)\(2\) of this title](#). Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under [section 1395i–3 of this title](#) during the pendency of an appeal under this subparagraph.

(C)

(i) The Secretary shall develop and implement a process to expedite proceedings under this subsection in which—

(I)

the remedy of termination of participation has been imposed;

(II)

a remedy described in clause (i) or (iii) of [section 1395i–3\(h\)\(2\)\(B\) of this title](#) has been imposed, but only if such remedy has been imposed on an immediate basis; or

(III)

a determination has been made as to a finding of substandard quality of care that results in the loss of approval of a skilled nursing facility's nurse aide training program.

(ii)

Under such process under clause (i), priority shall be provided in cases of termination described in clause (i)(I).

(iii)

Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under [section 1395i–3 of this title](#) during the pendency of an appeal under this subparagraph.

(2)

An institution or agency is not entitled to separate notice and opportunity for a hearing under both [section 1320a–7 of this title](#) and this section with respect to a determination or determinations based on the same underlying facts and issues.

42 U.S.C. 1395ff(b)

(F) Expedited proceedings

(i) **Expedited determination**In the case of an individual who has received notice from a provider of services that such provider plans—

(I)

to terminate services provided to an individual and a physician certifies that failure to continue the provision of such services is likely to place the individual's health at significant risk, or

(II)

to discharge the individual from the provider of services,

the individual may request, in writing or orally, an expedited determination or an expedited reconsideration of an initial determination made under subsection (a)(1) of this section, as the case may be, and the Secretary shall provide such expedited determination or expedited reconsideration.

(ii) **Reference to expedited access to judicial review**

For the provision relating to expedited access to judicial review, see paragraph (2).

(G) Reopening and revision of determinations

The Secretary may reopen or revise any initial determination or reconsidered determination described in this subsection under guidelines established by the Secretary in regulations.

(2) Expedited access to judicial review

(A) In general

The Secretary shall establish a process under which a provider of services or supplier that furnishes an item or service or an individual entitled to benefits under part A of this subchapter or enrolled under part B of this subchapter, or both, who has filed an appeal under paragraph (1) (other than an appeal filed under paragraph (1)(F)(i)) may obtain access to judicial review when a review entity (described in subparagraph (D)), on its own motion or at the request of the appellant, determines that the Departmental Appeals Board does not have the authority to decide the question of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute. The appellant may make such request only once with respect to a question of law or regulation for a specific matter in dispute in a case of an appeal.

(B) Prompt determinations

If, after or coincident with appropriately filing a request for an administrative hearing, the appellant requests a determination by the appropriate review entity that the Departmental Appeals Board does not have the authority to decide the question of law or regulations relevant to the matters in controversy and that there is no material issue of fact in dispute, and if such request is accompanied by the documents and materials as the appropriate review entity shall require for purposes of making such determination, such review entity shall make a determination on the request in writing within 60 days after the date such review entity receives the request and such accompanying documents and materials. Such a determination by such review entity shall be considered a final decision and not subject to review by the Secretary.

(C) Access to judicial review

(i) **In general**If the appropriate review entity—

(I)

determines that there are no material issues of fact in dispute and that the only issues to be adjudicated are ones of law or regulation that the Departmental Appeals Board does not have authority to decide; or

(II)

fails to make such determination within the period provided under subparagraph (B),

then the appellant may bring a civil action as described in this subparagraph.

(ii) **Deadline for filing**Such action shall be filed, in the case described in—

(I)

clause (i)(I), within 60 days of the date of the determination described in such clause; or

(II)

clause (i)(II), within 60 days of the end of the period provided under subparagraph (B) for the determination.

(iii) Venue

Such action shall be brought in the district court of the United States for the judicial district in which the appellant is located (or, in the case of an action brought jointly by more than one applicant, the judicial district in which the greatest number of applicants are located) or in the District Court for the District of Columbia.

(iv) Interest on any amounts in controversy

Where a provider of services or supplier is granted judicial review pursuant to this paragraph, the amount in controversy (if any) shall be subject to annual interest beginning on the first day of the first month beginning after the 60-day period as determined pursuant to clause (ii) and equal to the rate of interest on obligations issued for purchase by the Federal Supplementary Medical Insurance Trust Fund for the month in which the civil action authorized under this paragraph is commenced, to be awarded by the reviewing court in favor of the prevailing party. No interest awarded pursuant to the preceding sentence shall be deemed income or cost for the purposes of determining reimbursement due providers of services or suppliers under this subchapter.

(D) Review entity defined

For purposes of this subsection, the term “review entity” means an entity of up to three reviewers who are administrative law judges or members of the Departmental Appeals Board selected for purposes of making determinations under this paragraph.

(3) Requiring full and early presentation of evidence by providers

A provider of services or supplier may not introduce evidence in any appeal under this section that was not presented at the reconsideration conducted by the qualified independent contractor under subsection (c) of this section, unless there is good cause which precluded the introduction of such evidence at or before that reconsideration.

42 U.S.C. 1395ii

The provisions of sections 406 and 416(j) of this title, and of subsections (a), (d), (e), (h), (i), (j), (k), and (l) of section 405 of this title, shall also apply with respect to this subchapter to the same extent as they are applicable with respect to subchapter II of this chapter, except that, in applying such provisions with respect to this subchapter, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

42 U.S.C. 1395i-3(g) Survey and certification process**(1) State and Federal responsibility****(A) In general**

Pursuant to an agreement under [section 1395aa of this title](#), each State shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of skilled nursing facilities (other than facilities of the State) with the requirements of subsections (b), (c), and (d) of this section. The Secretary shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of State skilled nursing facilities with the requirements of such subsections.

* * *

(2) Surveys**(A) Standard survey****(i) In general**

Each skilled nursing facility shall be subject to a standard survey, to be conducted without any prior notice to the facility. Any individual who notifies (or causes to be notified) a skilled nursing facility of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed \$2,000. The provisions of [section 1320a-7a of this title](#) (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under [section 1320a-7a\(a\) of this title](#). The Secretary shall review each State's procedures for the scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

(ii) Contents Each standard survey shall include, for a case-mix stratified sample of residents—

(I)

a survey of the quality of care furnished, as measured by indicators of medical, nursing, and rehabilitative care, dietary and nutrition services, activities and social participation, and sanitation, infection control, and the physical environment,

(II)

written plans of care provided under subsection (b)(2) of this section and an audit of the residents' assessments under subsection (b)(3) of this section to determine the accuracy of such assessments and the adequacy of such plans of care, and

(III)

a review of compliance with residents' rights under subsection (c) of this section.

(iii) Frequency**(I) In general**

Each skilled nursing facility shall be subject to a standard survey not later than 15 months after the date of the previous standard survey conducted under this subparagraph. The Statewide average interval between standard surveys of skilled nursing facilities under this subsection shall not exceed 12 months.

(II) Special surveys

If not otherwise conducted under subclause (I), a standard survey (or an abbreviated standard survey) may be conducted within 2 months of any change of ownership, administration, management of a skilled nursing facility, or the director of nursing in order to determine whether the change has resulted in any decline in the quality of care furnished in the facility.

(B) Extended surveys**(i) In general**

Each skilled nursing facility which is found, under a standard survey, to have provided substandard quality of care shall be subject to an extended survey. Any other facility may, at the

Secretary's or State's discretion, be subject to such an extended survey (or a partial extended survey).

(ii) Timing

The extended survey shall be conducted immediately after the standard survey (or, if not practicable, not later than 2 weeks after the date of completion of the standard survey).

(iii) Contents

In such an extended survey, the survey team shall review and identify the policies and procedures which produced such substandard quality of care and shall determine whether the facility has complied with all the requirements described in subsections (b), (c), and (d) of this section. Such review shall include an expansion of the size of the sample of residents' assessments reviewed and a review of the staffing, of in-service training, and, if appropriate, of contracts with consultants.

(iv) Construction

Nothing in this paragraph shall be construed as requiring an extended or partial extended survey as a prerequisite to imposing a sanction against a facility under subsection (h) of this section on the basis of findings in a standard survey.

(C) Survey protocol Standard and extended surveys shall be conducted—

(i)

based upon a protocol which the Secretary has developed, tested, and validated by not later than January 1, 1990, and

(ii)

by individuals, of a survey team, who meet such minimum qualifications as the Secretary establishes by not later than such date.

The failure of the Secretary to develop, test, or validate such protocols or to establish such minimum qualifications shall not relieve any State of its responsibility (or the Secretary of the Secretary's responsibility) to conduct surveys under this subsection.

(D) Consistency of surveys

Each State and the Secretary shall implement programs to measure and reduce inconsistency in the application of survey results among surveyors.

(E) Survey teams

(i) In general

Surveys under this subsection shall be conducted by a multidisciplinary team of professionals (including a registered professional nurse).

(ii) Prohibition of conflicts of interest

A State may not use as a member of a survey team under this subsection an individual who is serving (or has served within the previous 2 years) as a member of the staff of, or as a consultant to, the facility surveyed respecting compliance with the requirements of subsections (b), (c), and (d) of this section, or who has a personal or familial financial interest in the facility being surveyed.

(iii) Training

The Secretary shall provide for the comprehensive training of State and Federal surveyors in the conduct of standard and extended surveys under this subsection, including the auditing of resident assessments and plans of care. No individual shall serve as a member of a survey team unless the individual has successfully completed a training and testing program in survey and certification techniques that has been approved by the Secretary.

* * *

42 U.S.C. 1395i-3(h) Enforcement process

(1) In general If a State finds, on the basis of a standard, extended, or partial extended survey under subsection (g)(2) of this section or otherwise, that a skilled nursing facility no longer meets a requirement of subsection (b), (c), or (d) of this section, and further finds that the facility's deficiencies—

(A)

immediately jeopardize the health or safety of its residents, the State shall recommend to the Secretary that the Secretary take such action as described in paragraph (2)(A)(i); or

(B)

do not immediately jeopardize the health or safety of its residents, the State may recommend to the Secretary that the Secretary take such action as described in paragraph (2)(A)(ii).

If a State finds that a skilled nursing facility meets the requirements of subsections (b), (c), and (d) of this section, but, as of a previous period, did not meet such requirements, the State may recommend a civil money penalty under paragraph (2)(B)(ii) for the days in which it finds that the facility was not in compliance with such requirements.

(2) Secretarial authority

(A) In general With respect to any skilled nursing facility in a State, if the Secretary finds, or pursuant to a recommendation of the State under paragraph (1) finds, that a skilled nursing facility no longer meets a requirement of subsection (b), (c), (d), or (e) of this section, and further finds that the facility's deficiencies—

(i)

immediately jeopardize the health or safety of its residents, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in subparagraph (B)(iii), or terminate the facility's participation under this subchapter and may provide, in addition, for one or more of the other remedies described in subparagraph (B); or

(ii)

do not immediately jeopardize the health or safety of its residents, the Secretary may impose any of the remedies described in subparagraph (B).

Nothing in this subparagraph shall be construed as restricting the remedies available to the Secretary to remedy a skilled nursing facility's deficiencies. If the Secretary finds, or pursuant to the recommendation of the State under paragraph (1) finds, that a skilled nursing facility meets such requirements but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under subparagraph (B)(ii) for the days on which he finds that the facility was not in compliance with such requirements.

(B) Specified remedies The Secretary may take the following actions with respect to a finding that a facility has not met an applicable requirement:

(i) Denial of payment

The Secretary may deny any further payments under this subchapter with respect to all individuals entitled to benefits under this subchapter in the facility or with respect to such individuals admitted to the facility after the effective date of the finding.

(ii) Authority with respect to civil money penalties**(I) In general**

Subject to subclause (II), the Secretary may impose a civil money penalty in an amount not to exceed \$10,000 for each day of noncompliance. The provisions of [section 1320a-7a of this title](#) (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under [section 1320a-7a\(a\) of this title](#).

(II) Reduction of civil money penalties in certain circumstances

Subject to subclause (III), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause not later than 10 calendar days after the date of such imposition, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

(III) Prohibitions on reduction for certain deficiencies

(aa) Repeat deficiencies

The Secretary may not reduce the amount of a penalty under subclause (II) if the Secretary had reduced a penalty imposed on the facility in the preceding year under such subclause with respect to a repeat deficiency.

(bb) Certain other deficiencies

The Secretary may not reduce the amount of a penalty under subclause (II) if the penalty is imposed on the facility for a deficiency that is found to result in a pattern of harm or widespread harm, immediately jeopardizes the health or safety of a resident or residents of the facility, or results in the death of a resident of the facility.

(IV) Collection of civil money penalties In the case of a civil money penalty imposed under this clause, the Secretary shall issue regulations that—

(aa)

subject to item (cc), not later than 30 days after the imposition of the penalty, provide for the facility to have the opportunity to participate in an independent informal dispute resolution process which generates a written record prior to the collection of such penalty;

(bb)

in the case where the penalty is imposed for each day of noncompliance, provide that a penalty may not be imposed for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

(cc)

may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

(dd)

may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

(ee)

in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

(ff)

in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities implementing quality assurance programs, the appointment of temporary management firms, and other activities approved by the Secretary).

(iii) Appointment of temporary management In consultation with the State, the Secretary may appoint temporary management to oversee the operation of the facility and to assure the health and safety of the facility's residents, where there is a need for temporary management while—

(I)

there is an orderly closure of the facility, or

(II)

improvements are made in order to bring the facility into compliance with all the requirements of subsections (b), (c), and (d) of this section.

The temporary management under this clause shall not be terminated under subclause (II) until the Secretary has determined that the facility has the management capability to ensure continued compliance with all the requirements of subsections (b), (c), and (d) of this section.

The Secretary shall specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies. Such criteria shall be designed so as to minimize the time between the

identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies. In addition, the Secretary may provide for other specified remedies, such as directed plans of correction.

(C) Continuation of payments pending remediation The Secretary may continue payments, over a period of not longer than 6 months after the effective date of the findings, under this subchapter with respect to a skilled nursing facility not in compliance with a requirement of subsection (b), (c), or (d) of this section, if—

- (i) the State survey agency finds that it is more appropriate to take alternative action to assure compliance of the facility with the requirements than to terminate the certification of the facility,
- (ii) the State has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action, and
- (iii) the facility agrees to repay to the Federal Government payments received under this subparagraph if the corrective action is not taken in accordance with the approved plan and timetable.

The Secretary shall establish guidelines for approval of corrective actions requested by States under this subparagraph.

(D) Assuring prompt compliance

If a skilled nursing facility has not complied with any of the requirements of subsections (b), (c), and (d) of this section, within 3 months after the date the facility is found to be out of compliance with such requirements, the Secretary shall impose the remedy described in subparagraph (B)(i) for all individuals who are admitted to the facility after such date.

(E) Repeated noncompliance In the case of a skilled nursing facility which, on 3 consecutive standard surveys conducted under subsection (g)(2) of this section, has been found to have provided substandard quality of care, the Secretary shall (regardless of what other remedies are provided)—

- (i) impose the remedy described in subparagraph (B)(i), and
- (ii) monitor the facility under subsection (g)(4)(B) of this section, until the facility has demonstrated, to the satisfaction of the Secretary, that it is in compliance with the requirements of subsections (b), (c), and (d) of this section, and that it will remain in compliance with such requirements.

(3) Effective period of denial of payment

A finding to deny payment under this subsection shall terminate when the Secretary finds that the facility is in substantial compliance with all the requirements of subsections (b), (c), and (d) of this section.

(4) Immediate termination of participation for facility where Secretary finds noncompliance and immediate jeopardy

If the Secretary finds that a skilled nursing facility has not met a requirement of subsection (b), (c), or (d) of this section, and finds that the failure immediately jeopardizes the health or safety of its residents, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in paragraph (2)(B)(iii), or the Secretary, subject to [section 1320a–7j\(h\) of this title](#), shall terminate the facility's participation under this subchapter. If the facility's participation under this subchapter is terminated, the State shall provide for the safe and orderly transfer of the residents eligible under this subchapter consistent with the requirements of subsection (c)(2) and [section 1320a–7j\(h\) of this title](#).

(5) Construction

The remedies provided under this subsection are in addition to those otherwise available under State or Federal law and shall not be construed as limiting such other remedies, including any remedy available to an individual at common law. The remedies described in clauses (i), (ii)(IV), and (iii) of paragraph (2)(B) may be imposed during the pendency of any hearing.

(6) Sharing of information

Notwithstanding any other provision of law, all information concerning skilled nursing facilities required by this section to be filed with the Secretary or a State agency shall be made available by such facilities to Federal or State employees for purposes consistent with the effective administration of programs established under this subchapter and subchapter XIX of this chapter, including investigations by State medicaid fraud control units.

* * *

No. 15-13731

**IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT**

AGENCY FOR HEALTH CARE ADMINISTRATION,

AND

SECRETARY, UNITED STATES
DEPARTMENT OF HEALTH AND HUMAN SERVICES,

PLAINTIFFS - APPELLEES

VS.

BAYOU SHORES SNF LLC,

DEFENDANT - APPELLANT

**ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF FLORIDA**

**BRIEF FOR APPELLEE FLORIDA AGENCY FOR HEALTH CARE
ADMINISTRATION**

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*Florida Agency for Health Care Administration, et al. v. Bayou Shores,
SNF, LLC*
No. 15-13731-FF

**Amended Certificate of Interested Persons
and Corporate Disclosure Statement**

The following persons and entities have an interest in the outcome of this case:

1. Akerman LLP;
2. Baker, Donelson, Bearman, Caldwell & Berkowitz, PC;
3. Baker & Hostetler LLP;
4. Barnett, Denise, Esquire;
5. Bancroft, Zachary James, Esquire;
6. Bayou Shores, SNF, LLC;
7. Bentley, A. Lee, III, United States Attorney;
8. Bodnar, Roberta Josephina, Assistant United States Attorney;
9. Bogomilsky, Tzvi;
10. Bongiovanni, Greg, Assistant Regional Counsel, U.S. Department of Health and Human Services;
11. Cahill, Mathew M., Esquire;
12. Clair, Jeffrey A., Attorney, U.S. Department of Justice
13. Davis, Kirk S., Esquire;

*Florida Agency for Health Care Administration, et al. v. Bayou Shores,
SNF, LLC*
No. 15-13731-FF

14. Dudek, Elizabeth, Secretary, Florida Agency for Health Care Administration;
15. Emden, Christopher John, Assistant United States Attorney;
16. Falkner, William Carroll I., Esquire;
17. Florida Agency for Health Care Administration;
18. Flynn, Sean, Assistant United States Attorney;
19. GrayRobinson, P.A.;
20. Green, Elizabeth A., Esquire;
21. Horowitz, Alan, C., Esquire;
22. Kuntz, Jeffrey T., Esquire;
23. Layden, Andrew V., Esquire;
24. Lupinacci, Timothy M., Esquire;
25. Marlewski, Christine A., Esquire;
26. Mathews, Margaret Diane, Esquire;
27. Mizer, Benjamin C., Assistant Attorney General, Civil Division, U.S. Department of Justice;
28. Moody, Honorable James S., Jr., United States District Judge;
29. McKinstry, Molly, Deputy Secretary for Health Quality Assurance,

*Florida Agency for Health Care Administration, et al. v. Bayou Shores,
SNF, LLC*
No. 15-13731-FF

- Florida Agency for Health Care Administration;
30. Murphy-Davis, Colleen, Assistant United States Attorney;
 31. Parrish, Jimmy D., Esquire;
 32. Payne, Tiffany D., Esquire;
 33. Pinellas County Tax Collector;
 34. Raab, Michael S., Attorney, U.S. Department of Justice
 35. Rhodes, David P., Assistant United States Attorney, Chief, Appellate
Division;
 36. Rissler, Jerad, Esquire;
 37. Secretary, United States Department of Health and Human Services;
 38. Senior, Justin M., Medicaid Director, Florida Agency for Health Care
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 39. Sheeran, Andrew T., Assistant General Counsel, Florida Agency for
Health Care Administration;
 40. Sholl, Peter J., Assistant United States Attorney;
 41. Street, Leslei G., Chief Litigation Counsel, Florida Agency for Health
Care Administration;
 42. Synovus Bank, (ticker symbol SNV);

*Florida Agency for Health Care Administration, et al. v. Bayou Shores,
SNF, LLC*
No. 15-13731-FF

43. Terzo, Frank P., Esquire;
44. United States Trustee;
45. Vitale, Michael S.;
46. Walsh, Thomas J. II, Assistant General Counsel, Florida Agency for
Health Care Administration;
47. Weaver, Polly, Assistant Deputy Secretary for Health Quality
Assurance, Florida Agency for Health Care Administration;
48. Williams, Stuart F., General Counsel, Florida Agency for Health Care
Administration; and
49. Williamson, Honorable Michael G., United States Bankruptcy
Judge.

STATEMENT REGARDING ORAL ARGUMENT

The Agency for Health Care Administration (“AHCA”) respectfully requests oral argument. This appeal raises an issue of first impression in this Court involving the complex intersection of bankruptcy law with Medicare and Medicaid law. The central question presented is whether bankruptcy courts are bound by the jurisdictional bar set forth in 42 U.S.C. § 405(h), which provides in relevant part:

No findings of fact or decision of the Commissioner of Social Security shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Commissioner of Social Security, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

Because the Ninth Circuit has ruled that the jurisdictional bar does not apply to bankruptcy courts, this Court’s decision in this case could introduce a circuit split and invite Supreme Court review. Finally, the issue raises important public policy implications as a reversal of the district court’s decision could change the landscape of Medicare and Medicaid regulation of health care facilities in this Circuit. Given these considerations, AHCA believes the Court would benefit from oral argument.

TABLE OF CONTENTS

CERTIFICATE OF INTERESTED PERSONS AND CORPORATE DISCLOSURE STATEMENT	C1
STATEMENT REGARDING ORAL ARGUMENT	i
JURISDICTIONAL STATEMENT	1
STATEMENT OF THE ISSUES	2
STATEMENT OF THE CASE AND FACTS	2
STANDARD OF REVIEW	9
SUMMARY OF THE ARGUMENT	9
ARGUMENT	12
I. The Bankruptcy Court’s Orders Implicated Claims Arising Under the Medicare Act	13
II. The Bankruptcy Court’s Orders Violated the Jurisdictional Bar Established by 42 U.S.C. § 405(h)	17
III. The Bankruptcy Court Lacked Jurisdiction Over Bayou Shores’ Medicaid Provider Agreement to the Same Extent it Lacked Jurisdiction Over Bayou Shores’ Medicare Provider Agreement	27
IV. The District Court Properly Denied Bayou Shores’ Motions to Dismiss AHCA’s Appeals	31
CONCLUSION	38
CERTIFICATE OF COMPLIANCE	39
CERTIFICATE OF SERVICE	39, 40

TABLE OF CITATIONS

<u>Cases</u>	<u>Page(s)</u>
<i>Affiliated Prof'l Home Health Care Agency v. Shalala</i> , 164 F.3d 282 (5th Cir. 1999).....	14
<i>Allstar Care Inc. v. Blue Cross & Blue Shield of S. Carolina</i> , 184 F. Supp. 2d 1295 (S.D. Fla. 2002)	24, 25
<i>Arbaugh v. Y&H Corp.</i> , 546 U.S. 500 (2006).....	34
<i>Bayou Shores SNF LLC v. Sylvia Mathews Burwell, Marilyn Tavenner, and Elizabeth Dudek</i> , Case number 8:14-cv-01849	5
<i>Bodimetric Health Services, Inc. v. Aetna Life & Casualty</i> , 903 F.2d 480 (7th Cir. 1990).....	23, 24, 25, 26
<i>Bond v. Koscot Interplanetary</i> , 246 So. 2d 631 (Fla. 4th DCA 1971).....	30
<i>Caregivers Plus, Inc. v. Thompson</i> , 311 F. Supp. 2d 728 (N.D. Ind. 2004).....	25
<i>Cont'l Training Servs., Inc. v. Cavazos</i> , 893 F.2d 877 (7th Cir. 1990)	32
<i>Do Sung Uhm v. Humana, Inc.</i> , 620 F.3d 1134 (9th Cir. 2010)	26
<i>Erickson v. U.S. ex rel Dep't of Health & Human Servs.</i> , 67 F.3d 858 (9th Cir. 1995).....	36
<i>Excel Home Care, Inc. v. U.S. Dep't of Health & Human Servs.</i> , 316 B.R. 565 (D. Mass. 2004).....	23
<i>First American Health Care of Georgia Inc. v. Dep't of Health & Human Servs.</i> , 208 B.R. 985 (Bankr. S.D. Ga. 1996).....	19, 20
<i>First American Health Care of Georgia Inc. v. Dep't of Health & Human Servs.</i> , No. 96-2007, 1996 WL 282149 (Bankr. S.D. Ga. Mar. 11, 1996)	19

<i>Grupo Mexicano de Desarrollo S.A. v. Alliance Bond Fund, Inc.</i> , 527 U.S. 308 (1999).....	32
<i>In re AHN Homecare, LLC</i> , 222 B.R. 804 (Bankr. N.D. Tex. 1998).....	23
<i>In re Bayou Shores SNF, LLC</i> , Case No. 8:14-bk-09521-MGW	6
<i>In re Blue Stone Real Estate, Constr. & Dev. Corp.</i> , 396 B.R. 555 (Bankr. M.D. Fla. 2008)	20
<i>In re Canion</i> , 196 F.3d 579 (5th Cir. 1999).....	34
<i>In re Charter Commc'ns, Inc.</i> , 691 F.3d 476 (2d Cir. 2012)	37
<i>In re Club Associates</i> , 956 F.2d 1065 (11th Cir. 1992).....	35, 36
<i>In re Home Comp Care, Inc.</i> , 221 B.R. 202 (N.D. Ill. 1998).....	23
<i>In re Hosp. Staffing Servs., Inc.</i> , 258 B.R. 53 (S.D. Fla. 2000)	22
<i>In re House of Mercy, Inc.</i> , 353 B.R. 867 (Bankr. W.D. La. 2006).....	23
<i>In re Kmart Corp.</i> , 434 F.3d 536 (7th Cir. 2006).....	32
<i>In re Lett</i> , 632 F.3d 1216 (11th Cir. 2011).....	37
<i>In re Livingston</i> , 804 F.2d 1219 (11th Cir. 1986)	30
<i>In re Nurses' Registry & Home Health Corporation</i> , 533 B.R. 590 (Bankr. E.D. Ky. 2015).....	20, 21
<i>In re Semcrude, L.P.</i> , 728 F.3d 314 (3d Cir. 2013).....	37
<i>In re St. Johns Home Health Agency, Inc.</i> , 173 B.R. 238 (Bankr. S.D. Fla. 1994)	15, 19, 23
<i>In re St. Mary Hosp.</i> , 123 B.R.14 (E.D. Pa. 1991).....	22, 23
<i>In re Town & Country Home Nursing Servs., Inc.</i> , 963 F.2d 1146 (9th Cir. 1991).....	25, 26

<i>In re University Medical Center</i> , 973 F.2d 1065 (3d Cir. 1992).....	22
<i>In re Upsher Labs, Inc.</i> , 135 B.R. 117 (Bankr. W.D. Mo. 1991).....	23
<i>Jackson v. Astrue</i> , 506 F.3d 1349 (11th Cir. 2007).....	13
<i>Kaiser v. Blue Cross of California</i> , 347 F.3d 1107 (9th Cir. 2003).....	26
<i>King Iron Bridge & Mfg. Co. v. Cnty. of Otoe</i> , 120 U.S. 225 (1887).....	37
<i>Livingston Care Ctr., Inc. v. United States</i> , 934 F.2d 719 (6th Cir. 1991)	13, 14, 28
<i>Mallory & Evans Contractors & Engineers, LLC v. Tuskegee Univ.</i> , 663 F.3d 1304 (11th Cir. 2011)	34
<i>Matter of Vineyard Bay Dev. Co., Inc.</i> , 132 F.3d 269 (5th Cir. 1998).....	38
<i>Miami Center Limited Partnership v. Bank of New York</i> , 820 F.2d 376 (11th Cir. 1987).....	36
<i>N. Health Facilities, Inc. v. United States</i> , 39 F. Supp. 2d 563 (D. Md. 1998).....	28
<i>Nichole Med. Equip. & Supply, Inc. v. TriCenturion, Inc.</i> , 694 F.3d 340 (3d Cir. 2012).....	24
<i>Northwest Healthcare, L.P. v. Sullivan</i> , 793 F. Supp. 724 (W.D. Tex. 1992).....	28
<i>O'Bannon v. Town Court Nursing Ctr.</i> , 447 U.S. 773 (1980)	36
<i>Paul v. F.D.I.C.</i> , 91 F.3d 110 (11th Cir. 1996)	33
<i>Potts v. Rawlings Co., LLC</i> , 897 F. Supp. 2d 185 (S.D.N.Y. 2012)	25
<i>S. Pac. Transp. Co. v. Voluntary Purchasing Groups, Inc.</i> , 246 B.R. 532 (E.D. Tex. 2000).....	38
<i>Scarfo v. Ginsberg</i> , 175 F.3d 957 (11th Cir. 1999).....	33

<i>Shalala v. Illinois Council on Long Term Care, Inc.</i> , 529 U.S. 1 (2000).....	15
<i>United States v. Cotton</i> , 535 U.S. 625 (2002).....	33
<i>U.S. Dep’t of Health & Human Servs. v. James</i> , 256 B.R. 479 (W.D. Ky. 2000).....	23
<i>U.S. Nat’l Bank of Oregon v. Independent Ins. Agents of America, Inc.</i> , 508 U.S. 439 (1993).....	19, 20

Statutes

Page(s)

Deficit Reduction Act of 1984, § 2663(a)(4)(D), Pub. L. No. 98-369, 98 Stat. 494, 1162 (1984).....	18
Deficit Reduction Act of 1984, § 2664(b), 98 Stat. 494, 1171-72	<i>passim</i>
1 U.S.C. § 204(a)	20
11 U.S.C. § 365.....	15
11 U.S.C. § 365(b).....	16
11 U.S.C. § 541.....	15, 30
28 U.S.C. § 1291.....	1
28 U.S.C. § 1332.....	23, 26
28 U.S.C. § 1334.....	10, 18, 26, 27
28 U.S.C. § 158(a)	1
28 U.S.C. § 158(a)(1)	1
28 U.S.C. § 158(d)(1)	1
42 U.S.C. § 1395(b)(2)(A).....	12

42 U.S.C. § 1395cc	12
42 U.S.C. § 1395cc(h)(1)(A)	12, 14
42 U.S.C. § 1395i-3(h)(2)(A)(i)	12
42 U.S.C. § 1395ii	12, 17
42 U.S.C. § 1396a(a)(39).....	27, 30
42 U.S.C. § 405(b).....	12
42 U.S.C. § 405(g).....	12, 13, 14
42 U.S.C. § 405(h).....	<i>passim</i>
42 U.S.C. §§ 405(l).....	12
§ 409.913(14), Fla. Stat	28, 30

Regulations

42 C.F.R. § 488.330(b)	28
42 C.F.R. § 488.330(e)(1).....	29
42 C.F.R. § 488.410(a), (c).....	29
46 Fed. Reg. 13,262-63 (March 9, 1977)	12
66 Fed. Reg. 35,437 (July 5, 2001)	12

Rules

Page(s)

Fed. R. App. P. 32(a)(7)	39
Fed. R. Civ. P. 4(a)(1)(B)	1

Miscellaneous

Black’s Law Dictionary 1544 (8th ed. 2004)	10
American Heritage Dictionary 1293 (2 nd ed. 1985)	10

JURISDICTIONAL STATEMENT

The district court had jurisdiction to review and reverse the orders of the bankruptcy court pursuant to 28 U.S.C. § 158(a)(1), because the bankruptcy court's orders were final orders.

This Court has jurisdiction over the appeal of the district court's order pursuant to 28 U.S.C. § 158(d)(1), as the district court's orders constituted final decisions pursuant to 28 U.S.C. § 158(a). This Court also has jurisdiction pursuant to 28 U.S.C. § 1291, as this is an appeal of a final decision of a district court. The district court's order disposed of all the claims at issue in AHCA's appeal of the bankruptcy court's orders.

The district court's order reversing the bankruptcy court orders was entered on June 26, 2015. The notice of appeal was filed on August 19, 2015, within the 60-day timeframe established by Federal Rule of Civil Procedure 4(a)(1)(B) which applies where one of the parties is the United States. Thus, the appeal was timely filed.

STATEMENT OF THE ISSUES

1. Whether the orders issued by the bankruptcy court below implicated claims arising under the Medicare Act.
2. Whether 42 U.S.C. § 405(h) bars a bankruptcy court from exercising jurisdiction over claims arising under the Medicare Act.
3. Whether the bankruptcy court erred in exercising jurisdiction over Bayou Shores' Medicaid provider agreement.
4. Whether the district court properly denied the motions to dismiss filed by Bayou Shores SNF, LLC ("Bayou Shores") of AHCA's appeals of the bankruptcy court orders.

STATEMENT OF THE CASE AND FACTS

Appellant, Bayou Shores, operates a skilled nursing facility in St. Petersburg, Florida. [District Court ("D.C.") Doc. 72 at 2]. Bayou Shores provides Medicare and Medicaid services through provider agreements with the federal and state governments pursuant to the Social Security Act's Medicare and Medicaid provisions. [D.C. Doc. 72 at 2]. A Medicaid provider agreement is a contract between AHCA and a health care provider which sets forth the provider's responsibilities and the conditions under which AHCA will pay for Medicaid services provided to Medicaid-eligible recipients.

AHCA contracts with the Centers for Medicare and Medicaid Services (“CMS”), a division of the United States Department of Health and Human Services (“HHS”), to conduct surveys of skilled nursing facilities on behalf of CMS in order to determine whether skilled nursing facilities are in compliance with federal law governing Medicare providers. Surveyors employed by AHCA conducted a federal survey of Bayou Shores’ facility in late January and early February 2014. [D.C. Doc. 1-16]. This survey found numerous problems including residents left unattended in unhygienic conditions, unlocked medication carts, and errors in matching Do Not Resuscitate Orders (“DNRs”) to medical records, placing residents who had not signed DNRs at risk of death. [D.C. Doc. 1-16 at 2-21, 73-77, 81-82, 85-88]. CMS found that the conditions discovered in this survey caused immediate jeopardy to residents’ health and safety. [D.C. Doc. 1-31 at 20]. Though CMS had the legal authority to do so, CMS did not exercise its discretion to terminate Bayou Shores from participation in the Medicare and Medicaid programs; rather, CMS chose to grant Bayou Shores an opportunity to correct the problems and avoid termination. [D.C. Doc. 1-24 at ¶ 2].

AHCA surveyors returned to Bayou Shores on behalf of CMS in March 2014 and again found serious problems. [D.C. Doc. 1-17]. Bayou Shores had admitted from a hospital a resident whom the hospital had identified as a “prior sex offender.” [D.C. Doc. 1-17 at 15-18, 20]. The resident was placed in a room with

a disabled resident who was not informed of his new roommate's history, and the newly-admitted resident attempted to sexually molest the disabled roommate. [D.C. Doc. 1-17 at 17-18]. The surveyors also once again found medication carts with expired or undated medications. [D.C. Doc. 1-17 at 7-9]. For a second time, CMS found that the conditions discovered in the survey placed Bayou Shores' residents in immediate jeopardy to their health and safety. [D.C. Doc. 1-31 at 21]. For a second time, CMS chose not to immediately terminate Bayou Shores' participation in the Medicare and Medicaid programs, but rather permitted Bayou Shores to correct the problems found in the survey. [D.C. Doc. 1-24 at ¶ 2].

AHCA surveyors returned to Bayou Shores on behalf of CMS in July 2014 and, for a third time, found serious problems. [D.C. Doc. 1-24 at ¶ 2; D.C. Doc. 1-18]. The surveyors discovered that a mentally incapacitated resident of Bayou Shores' (allegedly) secured unit had wandered unnoticed off the premises. [D.C. Doc. 1-18 at 2-14, 17, 20, 78-79, 103; D.C. Doc. 1-24 at ¶ 2]. The resident was later found at a bus stop several blocks away from the facility, sitting hatless in the hot sun. [D.C. Doc. 1-18 at 9, 11, 14; D.C. Doc. 1-24 at ¶ 2]. The surveyors found Bayou Shores' management had permitted this incident to occur due to numerous problems. [D.C. Doc. 1-18 at 78-79]. For the third time, CMS determined that the conditions outlined in the survey constituted immediate jeopardy to Bayou Shores' residents' health and safety. [D.C. Doc. 1-18 at 79; Doc. 1-20; Doc. 1-31 at 24].

Rather than granting Bayou Shores clemency for the third time in approximately five months, CMS instead exercised its discretion to terminate Bayou Shores' participation in the Medicare and Medicaid programs. [D.C. Doc. 1-20; D.C. Doc. 1-24 at ¶ 3]. In a letter dated July 22, 2014, CMS informed Bayou Shores that, as a result of its failure to maintain substantial compliance with Medicare and Medicaid requirements and the immediate jeopardy to Bayou Shores' residents' health and safety, Bayou Shores' "Medicare agreement will be terminated at 11:59 pm on August 3, 2014" and that Medicare and Medicaid payments would continue for only 30 days from that date. [D.C. Doc. 1-20 at 1-2]. Medicare- and Medicaid-eligible recipients could choose to continue to reside at Bayou Shores, but their services would no longer be paid for with state and federal funds.

On August 1, 2014, Bayou Shores initiated an action in the U.S. District Court for the Middle District of Florida, *Bayou Shores SNF LLC v. Sylvia Mathews Burwell, Marilyn Tavenner, and Elizabeth Dudek*, Case number 8:14-cv-01849 (the "Civil Action"), seeking a temporary restraining order ("TRO"), preliminary injunction, and permanent injunction against the termination of its Medicare and Medicaid provider agreements. After an *ex parte* hearing held on the same day Bayou Shores filed the Civil Action, the district court entered a TRO "temporarily enjoin[ing] and restrain[ing]" CMS and AHCA "from terminating St. Pete Rehab's

Medicare and Medicaid provider agreements, pending a pre-termination administrative hearing.” [D.C. Doc. 1-31 at 84].

On August 11, 2014, the United States filed a motion to dismiss the Civil Action for lack of subject matter jurisdiction, based on the same principles of law at issue in this appeal. On August 15, 2014, at 12:58 p.m., the district court granted the United States’ motion, dismissing the Civil Action and dissolving the TRO. [D.C. Doc. 1-26; D.C. Doc. 1-31 at 85]. At this point, the Medicare and Medicaid provider agreements were terminated as a matter of fact and by operation of law, retroactive to the date supplied in the notice or, at the latest, upon the district court’s dismissal of the Civil Action. [Doc. 1-20 at 2].

Less than an hour after the district court dismissed the Civil Action, at 1:52 p.m., Bayou Shores, now as Debtor, filed a Voluntary Petition for Chapter 11 bankruptcy in the United States Bankruptcy Court for the Middle District of Florida, *In re Bayou Shores SNF, LLC*, Case No. 8:14-bk-09521-MGW (the “Bankruptcy Case”). [Doc. 1-31 at 85]. The close proximity of the dismissal of the Civil Action with the filing of Bayou Shores’ bankruptcy petition creates the strong inference that the purpose of Bayou Shores’ Chapter 11 filing was solely to prevent the termination of Bayou Shores’ Medicare and Medicaid provider agreements. This inference becomes inescapable when coupled with the fact that Bayou Shores’ Chapter 11 reorganization plan provided for payment of all of its

creditors in full. [Bankruptcy Court (“Bk. Ct.”) Doc. 186 at 11-15]. Bayou Shores did not file for bankruptcy to reorganize its debts; it simply needed to prevent the termination of its Medicare and Medicaid provider agreements.

Soon after filing its Chapter 11 petition, Bayou Shores filed a motion asking the bankruptcy court to formally enjoin CMS and AHCA from terminating Bayou Shores’ Medicare and Medicaid provider agreements. [D.C. Doc. 1-14]. The bankruptcy court provisionally granted Debtor’s motion and, after a final evidentiary hearing on August 26, 2014, the bankruptcy court issued an order on September 5, 2014, granting Debtor’s motion “for the reasons stated in open Court.” [D.C. Doc. 1-31; D.C. Doc. 1-2]. Both AHCA and the United States timely appealed the order. [D.C. Doc. 1-1; D.C. Doc. 2].

Bayou Shores filed its First Amended Disclosure Statement and First Amended Chapter 11 Plan of Reorganization on November 21, 2014. [D.C. Doc. 45-12, 45-14]. The United States filed timely written objections on December 15, 2014. [Bk. Ct. Doc. 242]. AHCA did not file written objections to Bayou Shores’ reorganization plan, but joined in the United States’ objection at the hearing held on December 22, 2014. [Bk. Ct. Doc. 281 at 65]. The bankruptcy court accepted AHCA’s joinder of the United States’ objection, and Bayou Shores asserted no objection. [Bk. Ct. Doc. 281 at 65]. On January 7, 2015, the bankruptcy court issued the Confirmation Order, in which the Bankruptcy Court asserted jurisdiction

over, and ordered the assumption of, Bayou Shores' Medicare and Medicaid provider agreements. [Bk. Ct. Doc. 285]. Both AHCA and the United States appealed the Confirmation Order. [D.C. Doc. 38, 45-1]. The district court consolidated the two appeals of the September 5, 2014 Order with the two appeals of the Confirmation Order under Case Number 8:14-cv-02816-JSM. [D.C. Doc. 19, 38].

Bayou Shores moved to dismiss the appeals of the September 5, 2014 Order as both constitutionally and equitably moot, which the district court denied. [D.C. Doc. 20, 31, 61, 65]. Bayou Shores moved to dismiss both the United States and AHCA's appeals of the Confirmation Order. Bayou Shores also moved to dismiss AHCA's appeal of the Confirmation Order on the grounds that AHCA had failed to preserve issues for appeal and failed to seek or obtain a stay of the Confirmation Order. [D.C. Doc. 54]. The district court denied the motion to dismiss as to AHCA's preservation of issues and stay. [D.C. Doc. 61].

On June 26, 2015, the district court issued its order reversing the bankruptcy court's September 5, 2014 Order and Confirmation Order with respect to the assertion of jurisdiction over, and assumption of, Bayou Shores' Medicare and Medicaid provider agreements (the "Reversal Order"). [D.C. Doc. 72]. The district court ruled that the bankruptcy court lacked subject matter jurisdiction over

the provider agreements as a result of the jurisdictional bar set forth in 42 U.S.C. § 405(h). [D.C. Doc. 72].

STANDARD OF REVIEW

The issues presented in this appeal are questions of law and subject to *de novo* review.

SUMMARY OF THE ARGUMENT

Congress created an exclusive process for the resolution of claims arising under the Medicare Act: a federal administrative hearing followed by judicial review by the federal district court. Outside of this process, no court may exercise jurisdiction over claims arising under the Medicare Act.

The bankruptcy court exercised jurisdiction over the Medicare and Medicaid provider agreements by reasoning that its actions did not implicate the Medicare Act. This reasoning is not well founded. The universe of claims “arising under” the Medicare Act is not limited to monetary claims. The termination of a health care provider’s Medicare and Medicaid provider agreements by the Secretary of the U.S. Department of Health and Human Services is quintessentially a matter arising under the Medicare Act. Without a provider agreement, there would be no “provider” receiving Medicare or Medicaid funding for providing services. Thus, an action brought by the provider to enjoin, prevent, or delay such termination is subject to the jurisdictional bar set forth in 42 U.S.C. § 405(h). That a bankruptcy

court's orders enjoining, preventing, or delaying the termination of Bayou Shores' Medicare and Medicaid provider agreements were ostensibly issued pursuant to Congress' jurisdictional grants to bankruptcy courts does not change the fact that these were claims arising under the Medicare Act and the jurisdictional bar applied.

Although the jurisdictional bar set forth in 42 U.S.C. § 405(h) does not explicitly reference bankruptcy courts or 28 U.S.C. § 1334, it nevertheless applies to bankruptcy courts as it does to all other courts. On its face, the jurisdictional bar applies to “any person, tribunal, or governmental agency.” 42 U.S.C. § 405(h) (emphasis added). The common meaning of “tribunal” is “a court or other adjudicatory body.” Black's Law Dictionary 1544 (8th ed. 2004); *accord* The American Heritage Dictionary 1293 (2nd ed. 1985) (defining “tribunal” first as “a seat or court of justice”).

Moreover, an uncodified portion of the 1984 legislation amending § 405(h) provides that the amendment is not intended to alter “any right, liability, status, or interpretation which existed” under the previous legislation, and the previous legislation explicitly referenced the jurisdiction of bankruptcy courts in the jurisdictional bar. Deficit Reduction Act of 1984, § 2664(b), Pub. L. No. 98–369, 98 Stat. 494, 1171–72 (1984). Numerous courts have held that, post-1984, the jurisdictional bar continues to apply to bankruptcy courts. The courts that have

held otherwise have failed to take into account Congress' explicit direction that its amendment of § 405(h) not be interpreted to effect substantive changes.

The district court properly addressed AHCA's appeals of the bankruptcy court's orders. AHCA's appeal of the bankruptcy court's September 5, 2014 Order was not constitutionally moot, because that order, if affirmed, may bar any efforts AHCA might wish to pursue to recover the Medicaid payments it was unlawfully required to pay as a result of the bankruptcy court's injunction. Because AHCA was challenging the subject matter jurisdiction of the bankruptcy court to issue the Confirmation Order, any failure by AHCA to object to the reorganization plan or to preserve issues for appeal is irrelevant. Objections to subject matter jurisdiction cannot be waived. Finally, the substantial consummation of Bayou Shores' reorganization plan does not bar AHCA's appeal of the Confirmation Order, because the district court was still able to grant effective relief. The district court's non-discretionary obligation to reverse the bankruptcy court's orders in excess of subject matter jurisdiction supersedes its discretionary option to dismiss based on equitable mootness.

ARGUMENT

Congress has established broad discretionary authority in the Secretary of HHS (the “Secretary”) over decisions concerning the Medicare program.¹ 42 U.S.C. § 405(h) (made applicable to Medicare via 42 U.S.C. § 1395ii). This includes the authority to enter into Medicare provider agreements with health care providers, 42 U.S.C. § 1395cc, and to terminate such agreements when the provider fails to comply substantially with the provisions of the agreements, the Medicare Act, or the applicable regulations, 42 U.S.C. § 1395(b)(2)(A). Specifically with regard to skilled nursing facilities, Congress has granted the Secretary the authority and discretion to “terminate a facility’s participation” in the Medicare program, 42 U.S.C. § 1395i-3(h)(2)(A)(i), where the Secretary finds that a facility’s deficiencies “immediately jeopardize the health or safety of its residents,” *id.* at (4).

A health care provider terminated from participation in the Medicare program by the Secretary is entitled to a hearing conducted pursuant to 42 U.S.C. § 405(b). 42 U.S.C. § 1395cc(h)(1)(A). After the hearing, the provider may seek judicial review of the Secretary’s decisions in the district court pursuant to 42 U.S.C. § 405(g). *Id.* And that is all the review afforded. As confirmed in 42 U.S.C. § 405(h), in relevant part:

¹ The Secretary’s authority over the Medicare and Medicaid programs has been delegated to CMS. 66 Fed. Reg. 35,437 (July 5, 2001); 46 Fed. Reg. 13,262-63 (March 9, 1977); 42 U.S.C. §§ 405(l), 1395ii.

No findings of fact or decision of the Commissioner of Social Security shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Commissioner of Social Security, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

This process of administrative hearing followed by district court review is the sole means for challenging a decision of the Secretary under the Medicare program. *See Jackson v. Astrue*, 506 F.3d 1349, 1353 (11th Cir. 2007) (holding that the judicial review provision in § 405(g) is “the exclusive source of federal court jurisdiction over cases involving [the programs under the Social Security Act].”)

I. The bankruptcy court’s orders implicated claims arising under the Medicare Act.

Bayou Shores argues that, because the bankruptcy court orders did not involve a dispute regarding a right to payment under Medicare, the orders did not involve a matter “arising under” the Medicare Act. [Brief at 57]. This argument is emblematic of Bayou Shores’ bankruptcy-focused myopia: because “claim” refers to a right to payment in a bankruptcy context, it must mean a right to payment in the Medicare context as well. There is no basis for this conclusion. The question of whether a dispute over the termination of Medicare and Medicaid provider agreements “arises under” the Medicare Act is easily answered; it clearly does. As the Sixth Circuit explained in *Livingston Care Center, Inc. v. United States*, 934

F.2d 719, 721 (6th Cir. 1991), a claim for wrongful termination of a Medicare provider agreement should be excluded as “arising under” the Medicare Act. *See Affiliated Prof'l Home Health Care Agency v. Shalala*, 164 F.3d 282 (5th Cir. 1999) (holding that the jurisdictional bar set by § 405(g) applied to a challenge to the termination of a Medicare provider agreement). Indeed, Congress made explicit that the Secretary’s decision to terminate a Medicare provider agreement is a determination that fits squarely within the limitations set forth in § 405(h). *See* 42 U.S.C. § 1395cc(h)(1)(A) (“an institution or agency dissatisfied . . . with a determination described in subsection (b)(2) of this section shall be entitled . . . to judicial review of the Secretary’s final decision *after* such hearing as is provided in section 405(g) of this title”) (emphasis added). Bayou Shores cites no cases standing for the proposition that a bankruptcy court’s exercise of jurisdiction over a health care provider’s Medicare and Medicaid provider agreements does not involve a matter arising under the Medicare Act.

The fact that the cases cited by the district court involved monetary claims is of no significance. In the cited cases, the *Medicare decisions* at issue involved Medicare reimbursements. The courts in those cases correctly held that they lacked subject matter jurisdiction over those matters and correctly refused to adjudicate those issues. In this case, the Medicare decision at issue relates to the continued existence of Bayou Shores’ Medicare and Medicaid provider

agreements. The bankruptcy court lacked subject matter jurisdiction to adjudicate that issue. Bayou Shores does not present any cases to support the principle that the jurisdictional bar in § 405(h) applies *only* to monetary claims. In fact, the Supreme Court has explicitly rejected such a notion. *See Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 3 (2000) (refusing to “accept a distinction that limits § 405(h)'s scope to claims for monetary benefits”).

Bayou Shores also argues that the bankruptcy court’s orders did not involve a claim arising under the Medicare Act where the bankruptcy court’s orders determined under bankruptcy law whether the provider agreements constituted property of the estate under 11 U.S.C. § 541 and whether they could be assumed pursuant to 11 U.S.C. § 365. [Brief at 58]. However, the bankruptcy court’s attempts to make such determinations pursuant to bankruptcy law does not somehow exempt those actions from the jurisdictional bar of section 405(h), where those determinations necessarily involve matters arising under the Medicare Act.

Bayou Shores’ argument on this point is belied by the very case that Bayou Shores identified as “instructive.” [Brief at 57]. In *In re St. Johns Home Health Agency, Inc.*, 173 B.R. 238 (Bankr. S.D. Fla. 1994), the debtor was the subject of an audit conducted under the auspices of CMS’ predecessor, the Health Care Financing Administration (“HCFA”). The purpose of the audit was in part to determine the amount of any overpayments. *St. Johns*, 173 B.R. at 241. The

debtor moved the bankruptcy court to assume its Medicare provider agreement and concomitantly to determine (on a “‘provisional’ basis”) the amount of any defaults for the purposes of 11 U.S.C. § 365(b). *Id.* The debtor’s trustee argued that, because the assumption of the Medicare provider agreement constituted a “core proceeding” under bankruptcy law, the bankruptcy court had jurisdiction to determine the amount of any defaults pursuant to 11 U.S.C. § 365(b). *Id.* at 242. The Bankruptcy Court for the Southern District of Florida held that § 405(h) deprived it of jurisdiction to consider claims related to Medicare reimbursement prior to the exhaustion of administrative remedies. *Id.* at 248. Finding that the determination of prepetition overpayments was “[p]art and parcel” of the debtor’s trustee’s request to assume the Medicare provider agreement, the court held that for the bankruptcy court to make such a determination “would be in contravention of 42 U.S.C. § 405(h).” *Id.* at 242-243. Because the debtor’s business was “inextricably tied” to its relationship with HCFA, the court explained that the filing of a bankruptcy petition “does not confer upon a Medicare provider a right to immediate judicial review of Medicare overpayment determinations when that right is expressly denied outside of bankruptcy, and is precluded under the Medicare Act itself.” *Id.* at 245-246. The jurisdictional bar created by § 405(h) prevented the court from conducting a “core proceeding” under bankruptcy—in that case, to assume a Medicare provider agreement. In the same way, § 405(h)

prohibited the actions taken by the bankruptcy court below, notwithstanding the fact that these actions were “core proceedings” or pursuant to authority granted by the Bankruptcy Code.

Notwithstanding Bayou Shores’ attempts to distinguish its set of facts from those “arising under” the Medicare Act, there can be no real question that the bankruptcy court’s orders involved a matter “arising under” that Act. CMS terminated Bayou Shores’ Medicare (and Medicaid) provider agreements, and the bankruptcy court intervened to reverse, prevent, or delay the termination. The bankruptcy court’s orders were in direct opposition to CMS’ decision to terminate the provider agreements and for the purpose of protecting Bayou Shores from the effect of the termination.

II. The bankruptcy court’s orders violated the jurisdictional bar established by 42 U.S.C. § 405(h).

The central issue in this case—and the question of pressing legal significance—is whether the jurisdictional bar set by § 405(h) applies to bankruptcy courts. On its face, the second sentence of this provision is clear that “[n]o findings of fact or decision of [the Secretary] shall be reviewed by any person, tribunal, or governmental agency except as herein provided.” 42 U.S.C. § 405(h); *cf.* 42 U.S.C. § 1395ii. There is no exception in § 405 for bankruptcy courts. This fact alone ought to dispose of the matter: bankruptcy courts are not

authorized to interfere with the decisions of the Secretary (or CMS) in administering the Medicare program.

Notwithstanding the clarity of the second sentence of § 405(h), Bayou Shores argues that Congress created an exception from the jurisdictional bar for bankruptcy courts because the third sentence does not include a reference to 28 U.S.C. § 1334. Thus, Bayou Shores' "plain language" argument hinges not on what is written in the text of this statutory provision, but rather on what is omitted from a portion of it. The conclusions Bayou Shores wishes this Court to draw from that omission are directly contradicted by the sweeping scope of the second sentence of § 405(h). At most, Bayou Shores' argument results in an ambiguity in the meaning of § 405(h). There is no "plain" exception for bankruptcy courts.

Any alleged ambiguity is resolved, however, upon reference to the 1984 legislation that amended § 405. The amendment to § 405(h) was placed under the heading "Technical Corrections." Deficit Reduction Act of 1984, § 2663(a)(4)(D), Pub. L. No. 98-369, 98 Stat. 494, 1162 (1984). Granting jurisdiction over Medicare and Medicaid provider agreements to a court that had not previously enjoyed jurisdiction is no mere technical amendment. More importantly, an uncodified provision of this legislation provides that the amendments were not intended to alter "any right, liability, status, or interpretation which existed" under the previous legislation. *Id.* at § 2664(b), 98 Stat. 494, 1171-72.

There is no dispute that the prior version of § 405(h) precluded bankruptcy court jurisdiction. *See St. Johns*, 173 B.R. at 244 (prior version of § 405(h) “specifically barred bankruptcy jurisdiction.”) Indeed, this point is acknowledged even by the case upon which Bayou Shores relies most. *See First American Health Care of Georgia Inc. v. Dep't of Health & Human Servs.*, 208 B.R. 985, 988 (Bankr. S.D. Ga. 1996) (“As originally drafted, 42 U.S.C. Section 405(h) precluded bankruptcy jurisdiction over all disputes arising out of the Medicare program . . .”) (*Opinion vacated and superseded sub nom. on other grounds, First American Health Care of Georgia, Inc. v. U.S. Dep't of Health & Human Servs.*, No. 96-2007, 1996 WL 282149 (Bankr. S.D. Ga. Mar. 11, 1996)). If the 1984 amendment reversed this preclusion of bankruptcy court jurisdiction, then the amendment undeniably effected a substantive change. Such an amendment could hardly be called “technical” and it would certainly alter substantive rights, liabilities, statuses, and interpretations. But that is precisely what Congress explicitly stated it did *not* intend.

As it did below, Bayou Shores attempts to obscure the import of § 2664 of the Deficit Reduction Act of 1984 by dismissing it as mere “legislative history,” but this provision is not legislative history: it is the legislation itself. [Brief at 43]. Uncodified provisions of law – contained within the United States Statutes at Large – have the full force of law. *See U.S. Nat'l Bank of Oregon v. Independent*

Ins. Agents of America, Inc., 508 U.S. 439, 448 (1993) (“Though the appearance of a provision in the current edition of the United States Code is ‘prima facie’ evidence that the provision has the force of law, 1 U.S.C. § 204(a), it is the Statutes at Large that provides the ‘legal evidence of laws’”); *In re Blue Stone Real Estate, Constr. & Dev. Corp.*, 396 B.R. 555 (Bankr. M.D. Fla. 2008) (finding that uncodified provision of federal law is a “statute” for purposes of Rules of Bankruptcy Procedure).

Section 2664 is the most important evidence of legislative intent with respect to Congress’ amendment of § 405(h). It demonstrates unequivocally that, because bankruptcy court jurisdiction was precluded prior to the 1984 amendment, it must continue to be precluded afterwards. With a single exception addressed below, the cases cited by Bayou Shores do not even mention § 2664 in interpreting § 405(h). Even *First American*, which Bayou Shores cites precisely for its “best expla[nation]” of Congress’ intent in amending §405(h) and “thoughtful analysis” of legislative history, somehow misses this point. [Brief at 43-44]. See *First American*, 208 B.R. at 988-89. The failure of these courts to include § 2664 in their analyses seriously undermines the precedential value of these cases.

The one case Bayou Shores cites that discusses § 2664 is *In re Nurses’ Registry & Home Health Corporation*, 533 B.R. 590 (Bankr. E.D. Ky. 2015), but that court’s analysis is flawed. [Brief at 45-46]. The *Nurses’ Registry* court

acknowledges § 2664 and notes that the 1984 amendments to section 405(h) were classified as “Technical Corrections,” but downplays the significance of these provisions by seemingly attempting to “catch” Congress enacting substantive changes through purportedly technical amendments. *See Nurses’ Registry*, 533 B.R. at 595-96 (“[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.”) However, each of the examples the court provides of these supposedly substantive changes made under the cover of technical amendments fails: the examples provided are technical and non-substantive. Indeed, the “most remarkabl[e]” example the bankruptcy court cited of a substantive change was that the 1984 legislation “repealed an entire title of the SSA . . . which provided a program of unemployment benefits for federal seamen.” *Id.* at 596. The court concluded that if technical amendments “truly did not ‘chang[e] or affect[] any right,’ the Reconversion Unemployment Benefits for Seamen program is still federal law.” *Id.* However, a cursory research reveals that the Reconversion Unemployment Benefits for Seamen program ended in 1950—making the legislative change in 1984 surely technical.²

² National Commission on Unemployment Compensation, July 1980 Final Report, p. 228 (“This program ended on June 30, 1950.”) Available at: <http://babel.hathitrust.org/cgi/pt?id=mdp.39015008373212;view=1up;seq=7>.

Bayou Shores also relies upon the Third Circuit's decision in *In re University Medical Center*, 973 F.2d 1065 (3d Cir. 1992). [Brief at 25]. That case is particularly inapposite. Unlike here, *University Medical Center* did not deal with the question of whether a bankruptcy court can assert jurisdiction over a matter arising under the Medicare Act. The issue was, rather, that the matter in question did not arise under the Medicare Act at all.

However, the *University Medical Center* decision does have bearing in this case to the extent that it provides guidance regarding a bankruptcy court's jurisdiction over a matter that does arise under the Medicare Act. The Third Circuit acknowledged that if the matter *had* arisen under the Medicare Act, it would be deprived of jurisdiction pursuant to § 405(h). *Id.* at 1073 (“*Our ability to exercise jurisdiction over this appeal* thus turns on whether UMC's claims actually arise under the Medicare statute”) (emphasis added). Thus, with regard to the central question in this appeal—whether bankruptcy courts can exercise jurisdiction over a matter arising under the Medicare Act, the Third Circuit's decision in *University Medical Center* supports AHCA's position, not that of Bayou Shores.

Numerous courts have concluded that § 405(h) prohibits bankruptcy courts from exercising jurisdiction over matters arising under the Medicare Act. *See, e.g., In re Hosp. Staffing Servs., Inc.*, 258 B.R. 53 (S.D. Fla. 2000); *In re St. Mary*

Hosp., 123 B.R. 14 (E.D. Pa. 1991); *U.S., Dep't of Health & Human Servs. v. James*, 256 B.R. 479 (W.D. Ky. 2000); *Excel Home Care, Inc. v. U.S. Dep't of Health & Human Servs.*, 316 B.R. 565 (D. Mass. 2004); *In re Home Comp Care, Inc.*, 221 B.R. 202 (N.D. Ill. 1998); *St. Johns*, 173 B.R. 238, *supra*; *In re Upsher Labs., Inc.*, 135 B.R. 117 (Bankr. W.D. Mo. 1991); *In re AHN Homecare, LLC*, 222 B.R. 804 (Bankr. N.D. Tex. 1998); *In re House of Mercy, Inc.*, 353 B.R. 867 (Bankr. W.D. La. 2006). These cases demonstrate that, where there is a direct conflict between Medicare law and the Bankruptcy Code, Medicare must prevail.

The Seventh Circuit's decision in *Bodimetric Health Services, Inc. v. Aetna Life & Casualty*, 903 F.2d 480 (7th Cir. 1990), also supports AHCA's interpretation of § 405(h). In *Bodimetric*, the Seventh Circuit was faced with the question of whether § 405(h) precludes a claim brought pursuant to diversity jurisdiction, 28 U.S.C. § 1332. *Bodimetric*, 903 F.2d at 488. Note that the relationship between § 405(h) and diversity jurisdiction is identical to the relationship between § 405(h) and bankruptcy jurisdiction: both bankruptcy and diversity jurisdiction were precluded prior to the 1984 amendments; neither is mentioned in the amended § 405(h). *See id.* The *Bodimetric* court acknowledged that the amended § 405(h) "on its face, appears to bar actions brought pursuant to federal question jurisdiction and actions brought against the United States but appears to permit actions brought pursuant to diversity jurisdiction," but held that

“a close reading of the statute (and its legislative history) does not support such a straightforward result.” *Id.* The Seventh Circuit proceeded to conduct the same analysis as above: citing to § 2664 of the Deficit Reduction Act of 1984, the court found that “Congress clearly expressed its intent not to alter the substantive scope of section 405(h).” *Id.* at 489. Based on this, the court held that “[b]ecause the previous version of section 405(h) precluded judicial review of diversity actions, so too must newly revised section 405(h) bar these actions.” *Id.* Any other result, the court held, “would contravene section 2664(b) by ‘changing or affecting [a] right, liability, status, or interpretation’ of section 405(h) that existed before the Technical Corrections were enacted.” *Id.*

Many courts have followed the Seventh Circuit’s reasoning in *Bodimetric*. See *Midland Psychiatric Assocs., Inc. v. United States*, 145 F.3d 1000, 1004 (8th Cir. 1998) (finding “the Seventh Circuit’s analysis persuasive” and holding that “the jurisdictional bar imposed by sentence three of § 405(h) extends to claims based on diversity of citizenship”); *Nichole Med. Equip. & Supply, Inc. v. TriCenturion, Inc.*, 694 F.3d 340, 347 (3d Cir. 2012) (holding that a party’s “attempt to rely on the court’s diversity jurisdiction by filing under § 1332 is barred by § 405(h) if those claims ‘arise under’ the Medicare Act” because “Congress clearly prohibited federal courts from exercising subject matter jurisdiction or diversity jurisdiction over claims arising under the Act”); *Allstar Care Inc. v. Blue*

Cross & Blue Shield of S. Carolina, 184 F. Supp. 2d 1295, 1298-99 (S.D. Fla. 2002) (holding that “the original understanding of § 405(h) continues to control” because “a literal interpretation of § 405(h), as revised, would change or affect ‘a right, liability, status, or interpretation’ existing prior to” the 1984 amendment); *Potts v. Rawlings Co., LLC*, 897 F. Supp. 2d 185, 191 (S.D.N.Y. 2012) (“[T]he Seventh Circuit persuasively reasoned, based on the legislative history of the relevant provisions, that section 405(h) was, in fact, meant to bar jurisdiction based on diversity as well”); *Caregivers Plus, Inc. v. Thompson*, 311 F. Supp. 2d 728, 734 (N.D. Ind. 2004) (holding that “Congress did not intend to exclude claims of state law violations brought pursuant to diversity jurisdiction from the jurisdictional bar of section 405(h)”).

The Seventh Circuit’s analysis in *Bodimetric*—as well as that of each of the numerous courts which have followed *Bodimetric*—applies with equal force to bankruptcy court jurisdiction as to diversity jurisdiction, and for the exact same reason. Because the previous version of § 405(h) precluded bankruptcy court jurisdiction over matters arising under the Medicare Act, so too must the revised § 405(h) bar these actions.

The Ninth Circuit is the only circuit court to hold that § 405(h) does *not* preclude bankruptcy court jurisdiction. See *In re Town & Country Home Nursing Servs., Inc.*, 963 F.2d 1146 (9th Cir. 1991). Its reasoning is unpersuasive,

however, as it—like most of the cases Bayou Shores relies upon—completely ignores § 2664 of the Deficit Reduction Act of 1984, the very provision that led the Seventh Circuit to conclude that diversity jurisdiction remains precluded post-1984 under § 405(h). Incredibly, the Ninth Circuit in a subsequent case *relied upon* the Seventh Circuit’s “perfectly applicable” decision in *Bodimetric* for the principle “that ‘litigants who have been denied benefits’ should not be allowed to obtain federal jurisdiction by ‘recharacterizing their claims under state and federal causes of action.’” *Kaiser v. Blue Cross of California*, 347 F.3d 1107, 1114 (9th Cir. 2003). The Ninth Circuit later attempted to reconcile *Kaiser* with *Town & Country*, with which it “might seem to conflict.” *Do Sung Uhm v. Humana, Inc.*, 620 F.3d 1134, 1141 n.11 (9th Cir. 2010). The court reasoned that because *Town & Country* “relies almost exclusively on the special status of § 1334’s ‘broad jurisdictional grant over all matters conceivably having an effect on the bankruptcy estate . . .’ its reading of 42 U.S.C. § 405(h) can reasonably be understood to apply only to actions brought under § 1334, while not bearing on the relationship between § 405(h) and other jurisdictional provisions such as § 1332.” *Id.* Here, the Ninth Circuit gets it exactly backwards: the question is not whether the reasoning in *Town & Country* applies to diversity jurisdiction, but rather whether the reasoning in *Bodimetric* applies to bankruptcy court jurisdiction, which it undeniably does. The Ninth Circuit’s confused law on the issue can thus be

summarized as follows: the jurisdictional bar in § 405(h) applies to diversity jurisdiction despite its omission from the current version of the statute because it applied to diversity jurisdiction prior to the 1984 amendment and Congress did not intend to effect any substantive changes in its 1984 amendment; however, § 405(h)'s jurisdictional bar *does not* apply to bankruptcy jurisdiction because it is omitted from the current version (though not the prior version) of the statute and this omission, considering the special status of § 1334's broad jurisdictional grant, is a clear sign that Congress intended to effect a substantive change in its 1984 amendment. Such legal reasoning does not invite adoption.

III. The bankruptcy court lacked jurisdiction over Bayou Shores' Medicaid provider agreement to the same extent it lacked jurisdiction over Bayou Shores' Medicare provider agreement.

Federal law requires that a state terminate a provider from its Medicaid program where that provider has been terminated from the Medicare program. 42 U.S.C. § 1396a(a)(39) (a state Medicaid agency “shall . . . terminate the participation of any individual or entity in such program if . . . participation of such individual or entity is terminated under [the Medicare program]”). The prohibition on payment “during such period” makes clear that the termination from Medicaid must be temporally coterminous with the termination from Medicare. Likewise, Florida law requires AHCA to “immediately . . . terminate” a provider from the Florida Medicaid program where that provider has been terminated from the

Medicare program by CMS. Fla. Stat. § 409.913(14); *see also Livingston Care Ctr., Inc. v. United States*, 934 F.2d 719, 720 (6th Cir. 1991) (“The Secretary of Health and Human Services's termination of the plaintiffs' Medicare certification automatically triggered termination of plaintiffs' Medicaid certification as well.”); *N. Health Facilities, Inc. v. United States*, 39 F. Supp. 2d 563, 567 n.2 (D. Md. 1998) (“Termination from Medicaid is automatic upon termination from Medicare.”) (citation omitted); *Northwest Healthcare, L.P. v. Sullivan*, 793 F. Supp. 724, 726 (W.D. Tex. 1992) (“When the Secretary notifies the [state] that he has terminated a Medicare agreement with a skilled nursing facility, the Medicaid agreement with that facility must also be terminated, effective on the same date as the Medicare termination.”).

While the statutory provisions linking the status of a provider's Medicare agreement to the status of its Medicaid agreement apply to all types of providers participating in the two programs, the connection between Medicare and Medicaid is particularly close in the case of skilled nursing facilities. This is because skilled nursing facilities are governed by a single regulatory regime applicable to both programs. The same certification procedures determine whether a skilled nursing facility is qualified to participate in both Medicare and Medicaid. *See* 42 C.F.R. § 488.330(b). Where a survey conducted by the state results in a finding of noncompliance with the regulatory scheme governing Medicare and Medicaid

skilled nursing facilities, the state is required to “impose remedies promptly on any provider of services participating in the Medicaid program”; and this requirement is “[n]otwithstanding any provision of State law.” 42 C.F.R. § 488.330(e)(1). The same finding of immediate jeopardy can result in the termination of provider agreements under both Medicare and Medicaid. *See* 42 C.F.R. § 488.410(a), (c).

The July 22, 2014 letter from CMS terminating Bayou Shores from the Medicare program evidences this close connection. The letter noted that a skilled nursing facility must meet the requirements in the federal regulations in order to qualify for participation in both the Medicare and Medicaid programs. [D.C. Doc. 1-20 at 1]. The letter noted that the survey was intended “to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid program” and announced the finding that the Facility “was not in substantial compliance with the participation requirements.” [D.C. Doc. 1-20 at p. 1 (emphasis added)]. The letter notified Bayou Shores that “Medicare and Medicaid payments” would only continue for 30 days and that “any filing of Medicare and Medicaid claims for new admissions” after July 24, 2014, could result in serious penalties under the law. [D.C. Doc. 1-20 at p. 2 (emphasis added)].

As a result of this close connection, CMS’ decision to terminate Bayou Shores’ Medicare provider agreement also constituted a decision to terminate

Bayou Shores' Medicaid provider agreement. Thus, pursuant to § 405(h), the bankruptcy court lacked subject matter jurisdiction over the Medicaid provider agreement to the same extent that it lacked subject matter jurisdiction over the Medicare provider agreement. Therefore, Bayou Shores' attempt to separately moot AHCA's appeal should be rejected. [Brief at 53-54].

A reversal of the district court's orders with respect to the Medicaid provider agreement only would lead to an absurd result. A provider's Medicaid provider agreement cannot be assumed in bankruptcy following the termination of its Medicare provider agreement. Such an agreement would be an illegal and unenforceable contract. *See* 42 U.S.C. § 1396a(a)(39); Fla. Stat. § 409.913(14). In Florida, "an agreement which violates a statute or is contrary to public policy is illegal, void and unenforceable." *Bond v. Koscot Interplanetary, Inc.*, 246 So. 2d 631, 634 (Fla. 4th DCA 1971).

While bankruptcy law may consider a Medicaid provider agreement to be property for the purposes of 11 U.S.C. § 541(a), the "nature of the interest" is defined by non-bankruptcy law. *In re Livingston*, 804 F.2d 1219, 1221 (11th Cir. 1986). The applicable non-bankruptcy law defines the right to a Medicaid provider agreement as *subject to* the status of the provider's Medicare provider agreement. U.S.C. § 1396a(a)(39), Fla. Stat. § 409.913(14). If Bayou Shores' Medicare

provider agreement has been terminated, Bayou Shores has no legal right to its Medicaid provider agreement.

IV. The district court properly denied Bayou Shores' motions to dismiss AHCA's appeals.

A. AHCA's appeal of the bankruptcy court's September 5, 2014 Order was not constitutionally moot.

Bayou Shores appeals two orders of the district court denying three of Bayou Shores' motions to dismiss. [D.C. Doc. Nos. 20, 31, 54, 61, 65]. Bayou Shores argues that, because the bankruptcy court's injunction and the automatic stay expired on January 9, 2015, the appeals brought by AHCA and HHS of the bankruptcy court's September 5, 2014 Order were moot as they no longer presented a live "case" or "controversy" under Article III of the U.S. Constitution.

Yet even Bayou Shores acknowledges the "possib[ility]" the bankruptcy court's conclusion that the Medicare and Medicaid provider agreements had not terminated by the time Bayou Shores filed its bankruptcy petition remains live. [Brief at 21]. With this, Bayou Shores concedes that the district court addressed a live controversy in its Reversal Order and not a moot issue. Thus, even if some aspects of the bankruptcy court's September 5, 2014 Order were moot, the appeals brought by AHCA and HHS were not moot.

Importantly, however, other aspects of the September 5, 2014 Order were *not* moot. Ordinarily an appeal from a preliminary injunction becomes moot upon

the issuance of a permanent injunction. *See Cont'l Training Servs., Inc. v. Cavazos*, 893 F.2d 877 (7th Cir. 1990). However, there are circumstances where the “substantive validity of the final injunction does *not* establish the substantive validity of the preliminary one.” *Grupo Mexicano de Desarrollo S.A. v. Alliance Bond Fund, Inc.*, 527 U.S. 308, 315 (1999) (emphasis in original). Where, as here, a preliminary injunction “was issued not to enjoin unlawful conduct, but rather to render unlawful conduct that would otherwise be permissible, in order to protect the anticipated judgment of the court,” a party may “have been harmed by issuance of the unauthorized preliminary injunction.” *Id.*

The bankruptcy court’s September 5, 2014 Order has continuing validity in spite of its expiration in that it serves as a bar to any efforts of AHCA and HHS to recover the Medicaid and Medicare funds paid to Bayou Shores while the September 5, 2014 Order was in effect. In this way it continues to present a live controversy and is not moot. *See In re Kmart Corp.*, 434 F.3d 536, 538 (7th Cir. 2006) (“a concrete dispute about damages preserves a justiciable controversy about whether the injunction was valid, even though no prospective relief remains in dispute”).

B. The district court did not err in denying Bayou Shores' motion to dismiss AHCA's appeal of the Confirmation Order based on waiver and failure to preserve issues for appeal.

Bayou Shores argues that AHCA failed to preserve its right to attack the bankruptcy court's Confirmation Order because AHCA did not file a written objection to the reorganization plan. However, HHS filed a timely written objection [Bk. Ct. Doc. 242], which AHCA orally joined at the hearing held on December 22, 2014. [Bk. Ct. Doc. 281 at 65]. The bankruptcy court clearly accepted AHCA's joinder of HHS' objection, and Bayou Shores failed to assert any objection to AHCA's method of joinder at the time. Thus, Bayou Shores has failed to preserve the issue of whether AHCA's oral adoption was valid.

Even if AHCA had failed to preserve its right to attack the Confirmation Order, the district court did not err in denying Bayou Shores' motion to dismiss because *AHCA was not required to preserve any rights*. AHCA's appeal of the Confirmation Order challenged the subject-matter jurisdiction of the bankruptcy court. Issues of subject-matter jurisdiction "can never be forfeited or waived." *United States v. Cotton*, 535 U.S. 625, 630 (2002); *see also Scarfo v. Ginsberg*, 175 F.3d 957, 960 (11th Cir. 1999) ("parties cannot waive subject matter jurisdiction, and [the Eleventh Circuit] may consider subject matter jurisdiction claims at any time during litigation"); *Paul v. F.D.I.C.*, 91 F.3d 110, 113 (11th Cir. 1996) (a party "does not have the power here to waive any objection to subject

matter jurisdiction”). Thus, any alleged failure of AHCA to preserve the issue of subject matter jurisdiction is irrelevant: AHCA was not required to preserve the issue in order to raise it on appeal. Indeed, even if AHCA failed to raise the issue of subject matter jurisdiction on appeal, the district court would have been obligated to take up any such issues *sua sponte*. See *Mallory & Evans Contractors & Eng’rs, LLC v. Tuskegee Univ.*, 663 F.3d 1304, 1304 (11th Cir. 2011) (Even where issue of subject matter jurisdiction is “not contested” the appellate court is “obligated to raise concerns about the [lower court’s] subject matter jurisdiction *sua sponte*.”)

C. AHCA’s appeal of the bankruptcy court’s Confirmation Order was not equitably moot.

Bayou Shores argues that AHCA’s appeal of the Confirmation Order was equitably moot because Bayou Shores’ Chapter 11 plan has already been substantially consummated. [Brief at 55]. Even if substantial consummation has already occurred, the substantial confirmation of the plan by Bayou Shores cannot confer subject matter jurisdiction on a bankruptcy court that otherwise lacked such jurisdiction. See *In re Canion*, 196 F.3d 579, 585 (5th Cir. 1999) (“parties cannot confer subject matter jurisdiction on federal courts”). Moreover, as stated above, a lack of subject matter jurisdiction may be challenged at *any stage* of the litigation. See *Arbaugh v. Y&H Corp.*, 546 U.S. 500, 506 (2006) (“The objection that a federal court lacks subject-matter jurisdiction . . . may be raised by a party, or by a

court on its own initiative, at any stage in the litigation, even after trial and the entry of judgment.”).

Plaintiff relies heavily on this Court’s decision in *In re Club Associates*, 956 F.2d 1065 (11th Cir. 1992), but that case is not applicable here. [Brief at 4, 7, 19, 20-22, 52-53, 55]. *In re Club Associates* involved a creditor challenging a debtor’s reorganization plan on the grounds that the creditor should have gotten a greater share of debtor’s property under the plan. It is easy to see why substantial consummation would be of great importance in such a context. If the payments and distributions under the plan are already well under way, it would be inequitable and impracticable to unwind that process for a court to recalculate which creditors get paid what amounts. However, such issues are not relevant in this case. AHCA did not challenge the bankruptcy court’s Confirmation Order in an attempt to secure a redistribution of funds that may have already been paid to other creditors. Indeed, as AHCA is not a creditor below, AHCA is not seeking payment under the reorganization plan at all. AHCA’s appeal of the Confirmation Order was solely based on a lack of subject matter jurisdiction. Thus, the district court’s reversal of the Confirmation Order has not and will not require Bayou Shores or the bankruptcy court to undo or recoup payments made under the plan.

Substantial consummation does not have some talismanic effect that automatically renders a case moot, especially in a case like this. The question is

“whether the reorganization plan has been so substantially consummated **that effective relief is no longer available.**” *Miami Center Ltd. P’ship v. Bank of New York*, 820 F.2d 376, 379 (11th Cir. 1987) (emphasis added). As this Court has noted, “substantial consummation by itself does not resolve the issue,” because “[e]ven if substantial consummation has occurred, a court must still consider all the circumstances of the case to decide whether it can grant effective relief.” *In re Club Assocs.*, 956 F.2d at 1069. Here, the district court clearly saw that effective relief could be (and was) granted to AHCA and HHS. Bayou Shores’ Medicaid and Medicare provider agreements can be finally terminated without having to undo anything that has occurred under the reorganization plan thus far. Moreover, the relief AHCA and HHS seek would not prejudice the rights of absent third parties, because neither Bayou Shores’ residents nor its creditors have any enforceable right to Bayou Shores’ continued participation in the Medicare or Medicaid programs. *See O’Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773 (1980) (holding that nursing home residents have no right to challenge the nursing home’s termination from Medicare and Medicaid); *Erickson v. U.S. ex rel. Dep’t of Health & Human Servs.*, 67 F.3d 858, 862 (9th Cir. 1995) (holding that providers “do not possess a property interest in continued participation in Medicare, Medicaid, or the federally-funded state health care programs”).

This Court's decision in *In re Lett*, 632 F.3d 1216 (11th Cir. 2011), is instructive here. In that case, a creditor wished to challenge a confirmed reorganization plan but failed to assert its issues before the bankruptcy court and failed to obtain a stay pending appeal. *In re Lett*, 632 F.3d at 1220. The Court held that the debtor had "not 'substantially consummated its reorganization plan to the extent that it [has] become[] legally and practically impossible to unwind that which has already been done.'" *Id.* at 1226 (internal citations omitted). This decision was based in part on the fact that the appellant did "not seek to undo or have [the debtor] recoup payments made to secured creditors" *Id.* The Court's reasoning applies equally to the present case.

The requirement that a court possess subject matter jurisdiction in order to act "is inflexible and without exception." *King Iron Bridge & Mfg. Co. v. Cnty. of Otoe*, 120 U.S. 225, 225 (1887). Likewise, when an appellate court recognizes that the lower court lacked subject matter jurisdiction, "it is called to act." *Id.* In contrast, equitable mootness is a *prudential* doctrine "under which the district court may dismiss a bankruptcy appeal" *In re Charter Commc'ns, Inc.*, 691 F.3d 476, 481 (2d Cir. 2012) (emphasis added); *see also In re Semcrude, L.P.*, 728 F.3d 314, 318 (3d Cir. 2013) (cautioning that the doctrine's "judge-made origin, coupled with the responsibility of federal courts to exercise their jurisdictional mandate, obliges [courts] . . . to proceed most carefully before dismissing an

appeal as equitably moot”); *Matter of Vineyard Bay Dev. Co., Inc.*, 132 F.3d 269, 271 (5th Cir. 1998) (holding that the “equitable mootness doctrine is prudential rather than jurisdictional”); *S. Pac. Transp. Co. v. Voluntary Purchasing Groups, Inc.*, 246 B.R. 532, 533 (E.D. Tex. 2000) (holding that the doctrine of “[e]quitable mootness does not implicate an appellate court's jurisdiction but is a matter of discretion”). Considering the inflexible nature of subject matter jurisdiction against the discretionary nature of equitable mootness, the district court did not err in denying Bayou Shores’ motions to dismiss and reversing the bankruptcy court’s Confirmation Order.

CONCLUSION

The district court’s Reversal Order should be affirmed.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I certify that this brief complies with Federal Rule of Appellate Procedures 32(a)(7). This brief was prepared using a 14-point, proportionally spaced font, and contains 10,832 words.

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No. 15-13731-FF
In The United States Court of Appeals
for the Eleventh Circuit

FLORIDA AGENCY FOR HEALTH CARE
ADMINISTRATION,

and

Plaintiffs - Appellees

THE UNITED STATES OF AMERICA, ON BEHALF
OF THE SECRETARY OF THE UNITED STATES
DEPARTMENT OF HEALTH AND HUMAN
SERVICES,

v.

BAYOU SHORES, SNF, LLC,

Defendant - Appellant.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF FLORIDA, TAMPA DIVISION

Case No. 8:14-cv-02816-T-30 (Lead Case) as consolidated with
8:14-cv-02617-T-30; 8:15-cv-00103-T-30; 8:15-cv-00128-T-30

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**CERTIFICATE OF INTERESTED PERSONS AND CORPORATE
DISCLOSURE STATEMENT BY COUNSEL FOR APPELLANT**

Appellant, Bayou Shores, SNF, LLC, (“Bayou”), by and through its undersigned counsel and pursuant to Rule 26.1 of the Federal Rules of Appellate Procedure and Eleventh Circuit Rule 26.1, hereby re-files its certificate of interested persons and corporate disclosure statement and identifies the following persons and entities:

CORPORATE DISCLOSURE STATEMENT

In accordance with Fed. R. App. P. 28(a)(1), 26.1(a) and Eleventh Circuit Rule 26.1-2, Bayou files this statement disclosing that no parent corporation or any publicly held corporation owns or has ever owned any stock in Bayou.

CERTIFICATE OF INTERESTED PERSONS

The following persons and entities have an interest in the outcome of this case:

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TABLE OF CONTENTS

CERTIFICATE OF INTERESTED PERSONS AND CORPORATE DISCLOSURE STATEMENT.....	C-1
I. The Plain and Unambiguous Language of § 405(h) Does Not Require Administrative Exhaustion and Does Not Bar Bankruptcy Court Jurisdiction over Medicare- Related Issues or Medicare/Medicaid provider agreements.....	1
II. The Bankruptcy Court Did Not Exceed its Subject Matter Jurisdiction in Reviewing, <i>de novo</i> , Issues Arising under Title 11.....	14
III. HHS Cannot Use “Evidence” it Failed to Present to the Bankruptcy Court in Support of This Case on Appeal.....	19
IV. Applying the Equitable Mootness Doctrine is Absolutely Merited Under the Law and the Facts.....	21
V. Appellees Place Unproven Allegations Before Every Federal Court in this Appeal Despite Arguing The Allegations are Unreviewable.....	28
CONCLUSION.....	30
CERTIFICATE OF COMPLIANCE.....	32
CERTIFICATE OF SERVICE.....	32

TABLE OF AUTHORITIES

	Page(s)
Cases	
<i>Ashbrook v. Block</i> , 917 F.2d 918 (6th Cir. 1990)	13
<i>Beeman v. BGI Creditor’s Liquidating Tr. (In re BGI, Inc.)</i> , 772 F.3d 102 (2d Cir. 2014) cert. denied, 136 S. Ct. 155 (2015).....	17
<i>CBS Inc. v. Primetime 24 JV</i> , 245 F.3d 1216 (11th Cir. 2001)	1
<i>In re Club Associates</i> , 956 F.2d 1065, 1069, n. 11 (11th Cir. 1992)	21, 28
<i>Do Sung Uhm v. Humana, Inc.</i> , 620 F.3d 1134 (9th Cir. 2010)	11, 12
<i>Exxon Mobil Corp. v. Allapattah Servs., Inc.</i> , 545 U.S. 546 (2005).....	8
<i>Fietz v. Great Western Savings (In re Fietz)</i> , 852 F.2d 455 (9th Cir. 1988)	12
<i>Fla. Dep’t of Revenue v. Piccadilly Cafeterias, Inc.</i> , 554 U.S. 33 (2008).....	17, 18
<i>In re Herrington</i> , 374 B.R. 133 (Bankr. E.D. Pa. 2007)	10
<i>In re Jason Realty, L.P.</i> , 59 F.3d 423 (3d Cir. 1995)	17, 18
<i>Katchen v. Landy</i> , 382 U.S. 323	9
<i>Kenny v. Block (In re Kenny)</i> , 75 B.R. 515 (Bankr.E.D.Mich.1987).....	11

<i>The Kilbarr Corp. v. Gen. Servs. Admin. (In re Remington Rand Corp.),</i> 836 F.2d 825 (3rd Cir. 1988)	11
<i>King v. Burwell,</i> 135 S.Ct. 2480 (Scalia, J., dissenting)	9
<i>King v. St. Vincents Hosp.,</i> 502 U.S. 215 (1991)	14
<i>In re Kmart Corp.,</i> 434 F.3d 536 (7th Cir. 2006)	27, 28
<i>Kozak v. Hillsborough Cty., Fla.,</i> 644 F.3d 1347 (11th Cir. 2011)	14, 16
<i>Lamie v. United States Tr.,</i> 540 U.S. 526 (2004)	8
<i>In re Lett,</i> 632 F.3d 1216 (11th Cir. 2011)	17, 18
<i>Lowery v. Ala. Power Co.,</i> 483 F.3d 1184 (11th Cir. 2007)	1
<i>Med. Transp. Mgmt. v. Comm’r,</i> 506 F.3d 1364 (11th Cir. 2007)	1
<i>Northern Pipeline Construction Co. v. Marathon Pipe Line Co.,</i> 458 U.S. 50 (1982)	9
<i>Nurses’ Registry and Home Health Corp. v. Burwell (In re Nurses’ Registry and Home Health Corp.),</i> 533 B.R. 590 (Bankr. E.D. Ky. 2015)	3, 5, 9
<i>In re R & W Enters.,</i> 181 B.R. 624 (Bankr. N.D. Fla. 1994)	9, 12, 13
<i>Rispler v. Spitz,</i> 377 F. App’x 111 (2d Cir. 2010)	20
<i>Shotz v. City of Plantation, Fla.,</i> 344 F.3d 1161 (11th Cir. 2003)	14

<i>Sullivan v. Town & Country Home Nursing Services, Inc. (In re Town & Country Home Nursing Services, Inc.),</i> 963 F.2d 1146 (9th Cir. 1991)	11, 12
<i>Theriot v. Parish of Jefferson,</i> 185 F.3d 477 (5th Cir. 1999)	20
<i>In re Town & Country Anderson v. F.D.I.C.,</i> 918 F.2d 1139 (4th Cir. 1990)	13
<i>United States v. Atl. Research Corp.,</i> 551 U.S. 128 (2007)	14
<i>United States v. Chafin,</i> --- F.3d ---, 2015 WL 6500852 (11th Cir. 2015)	1
<i>In re Univ. Med. Ctr.,</i> 973 F.2d 1065 (3rd Cir. 1992)	12, 13
<i>V.N.A. of Greater Tift County v. Heckler,</i> 711 F.2d 1020 (11th Cir. 1983)	18
<i>Washington-Dulles Transp. Ltd. v. Metro. Washington Airports Auth.,</i> 263 F.3d 371 (4th Cir. 2001)	2
<i>Weinstock v. Columbia Univ.,</i> 224 F.3d 33 (2d Cir. 2000)	20
<i>In re Zenith Electronics Corp.,</i> 250 B.R. 207 (D. Del. 2000)	21
Statutes	
1 U.S.C. § 112	2
11 U.S.C. § 105	13
11 U.S.C. § 105(a)	17
11 U.S.C. § 106	13
11 U.S.C. Section 106(a)	12
11 U.S.C. § 362	13

11 U.S.C. § 362(a)	16
11 U.S.C. § 365	13
11 U.S.C. § 541(a)	16, 18
11 U.S.C. § 1101(2)	22
28 U.S.C. §§ 157 and 1334	10, 18
28 U.S.C. § 1331	1
28 U.S.C. § 1331 and § 1346	9
28 U.S.C. § 1332	12
28 U.S.C. § 1334	<i>passim</i>
28 U.S.C. § 1334(b)	10, 11
28 U.S.C. § 1334(e)(1)	18
28 U.S.C. § 1346	1
42 U.S.C. § 405(g)	14, 15, 17, 18
42 U.S.C. § 405(h)	<i>passim</i>
42 U.S.C. § 405(h)	14, 15
42 U.S.C. § 422(b)(4)	5
42 U.S.C. § 1307	3, 4
42 U.S.C. § 1396a(a)(39)	13
28, U.S.C. section 1331 and 1346	7
All Writs Act	18
Bankruptcy Code § 365	19
Bankruptcy Reform Act of 1978	9
Deficit Reduction Act of 1984 (98 Stat. 1156)	2

DRA	3, 5, 7, 8
Fla Stat. § 409.907(2).....	13
House and Senate Reports on the Bankruptcy Reform Act.....	11
Medicare Act.....	18
Pub. L. No. 98-369, § 2663.....	<i>passim</i>
Pub. L. No. 98-369, § 2663(a)(4)(D)	5, 7
Pub. L. No. 98-369, § 2663(a)(15)(C)	5, 7
Pub. L. No. 98-369, § 2663(e)(2)(3)	3, 4
Pub. L. No. 98-369, § 2663(e)(2)(B)(3)	5, 7
Pub. L. No. 98-369, § 2663.....	8
Pub. L. No. 98-369, § 2664(b).....	2, 3, 8
Pub. L. No. 98-369, § 2663(a)(4)(D).....	2
Welfare Technical Corrections Act of 1997	6
Rules	
Bankruptcy Rule 3020(e).....	24
Eleventh Circuit Rule 26.1	1
Eleventh Circuit Rule 26.1-2	1
Fed. R. App. P. 28(a)(1), 26.1(a)	1
Fed. R. Bankr. P. 3020(e)	21, 25
Rule 25 of the Federal Rule of Appellate Procedure	32
Rule 26.1 of the Federal Rules of Appellate Procedure	1
Rule 3020(e).....	25

Other Authorities

42 C.F.R. § 488.456(c).....	20
2d Sess., <i>reprinted in</i> 1978 U.S.C.C.A.N. 5787	11
2d Sess., <i>reprinted in</i> 1978 U.S.C.C.A.N. 5963	11
Article III, United States Const.....	9
1 <i>Collier on Bankruptcy</i> at 3-22 (L. King, 15th ed. 1990)	10
H.R. REP. 98-432, 1659, 1984 U.S.C.C.A.N. 697	4
http://millercenter.org/oralhistory/interview/donna-shalala	7
http://uscode.house.gov/codification/legislation.shtml . Title 42	2
Rep. No. 95-595, 95th.....	11
S. Rep. No. 95-989, 95.....	11
Title 11, United States Code.	9

I. The Plain and Unambiguous Language of § 405(h) Does Not Require Administrative Exhaustion and Does Not Bar Bankruptcy Court Jurisdiction over Medicare-Related Issues or Medicare/Medicaid provider agreements.

A facial examination of the third sentence of § 405(h)¹ is fatal to Appellees' case on appeal because it clearly does *not* bar actions based upon bankruptcy court jurisdiction (§ 1334). The third sentence of § 405(h) plainly bars actions based upon federal question jurisdiction (§ 1331) and suits against the United States (§ 1346) to recover on claims arising under Subchapter II of Chapter 7 of Title 42 only. As detailed in Bayou's initial brief (pgs. 43–47), when the words of a statute are unambiguous, “judicial inquiry is complete.” *See, e.g., CBS Inc. v. Primetime 24 JV*, 245 F.3d 1216, 1222 (11th Cir. 2001).

The third sentence of § 405(h) is also not susceptible to more than one reasonable interpretation. *See United States v. Chafin*, --- F.3d ----, 2015 WL 6500852, at *5 (11th Cir. 2015) (citing *Med. Transp. Mgmt. v. Comm'r*, 506 F.3d 1364, 1368 (11th Cir. 2007)). Therefore, it is error for the Court to go beyond its plain language in search of an alternative meaning. *Lowery v. Ala. Power Co.*, 483 F.3d 1184, 1205 (11th Cir. 2007). On its face, § 405(h) simply does not subordinate § 1334 jurisdiction.

¹ All statutes referred to herein are printed in the statutory addendum hereto.

Nevertheless, AHCA² argues that the omission of § 1334 creates an ambiguity because “[g]ranting jurisdiction over Medicare and Medicaid provider agreements ... is no mere technical amendment.” AHCA Br. at 18. AHCA argues that the “ambiguity” can be resolved by resorting to the “Statutes at Large” which provide the legal evidence of the law. *Id.* It is true that, in the event of a discrepancy between the Statutes at Large and a codified version of the law, the former controls the latter.³ *Washington-Dulles Transp. Ltd. v. Metro. Washington Airports Auth.*, 263 F.3d 371, 378 (4th Cir. 2001) (*citing* 1 U.S.C. § 112). But here there is no discrepancy. Section 405(h) was as codified *exactly* as instructed. *See* 98 Stat. 1162, § 2663(a)(4)(D).

Faced with an unambiguous sentence codified exactly as § 2663(a)(4)(D) instructed, Appellees are left to argue that a different section (§ 2664(b)) contained in the Deficit Reduction Act of 1984 (“DRA”) (98 Stat. 1156), should control the interpretation of § 405(h). They also argue that changes to § 2663 were placed in a

² All capitalized terms herein shall have that same meaning ascribed in Bayou’s Initial Brief.

³ Title 11 and Title 28 are positive law titles and constitute legal evidence of the law. *See* <http://uscode.house.gov/codification/legislation.shtml>. Title 42 has not been enacted as a positive law title, and is thus only *prima facie* evidence of the law.

section called “Technical Corrections” and thus could not have effectuated substantive changes. There are multiple problems with Appellees’ arguments.

First, many *substantive* changes were made in § 2663 despite being placed under a “Technical Corrections” heading, “belying Congress’s blanket assertion that none of the technical amendments were intended to affect any preexisting rights or interpretations.” *See Nurses’ Registry and Home Health Corp. v. Burwell (In re Nurses’ Registry and Home Health Corp.)*, 533 B.R. 590, 596 (Bankr. E.D. Ky. 2015). Second, Section 2664(b) falls short as a model of clarity, is out of place under the heading “EFFECTIVE DATES,” and contains an ambiguity leading to absurdity under any construction.

Significant non-technical changes were made in § 2663. First, Congress directed a major substantive change to 42 U.S.C. § 1307 which, prior to the amendments in the DRA, applied only to women. Before the DRA, women could be subject to criminal liability for impersonating a “former wife divorced” of a Social Security beneficiary for purposes of obtaining benefit information.

However, the amendment to the DRA significantly and materially expanded the scope of criminal liability to include not only women but also men. The amendment made it a crime for a man to impersonate a: (i) divorced husband; (ii) surviving divorced husband; and also (iii) a surviving divorced father, in order to secure information about a woman’s Social Security number or benefits. Pub. L.

No. 98–369, § 2663(e)(2)(3). The amendment also expanded the scope of female criminal impersonations to make it a crime to pretend to be a surviving divorced wife or surviving divorced mother. Amending a statute to define three new types of criminal liability applicable to men where the previous statute applied only to women is not a merely “technical.” Additionally, expanding the scope of female criminal impersonations to make it a crime to pretend to impersonate two other categories of people—a surviving divorced wife or surviving divorced mother—is also not merely “technical.”⁴

If § 2664(b) is read in the manner Appellees urge and not a single amendment in § 2663 can be interpreted to change any construction, etcetera, previously existing under the “provisions of law involved” then § 1334—a provision *omitted* from § 2663(a)(4)(D) *and* its codification in § 405(h)—must be read *into* § 405(h). With respect to § 2663(e)(2)(3), five categories of criminal impersonations added in § 2663(e)(2)(3) as codified in § 1307 must be read *out of* 1307. If § 2664(b) compels this Court to disregard the § 2663 amendments as merely technical, it follows that five categories of impersonations that give rise to

⁴ See H.R. REP. 98-432, 1659, 1984 U.S.C.C.A.N. 697, 1281-82.

criminal liability are nullities, and that Social Security impersonators may still *only* be prosecuted for impersonating divorced *wives* of Social Security beneficiaries. *See Nurses' Registry*, 533 B.R. at 596.

Second, Congress directed another substantive change in the DRA to a statute, 42 U.S.C. § 422(b)(4), which had previously excepted “full-time students” between the ages of eighteen and twenty-two from a provision that generally mandated deductions from benefits of Social Security beneficiaries who refused to accept rehabilitation services. Pub. L. No. 98–369, § 2663(a)(15)(C). After the DRA, § 422(b)(4) pertained to students those same ages but limited it to “full-time elementary or secondary school students” rather than *all* full-time students. Thus, the statute no longer encompassed college students. If Appellees’ suggested interpretation of § 2664(b) is adopted, college students between the ages of eighteen to twenty-two would have continued to be excepted from § 422(b)(4) until the statute’s eventual repeal in 1999. *See* 533 B.R. at 596.

Certainly, § 2663 does contain many technical amendments, but also contains at least three amendments clearly intending and effectuating substantive change: § 2663(a)(4)(D); § 2663(a)(15)(C); and § 2663(e)(2)(B)(3). The substantive changes to each of these sections cannot be undone by their placement in a section called “technical corrections.” Oranges do not become apples when they are placed in a bin labeled “apples”; they remain oranges, despite being placed in the wrong bin.

Further, the language following the semicolon in § 2664(b) upon which Appellees so strenuously rely is out of place in a section supposedly just pertaining to the dates the changes in § 2663 would take effect, just like significant substantive changes appear out of place in a section called “Technical Corrections,” yet it is there they appear.⁵ However, § 2663(a)(4)(D), § 2663(a)(15)(C), and § 2663(e)(2)(B)(3) *as codified* are each clear and unambiguous and § 2664(b) is not.

⁵ As the excerpts below from an oral history interview of Donna Shalala, Secretary of Health and Human Services under President Clinton discussing changes to a welfare reform bill included in the Welfare Technical Corrections Act of 1997 reveal, substantive changes can be placed under a “technical corrections” heading merely for political reasons:

[Interviewer] Riley

“Did you also go back to the Hill and get some”—

[Interviewee] Shalala

“Yes, we went back to the Hill and got a whole set of changes, which they were willing to accept because they were under the radar by that time. We went back with a big bill with lots of changes.”

[Interviewer] Martin

“They weren’t just technical corrections”—

[Interviewee] Shalala

“No, we called them technical corrections but”—

continued on next page...

For example, the phrase “provisions of law involved” in § 2664(b) cannot be construed in a way that does not result in absurdity. The language may mean that none of the statutes being amended in § 2663 should be construed as changing or affecting any interpretation, etcetera, of the statutes before § 2663’s amendments. *But this construction reads all of the substantive amendments to § 2663(a)(4)(D), § 2663(a)(15)(C), and § 2663(e)(2)(B)(3) right out of the statutes, as codified, nullifying Congress’s actions in modifying those statutes under the DRA in the first instance.* Therefore, that construction cannot prevail.

Alternatively, as relevant to § 2663(a)(4)(D), the phrase “provisions of law involved” may be construed to refer to “section 1331 and 1346” *alone*. In other words, it refers to the provisions of law *remaining in* § 2663(a)(4)(D), and does not refer to provisions of law *removed from* § 2663(a)(4)(D). Certainly, a provision stricken is no longer a provision “involved.” The issue with this construction is that

...continued from previous page

[Interviewer] Martin

“Just for political cover?”

[Interviewee] Shalala

“Political cover.”

See, <http://millercenter.org/oralhistory/interview/donna-shalala>

many portions of § 2663 do not contain “provisions of law” in that they do not refer to explicit statutes as does § 2663(a)(4)(D). Ergo, § 2664(b) is ambiguous. An ambiguous, uncodified section (§2664(b)) in a title that has not been enacted into positive law (Title 42) should not be relied upon to construe the meaning of § 405(h) where § 405(h) does not preclude § 1334 jurisdiction on its face, and should also not be used to muddy the unequivocal grants of bankruptcy court jurisdiction (§ 1334 and § 157) in a title that has been enacted into positive law (Title 28) or to invoke sovereign immunity where such has been specifically abrogated in another positive law title (Title 11) by §106(a).

Obviously, several of § 2663’s changes are out of place in a “Technical Corrections” section of the DRA. Perhaps the substantive changes in § 2663(a)(4)(D), § 2663(a)(15)(C), and § 2663(e)(2)(B)(3) were inadvertently placed in the wrong section of the DRA. Or perhaps there were political reasons that resulted in their placement in that section. *See* n. 5, *supra*. This uncertainty, coupled with § 2664(b)’s ambiguity, means § 2664(b) cannot be relied upon to “fix” any purported unintentional omission of § 1334 from § 405(h). This is particularly so because the meaning of § 2663(a)(4)(D) as codified in the third sentence of § 405(h) is entirely clear. As the Supreme Court explained in *Exxon Mobil Corp. v. Allapattah Servs., Inc.*, 545 U.S. 546, 565 (2005), a statute may contain an unintentional drafting error, but “it is up to Congress rather than the courts to fix it.”

See also Lamie v. United States Tr., 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 to its intent. It is beyond our province to rescue Congress from its drafting errors...”)(internal quotation marks and alteration omitted).

“Generally, 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.” *Nurses Registry*, 533 B.R. at 595 (quoting *King v. Burwell*, 135 S.Ct. 2480, 2505 (Scalia, J., dissenting) (citation omitted)). If Congress believed it was foreclosing all federal jurisdiction over unexhausted Medicare claims by only referencing § 1331 and § 1346, it made a major substantive mistake in designing the third sentence of § 405(h) that the courts cannot fix. Here, the third sentence in § 405(h) must be enforced as written, and results in no absurdity. In fact, a plain language construction is entirely consistent with the purpose of Title 11 as recognized by the Supreme Court. *In re R & W Enters.*, 181 B.R. 624, 643 (Bankr. N.D. Fla. 1994) (chief purpose of the bankruptcy laws is to secure a prompt resolution and to avoid delay) (citing *Katchen v. Landy*, 382 U.S. 323, 328–329(1966)).

In *Northern Pipeline Construction Co. v. Marathon Pipe Line Co.*, 458 U.S. 50 (1982), the Supreme Court struck down a significant and important aspect of the

Bankruptcy Reform Act of 1978 as granting overly broad jurisdictional power to bankruptcy judges, violating Article III of the Constitution. The Supreme Court stayed its ruling first to October 4, 1982 and finally to December 24, 1982. When Congress failed to act during the stay, the district courts adopted an interim emergency rule, drafted by the Judicial Conference of the United States, to permit the continued processing of bankruptcy cases throughout the country. Both the stay and the emergency rule created chaos, confusion and disagreement among many of the district courts. Faced with a potential shutdown of the bankruptcy courts, Congress finally enacted the amendments to the Bankruptcy Code including revisions to 28 U.S.C. §§ 157 and 1334 which and “ga[ve] rise to the current core/non-core components of bankruptcy court jurisdiction.” *In re Herrington*, 374 B.R. 133, 139 (Bankr. E.D. Pa. 2007). In crafting 28 U.S.C. § 1334(b), Congress intended “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.” 1 *Collier on Bankruptcy*, ¶ 3.01 at 3-22 (L. King, 15th ed. 1990). The language in § 1334(b) on this point could not be clearer: bankruptcy courts have jurisdiction “*notwithstanding any Act*

of Congress that that confers exclusive jurisdiction on a court or courts other than the district courts.” 28 U.S.C. § 1334(b) (emphasis added).⁶

Chapter 11 reorganizations cannot be at the mercy of lengthy administrative proceedings. *The Kilbarr Corp. v. Gen. Servs. Admin. (In re Remington Rand Corp.)*, 836 F.2d 825, 833 (3rd Cir. 1988) (elevating the importance of finality in bankruptcy proceedings over timing of procedures in the Contract Dispute Act of 1978). If Congress intended a bankruptcy debtor to exhaust administrative remedies, it would have expressly so provided. *Kenny v. Block (In re Kenny)*, 75 B.R. 515 (Bankr.E.D.Mich.1987). However, neither 1334 nor 157 contain any administrative exhaustion requirement.

All circuits visiting the issues of whether § 405(h) precludes § 1334 bankruptcy jurisdiction have found that it does not. In 2010, the Ninth Circuit in *Do Sung Uhm v. Humana, Inc.*, 620 F.3d 1134 (9th Cir. 2010) confirmed its earlier ruling, and reasoning, in *Sullivan v. Town & Country Home Nursing Services, Inc.*

⁶ The House and Senate Reports on the Bankruptcy Reform Act explain that a primary reason for expanding bankruptcy court jurisdiction was to eliminate the serious delay and expense of litigation by having all matters and proceedings tried in one action before the bankruptcy court. S. Rep. No. 95-989, 95 Cong., 2d Sess., *reprinted in* 1978 U.S.C.C.A.N. 5787, 5803; H. Rep. No. 95-595, 95th Cong., 2d Sess., *reprinted in* 1978 U.S.C.C.A.N. 5963, 6010.

(*In re Town & Country Home Nursing Services, Inc.*), 963 F.2d 1146, 1155 (9th Cir. 1991) that § 1334 affords a “broad jurisdictional grant over all matters conceivably having an effect on the bankruptcy estate...” and that the special status of bankruptcy jurisdiction is different and distinct from the relationship between § 405(h) and other jurisdictional provisions such as § 1332. 620 F.3d at 1141, n.11. In *Town & Country*, the Ninth Circuit concluded that § 1334 “allows a single court to preside over all of the affairs of the estate, which promotes a ‘congressionally endorsed objective: the efficient and expeditious resolution of all matters connected to the bankruptcy estate.’” 963 F.2d at 1155 (quoting *Fietz v. Great Western Savings (In re Fietz)*, 852 F.2d 455, 457 (9th Cir. 1988)) (*see also In re Univ. Med. Ctr.*, 973 F.2d 1065, 1073-74 (3rd Cir. 1992) (“where there is an independent basis for bankruptcy court jurisdiction, exhaustion of administrative remedies pursuant to other jurisdictional statutes is not required”). In addition, “Section 106(a) is a separate, independent waiver of sovereign immunity, unhampered by administrative processes and requirements.” *In re R & W Enters.*, 181 B.R. at 643 (discussing government claims against the bankruptcy estate). “The exhaustion of administrative remedies, which may otherwise be jurisdictional outside of

bankruptcy, [is] unnecessary...”.⁷ 181 B.R. at 643 (citing *In re Univ. Med. Ctr.*; *In re Town & Country Anderson v. F.D.I.C.*, 918 F.2d 1139, 1143-44 (§ 106 avoids 28 U.S.C. § 2675(a) administrative exhaustion requirement) (4th Cir. 1990); *Ashbrook v. Block*, 917 F.2d 918, 922-23 (6th Cir. 1990) (holding § 106 contains no administrative exhaustion requirement). Sovereign immunity is specifically abrogated by § 106 in connection with bankruptcy court determinations under § 105, § 362, and § 365.

Moreover, § 405(h) did not operate as a jurisdictional bar to the Bankruptcy Court’s consideration of issues regarding a *state* Medicaid provider agreement. The un rebutted record before the Bankruptcy Court made clear that AHCA failed to utilize its own methodology for terminating a Medicaid provider agreement pursuant to Fla Stat. § 409.907(2). Additionally, 42 U.S.C. § 1396a(a)(39) does not suggest a Medicaid provider agreement is “automatically” terminated by HHS. Rather, AHCA (the State of Florida) has its own process to finalize termination. Florida administrative law does not prohibit federal bankruptcy court jurisdiction, nor could it, due to federal pre-emption under § 1334.

II. The Bankruptcy Court Did Not Exceed its Subject Matter Jurisdiction in Reviewing, *de novo*, Issues Arising under Title 11.

⁷ See discussion on 106 in Bayou’s Initial Brief, pgs. 37, 39, 49.

Assuming for the sake of argument that § 405(h) *does* supply a bar despite its plain language, AHCA suggests that only the second and third sentences in 405(h) are “relevant,” and that the first sentence need not be considered. (AHCA Br. at i, 13). AHCA’s approach must be rejected. “Statutes must ‘be read as a whole.’” *United States v. Atl. Research Corp.*, 551 U.S. 128, 135 (2007) (adjacent provisions are structurally linked and should be interpreted together) (*citing King v. St. Vincents Hosp.*, 502 U.S. 215, 221 (1991)); *Kozak v. Hillsborough Cty., Fla.*, 644 F.3d 1347, 1349-50 (11th Cir. 2011) *citing Shotz v. City of Plantation, Fla.*, 344 F.3d 1161, 1173 (11th Cir. 2003) (“Every statute must be viewed in its entirety so that each part has a sensible and intelligent effect harmonious with the whole”). Each sentence in § 405(h) bears a relationship to the other sentences therein. Sentences within the same paragraph cannot be severed without affecting the paragraph’s meaning. Therefore, § 405(h) must be read as a whole.

The first two sentences in § 405(h) are particularly linked; the first contemplates a hearing and the entry of findings and a decision binding upon the parties and the second prescribes the method for seeking their review. The plain language of § 405(g) supports this conclusion and a reading of § 405(h)’s first and second sentences together; the second sentence of § 405(h) explains that the Secretary’s final decision discussed in the first sentence of § 405(h) must be reviewed in the manner provided in § 405(g). Section 405(g) requires the decision

in the first sentence of § 405(h) to be reviewed by commencing a specific action within a specific time before a specific court in a specific place.

At the time of the confirmation hearing, Bayou's administrative case was only in the discovery stage⁸ (it has since progressed). When a final decision *is* finally rendered in the administrative forum, if the result is unfavorable to Bayou, Bayou can commence review under § 405(g). Bayou has not side-stepped the administrative process. To date, however, the Secretary has not issued the final ruling contemplated in § 405(h)'s first sentence. Because Bayou does not have a final decision or findings as contemplated in § 405(h)'s first sentence, it certainly could not offer them up to the Bankruptcy Court (as opposed to the appropriate district court designated by § 405(g)) for review.

Presumably, AHCA rejects the relevance of the first sentence of § 405(h) to urge the broadest possible reading of what AHCA describes to be the "sweeping scope of the second sentence" (AHCA Br. at 18) hoping to shield from review *anything* a Secretary decides, rather than just the Secretary's findings and final decision entered after a hearing or other appropriate final disposition. However, this Court should reject any reading of the first and second sentences in § 405(h) that

⁸ HHS acknowledges Bayou is pursuing its administrative remedies. HHS Br. at 29 n.5.

strips them of their obvious structural link because such a reading does not result in “a sensible and intelligent effect harmonious with the whole.” *Kozak*, 644 F.3d at 1349-50. Regardless, even if the Court does reject any linkage between the first and second sentences (which it should not), the Bankruptcy Court still did not violate any purported jurisdictional bar in § 405(h) because *it never passed on the merits of any findings or decision of the Secretary at all*.

Not only did the Bankruptcy Court have no final decision to review (as contemplated by the first sentence of § 405(h)), it also never reviewed or otherwise second-guessed the Secretary’s *initial* decision to terminate Bayou as a Medicare provider. The Bankruptcy Court evaluated only whether Bayou had any legal or equitable interests remaining in its Provider Agreements within the meaning of 11 U.S.C. § 541(a), and concluded it did after HHS failed to prove the Medicare provider agreement had finally and irreversibly terminated. Acknowledging Bayou was pursuing its rights in the proper administrative forum, the Bankruptcy Court ordered that the automatic stay applied pursuant to 11 U.S.C. § 362(a) (after Appellees failed to demonstrate otherwise) based largely upon the wording of the Patient Letter AHCA issued post-petition (see full discussion of Patient Letter in Bayou’s Initial Brief at 8-9), and granted preliminary injunctive relief (dissolved

last January)⁹ pursuant to 11 U.S.C. § 105(a) to protect Bayou’s interests in the Provider Agreements while Bayou sought to reorganize as a going concern.

A bankruptcy court’s primary objective in Chapter 11 is to preserve a debtor’s going concern value. *In re Jason Realty, L.P.*, 59 F.3d 423, 429 (3d Cir. 1995); *Beeman v. BGI Creditor’s Liquidating Tr. (In re BGI, Inc.)*, 772 F.3d 102, 107, n.8 (2d Cir. 2014) *cert. denied*, 136 S. Ct. 155 (2015) (quoting *Fla. Dep’t of Revenue v. Piccadilly Cafeterias, Inc.*, 554 U.S. 33, 37 n.2 (2008)) (“central purpose of Chapter 11 is to facilitate reorganizations rather than liquidations”); *In re Lett*, 632 F.3d 1216, 1218 (11th Cir. 2011) (Chapter 11 focuses on reorganization rather than liquidation) (quoting 554 U.S. at 51). If the Secretary’s initial decision to terminate a provider from Medicare was final and irreversible as Appellees claim, there is little point to the review § 405(g) provides. The establishment of a system of review proves that both: (i) an initial decision, and (ii) the final decision contemplated in the first sentence of § 405(h) may be reversed and are therefore not final. The existence of § 405(g) supports the Bankruptcy Court’s conclusion that the

⁹ This injunctive relief was dissolved approximately one year ago, which is why particular issues on appeal (those pertaining to § 105(a) and § 362(a)) before the District Court were constitutionally moot. The District Court erred in exercising jurisdiction over these moot issues and in entering the Reversal Order.

Provider Agreements had *not* finally and irreversibly terminated on the Petition Date and that they were property of the estate within the meaning of § 541(a) falling under the Bankruptcy Court's exclusive subject matter jurisdiction pursuant to § 1334(e)(1). Absent preliminary injunctive relief,¹⁰ Bayou would have gone out of business, which would, in turn, deprive the District Court of its eventual jurisdiction to review the Secretary's decision in accordance with § 405(g), and undermine the debtor's reorganization as a going concern. 59 F.3d at 429; 554 U.S. at 37, n.2; 632 F. 3d at 1218.

Subsequently, after Appellees failed to seek any stay of the September 5 Order, Bayou's Chapter 11 case proceeded to confirmation whereupon the Bankruptcy Court was called upon to consider whether Bayou could assume the Provider Agreements. (See Bayou's Initial Br. at 48-50, explaining the Bankruptcy

¹⁰ HHS cites to *V.N.A. of Greater Tift County v. Heckler*, 711 F.2d 1020 (11th Cir. 1983) to argue injunctive relief is barred. Obviously, *Heckler* was decided *before* the enactment of revisions to 28 U.S.C. §§ 157 and 1334 in 1984 which significantly expanded bankruptcy court jurisdiction. Furthermore, HHS misconstrues *Heckler*, which held that the All Writs Act empowers district courts to enjoin the suspension by the Secretary of Health and Human Services of reimbursement payments to Medicare providers before providers have exhausted administrative remedies required by the Medicare Act. The issuance of an injunction pending review of an agency action is not prohibited; it is merely subject to higher standards. Moreover, the issue regarding injunctive relief in this case has been moot since January 2014, when all injunctive relief was dissolved by the Confirmation Order.

Court's jurisdiction to consider plan confirmation and assumption of executory contracts). In doing so, the Bankruptcy Court *still* did not pass on the merits of any findings or decision of the Secretary, other than to *liberally assume the truth of AHCA's findings against Bayou*.

[T]his Court, as part of its executory contract analysis discussed below, assumes that the Debtor was, in fact, in noncompliance. Because this Court assumes the Debtor was in noncompliance, it is not reviewing any findings of fact or agency decision, and as a consequence, 42 U.S.C. § 405(h) does not preclude this Court from considering whether the Debtor can assume its Medicare provider agreement under Bankruptcy Code § 365. (R. Doc. 45-36, p. 11).

Therefore, any claim that the Bankruptcy Court exercised jurisdiction over a Medicare determination or reviewed a final decision of the Secretary by entering the Confirmation Order is incorrect. The Bankruptcy Court did not exceed its jurisdiction, assuming, for the sake of argument only, that § 405(h) acts as a bar. The only *de novo* review undertaken by the Bankruptcy Court was limited to matters falling within its exact jurisdictional grants and for which sovereign immunity was abrogated.

III. HHS Cannot Use “Evidence” it Failed to Present to the Bankruptcy Court in Support of This Case on Appeal.

HHS attempts to persuade this Court that the Bankruptcy Court got it wrong in concluding that the Medicare provider agreement had not terminated by directing this Court to material HHS produced *for the very first time by attaching it to the*

second of its two reply briefs in District Court. (HHS Br. at 48). Before a provider agreement can be terminated, the public must be notified. However, no notice was produced to the Bankruptcy Court. The first time HHS mentioned any notice was in a reply brief to the District Court in its *second* appeal, *nine [9] months after* the issue of whether or not the Medicare provider agreement had terminated had been fully litigated.¹¹ CR. 67-1. As such, Appellees failed to prove a condition precedent to termination.

A party is not permitted to offer new evidence in a reply brief. *Rispler v. Spitz*, 377 F. App'x 111, 113 (2d Cir. 2010) (Documents that were not filed in the court below cannot be considered) (citing *Weinstock v. Columbia Univ.*, 224 F.3d 33, 46 (2d Cir. 2000)) (finding that evidence submitted for the first time on appeal was “simply not part of the record” and “cannot be considered”); *Theriot v. Parish*

¹¹ In the Emergency Motion, Bayou specifically argued that “no public notice was provided to indicate that the termination of the Medicare agreement would occur as required by 42 C.F.R. § 488.456(c). Consequently, the Medicare provider agreement was in effect on the Petition Date.” (Emergency Motion, p. 3, ¶ 11). Bayou further argued that “At no time prior to the petition date did ACHA take any action to terminate or attempt to terminate the Medicaid provider agreement. Moreover, the Debtor received no notice of any termination of the Medicaid provider agreement. Consequently, the Medicaid provider agreement was in effect on the Petition Date.” (Emergency Motion, p. 4, ¶ 12).

of *Jefferson*, 185 F.3d 477, 491 n. 26 (5th Cir. 1999); (appellate court “may not consider new evidence furnished for the first time on appeal and may not consider facts which were not before the [trial] court at the time of the challenged ruling”). Appellees are thus precluded from arguing this issue as a basis to uphold the District Court’s reversal of the Bankruptcy Court’s orders.

IV. Applying the Equitable Mootness Doctrine is Absolutely Merited Under the Law and the Facts.

HHS argues applying the equitable mootness doctrine is unfair because plan implementation should have been stayed for 14 days pursuant to Fed. R. Bankr. P. 3020(e) (“3020(e) Stay”). See, eg., HHS Br. at 42. The following timeline demonstrates Appellees waived any stay of plan implementation and that both the law and the equities merit application of the equitable mootness doctrine as outlined in *In re Club Associates*, 956 F.2d 1065, 1069, n. 11 (11th Cir. 1992).¹² The District Court erred by (i) failing to consider each element set forth in *Club Associates* and by (ii) denying Bayou’s motions to dismiss the first and second appeals of AHCA and the first appeal of HHS. As Bayou comprehensively

¹² As Bayou detailed to the District Court (C.R. 54, pgs. 25-26) the case of *In re Zenith Electronics Corp.*, 250 B.R. 207 (D. Del. 2000) is *exactly* on point and the same result should inure.

outlined in its motions to the District Court, (See C.R. 20, pgs. 1-18; C.R. 54, pgs. 20-31; C.R. 61, pgs. 2-4) the appeals were constitutionally and/or equitably moot and should have been dismissed particularly given the Bankruptcy Court's finding that Bayou had substantially consummated the Plan within the meaning of 11 U.S.C. § 1101(2).

HHS complains that the Bankruptcy Court eliminated the 3020(e) Stay “without any determination that immediate plan implementation was necessary, and without any consideration of the potential prejudice to [HHS's] appellate rights,” HHS Br. at 29, but this argument, unsupported by a citation to any authority that a bankruptcy court is required to make such a determination in the absence of any objection, misplaces the blame. Appellees had ample notice of when Bayou's Chapter 11 plan would become effective, and when all significant action would occur, including distributions to creditors (Bk. Ct. Doc. No. 281, p. 14, ll. 2 – 9). However, Appellees never objected to the proposed timing of plan payments, despite having notice since November 21, 2014 when Bayou filed its Disclosure Statement and Plan. Bayou served the Disclosure Statement and Plan upon counsel of record for Appellees in the bankruptcy case and upon all creditors and parties in interest. (Bk. Ct. Doc. No. 190). The Plan specifically disclosed that it could go effective (the “Effective Date”) even if an appeal of the confirmation order was pending if Bayou filed a notice setting forth the

“Effective Date” with the Bankruptcy Court. (Bk. Ct. Doc. No. 186, p. 7).

Bayou’s entire Plan was (and indeed, every Chapter 11 plan is) plainly premised upon payments and other events scheduled on and around an Effective Date. The Effective Date was the Plan’s triggering event. Payment of tax and priority claims commenced on the Effective Date. (Bk. Ct. Doc. No. 186, p. 13-14). Bayou reaffirmed a secured lender’s (Synovus Bank) liens on the Effective Date. (Bk. Ct. Doc. No. 186, p. 14). The Effective Date governed a credit infusion and the timing of the balloon payment thereon. (Bk. Ct. Doc. No. 186, p. 7-8); (Doc. No. 186, at 15, Art. VII, § A.). The Plan explicitly detailed that Class 3 claims could be paid after the Effective Date (*id.* at 15) and the Effective Date triggered the timing of commencement of distributions to Class 4. (Bk. Ct. Doc. No. 186 at 16). The Effective Date governed the timing for Bayou to cure monetary defaults under its assumed executory contracts (*id.*) and the vesting of equity interests. It defined the beginning of the time period for filing objections to claims, the timing for resolving controversies concerning the impairment of claims or interests, and the time Bayou could retain professionals without court approval. On the Effective Date, prepetition debts and claims were discharged. (*Id.* at 22, § C (1)).

The term Effective Date appeared 32 times in the Plan and 33 times in the Disclosure Statement. Id. at 21, §§ B (1)–(4). Bayou’s creditors cast their ballots in favor of the Plan which clearly informed them, and Appellees, how quickly the Plan

could become effective and when distributions would commence. Yet, *Appellees never objected to the proposed timing*. Indeed, as detailed in Bayou’s initial brief (pgs. 13 – 15), AHCA failed to timely file *any* objection to the Plan at all.

Yet, HHS blames the Bankruptcy Court for “eliminat[ing] [the] safeguard” of the 14 day stay.” (HHS Br. at 29). This blame too is misplaced. Neither HHS nor AHCA objected to the explicit waiver of the 3020(e) Stay when the draft of the confirmation order was circulated among counsel before the order was submitted to the Bankruptcy Court. When the Bankruptcy Court entered its ruling on December 31, 2014 announcing Plan confirmation, it directed Bayou (its counsel) to prepare a further order confirming the Plan. (Bk. Ct. Doc. No. 282, at 22). As directed, Bayou’s counsel drafted a proposed order, and circulated it to counsel for HHS and AHCA containing exactly the following language:

The objection by HHS to Assumption of the Medicare Provider Agreement (Doc. No. 255) is overruled and the Medicare provider agreement shall be assumed upon entry of this order.

Upon the Entry of the Confirmation Order, the Debtor’s Medicaid provider agreement shall be assumed.

The fourteen (14) day stay of Bankruptcy Rule 3020(e) shall not apply and this Confirmation Order shall become effective immediately upon its entry.

Several emails were exchanged among counsel that resulted in modifications to the proposed order. However, *neither AHCA nor HHS objected to the inclusion of the*

language quoted above. (Bk. Ct. Doc. No. 285, at 17, ¶ 26). Thus, the proposed order was submitted to the Bankruptcy Court, and executed on January 7, 2015. On January 9, 2015, Bayou filed its notice of Effective Date and commenced distributions. (Bk. Ct. Doc. No. 288).

HHS's request for a stay was only an afterthought when requested on January 15, 2015 (Bk. Ct. Doc. No. 329) – some fifteen [15] days after the Bankruptcy Court announced it was confirming the Plan, eight [8] days after the confirmation order was entered waiving the 3020(e) Stay, and two days after HHS filed its notice of appeal (Bk. Ct. Doc. No. 289). By this time Bayou had substantially consummated the Plan. Thus, HHS's request for a stay came too late. When HHS finally did seek a stay, the Bankruptcy Court found it was already waived. *See*, Initial Br. at 18-19. Fed. R. Bankr. P. 3020(e) provides for a stay “unless the court orders otherwise.” The Advisory Committee notes to 3020(e) grant a bankruptcy court the discretion to “order that Rule 3020(e) is not applicable so that the plan may be implemented and distributions may be made immediately” and this is exactly what happened here.

Next, HHS argues that “reversal of the confirmation order would not prejudice the reliance interests of other parties” because “the plan contemplated full payment of *all* claimants.” HHS Br. at 42. This argument defies logic. Reversing an order confirming a full payment plan eviscerates the plan and destroys the reliance

interest of every creditor. Bayou's income for plan payments derives in large part from the Medicaid provider agreement Bayou assumed over *no objection from AHCA*.¹³ The District Court plainly erred when it "partially reversed" the confirmation order stripping Bayou of its income, but leaving intact all of Bayou's payment obligations.

AHCA's arguments against equitable mootness are also unpersuasive. AHCA concludes that because *it* "is not seeking [plan] payment[s]" from Bayou, none of Bayou's plan payments and distributions to other creditors are "relevant." AHCA Br. at 35. In other words, because *AHCA* is not seeking payments under the Plan, none of the payments to Bayou's other creditors are relevant and their reliance interests can be cast aside. Yet, AHCA concedes that when "payments and distributions under the plan are already well underway, it would be inequitable and impracticable to unwind that process." *Id.*

In the District Court, Bayou explicitly detailed almost \$700,000 in distributions already paid in addition to numerous other actions taken in reliance upon and in furtherance of the confirmed plan. C.R. 20 at 10-11, 15-19; C.R. 54 at

¹³ In moving to dismiss AHCA's appeal of the confirmation order, Bayou explained AHCA failed to object to Bayou's assumption of the Medicaid provider agreement or timely object or join in the objection to confirmation filed by HHS. C.R. 54 at 2, 5-8; 10-20.

22-31. If the District Court's (partial) reversal order stands, it unwinds Bayou's entire plan, and Bayou, which has been struggling just to stay afloat due to the District Court's rejection of Bayou's mootness arguments and its restriction on new patient admissions, will be forced into liquidation. This result is inequitable and impractical and contrary to the reliance interests and expectations of every creditor in the case.

Endeavoring to demonstrate how a temporary injunction the Bankruptcy Court dissolved a year ago (when it entered the confirmation order authorizing Bayou to assume its Provider Agreements) still presents a "live" controversy, citing *In re Kmart Corp.*, 434 F.3d 536, 538 (7th Cir. 2006), AHCA argues Appellees' claims are still justiciable because the dissolved injunction "serves as a bar to any efforts of AHCA and HHS to recover the Medicaid and Medicare funds paid to Bayou Shores while the September 5, 2014 Order was in effect." (AHCA Br. at 32). In *Kmart Corp.*, the court stated that a "concrete dispute about damages" may "preserve a justiciable controversy regarding whether [a preliminary and/or dissolved] injunction was valid." 434 F.3d at 538.

AHCA's argument and its reliance on *Kmart Corp.* is unsound. Here, neither AHCA nor HHS has any claim for damages, much less one that is "concrete." Notably, neither Appellee filed an administrative claim in the bankruptcy case or asserted that *any* outstanding claim must be cured before Bayou could assume its

provider agreements. More importantly, Appellees overlook the fact that they would be required to pay for the care of Bayou's patients, if not at Bayou, *somewhere*, because the vast majority of Bayou's patients are indigent. As such, neither has been harmed and neither could sustain a claim for damages.

Bayou's arguments that the District Court appeals had become constitutionally and equitably moot were rejected without any apparent consideration. The District Court offered no analysis of how any particular issue presented a live case or controversy after the confirmation order was entered dissolving any injunction or stay, nor did it appear to consider the factors in *Club Associates*. The District Court erred and must be reversed.

V. Appellees Place Unproven Allegations Before Every Federal Court in this Appeal Despite Arguing The Allegations are Unreviewable

Appellees treat AHCA's findings of Immediate Jeopardy ("IJ") as if they were evidentiary facts when they are not, infusing all of their pleadings with dramatic and unproven allegations. *See, e.g.*, AHCA Br. at 16–17. Presumably, they do this to convince this Court that Bayou somehow "got what it deserved."¹⁴ But

¹⁴ HHS also devotes attention to describing horrific nursing home conditions detailed to the Senate Special Committee on Aging in 1986, *some thirty years ago*. HHS Brief, p. 19, fn. 2.

Bayou is contesting AHCA's deficiency claims in the administrative forum,¹⁵ which affords a full *de novo* review. By way of example, AHCA alleged Bayou's electronic records failed to include a "Do Not Resuscitate Order" ("DNRO") for certain patients and that this placed patients "at risk of death." (AHCA Brief, p. 16). In fact, although paper copies of DNROs were briefly omitted from certain patients' electronic records, this would not have placed patients at a risk of death but rather *could have caused a lifesaving attempt* against a patient's wishes. Thus, AHCA's claim that this presented a "risk of death" is clearly false. In the administrative tribunal, the court will conduct a *de novo* review of whether or not the omission of a DNRO from a patient's record qualifies as a Class 1 deficiency/IJ. It certainly did not present a risk of death. AHCA's claims regarding the second and third alleged IJ's are similarly seriously and materially flawed and are also being challenged by Bayou in the administrative courts.

There is no question that Bayou is, and has been, supplying good patient care. Indeed, most recently, on October 27, 2015, the District Court concluded that:

[A]s of this date, it is un rebutted that Bayou Shores is operating in substantial compliance with all applicable regulatory requirements. Its patients are receiving adequate care and do not want to leave the facility. Pankhurst testified that many of the patients' family members

¹⁵ A trial is taking place in the Department of Administrative Hearings.

and/or guardians refused to transfer their loved ones despite the uncertainty of Bayou Shores' future because they are happy with Bayou Shores' care. Dist. Ct. Doc. No. 101, p.7.

[T]here 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. Dist. Ct. Doc. No. 101, p.6.

CONCLUSION

For the reasons stated herein, as well as in Bayou's Initial Brief, and in the Bankruptcy Court's well-reasoned memorandum opinion and order on confirmation, the District's Court's orders denying Bayou's motions to dismiss and its order partially reversing the confirmation orders should be reversed in their entirety.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

This is to certify that this brief complies with Federal Rules of Appellate Procedures 32(a)(7). This brief was prepared in Microsoft Word using 14-point proportionally spaced font, and it contains 6,952 words.

/s/ Tiffany D. Payne
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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on January 7, 2016, the foregoing *Appellant, Bayou Shores, SNF, LLC's Reply Brief* was electronically filed via the Court's Electronic Case Files System in compliance with Rule 25, Federal Rule of Appellate Procedure, Eleventh Circuit General Order 37, which provided electronic notice to the following:

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STATUTORY ADDENDUM

A. Title 11 Statutes

11 U.S.C. § 105	36
11 U.S.C. § 106	37
11 U.S.C. § 365	38
11 U.S.C. § 541	39

B. Title 28 Statutes

28 U.S.C. § 157	43
28 U.S.C. § 1331	45
28 U.S.C. § 1332	45
28 U.S.C. § 1334	46
28 U.S.C. § 1346	47

C. Title 42 Statutes

42 U.S.C. § 405(g) Judicial review	48
42 U.S.C. § 405(h) Finality of Commissioner's decision	49
42 U.S.C. § 1307.....	50
42 U.S.C. § 1320a-7 Mandatory exclusion.....	50
42 U.S.C. § 1395cc(b)(2) Termination or nonrenewal of agreement.	62

42 U.S.C. § 1396 a(a)(39)	
State plan for medical assistance	63

D. Statutes at Large

98 Stat. 1162, § 2663(a)(4)(D).....	63
98 Stat. 1165, § 2663(a)(15)(C).....	63
98 Stat. 1168, § 2663(e)(2)(B)(3).....	63
98 Stat. 1171-72, § 2664.....	64

E. Florida Statutes

Fla Stat. 409.907(2).....	64

F. Code of Federal Regulations

42 C.F.R. 488.456(c).....	64

F. Federal Bankruptcy Rules

Fed. R. Bankr. P. 3020(e).....	64

11 U.S.C. § 105

(a) 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.

(b) Notwithstanding subsection (a) of this section, a court may not appoint a receiver in a case under this title.

(c) The ability of any district judge or other officer or employee of a district court to exercise any of the authority or responsibilities conferred upon the court under this title shall be determined by reference to the provisions relating to such judge, officer, or employee set forth in title 28. This subsection shall not be interpreted to exclude bankruptcy judges and other officers or employees appointed pursuant to chapter 6 of title 28 from its operation.

(d) The court, on its own motion or on the request of a party in interest--

(1) shall hold such status conferences as are necessary to further the expeditious and economical resolution of the case; and

(2) unless inconsistent with another provision of this title or with applicable Federal Rules of Bankruptcy Procedure, may issue an order at any such conference prescribing such limitations and conditions as the court deems appropriate to ensure that the case is handled expeditiously and economically, including an order that--

(A) sets the date by which the trustee must assume or reject an executory contract or unexpired lease; or

(B) in a case under chapter 11 of this title--

(i) sets a date by which the debtor, or trustee if one has been appointed, shall file a disclosure statement and plan;

(ii) sets a date by which the debtor, or trustee if one has been appointed, shall solicit acceptances of a plan;

(iii) sets the date by which a party in interest other than a debtor may file a plan;

(iv) sets a date by which a proponent of a plan, other than the debtor, shall solicit acceptances of such plan;

(v) fixes the scope and format of the notice to be provided regarding the hearing on approval of the disclosure statement; or

(vi) provides that the hearing on approval of the disclosure statement may be combined with the hearing on confirmation of the plan.

11 U.S.C. § 106

(a) Notwithstanding an assertion of sovereign immunity, sovereign immunity is abrogated as to a governmental unit to the extent set forth in this section with respect to the following:

(1) Sections 105, 106, 107, 108, 303, 346, 362, 363, 364, 365, 366, 502, 503, 505, 506, 510, 522, 523, 524, 525, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 722, 724, 726, 744, 749, 764, 901, 922, 926, 928, 929, 944, 1107, 1141, 1142, 1143, 1146, 1201, 1203, 1205, 1206, 1227, 1231, 1301, 1303, 1305, and 1327 of this title.

(2) The court may hear and determine any issue arising with respect to the application of such sections to governmental units.

(3) The court may issue against a governmental unit an order, process, or judgment under such sections or the Federal Rules of Bankruptcy Procedure, including an order or judgment awarding a money recovery, but not including an award of punitive damages. Such order or judgment for costs or fees under this title or the Federal Rules of Bankruptcy Procedure against any governmental unit shall be consistent with the provisions and limitations of section 2412(d)(2)(A) of title 28.

(4) The enforcement of any such order, process, or judgment against any governmental unit shall be consistent with appropriate nonbankruptcy law applicable to such governmental unit and, in the case of a money judgment against the United States, shall be paid as if it is a judgment rendered by a district court of the United States.

(5) Nothing in this section shall create any substantive claim for relief or cause of action not otherwise existing under this title, the Federal Rules of Bankruptcy Procedure, or nonbankruptcy law.

(b) A governmental unit that has filed a proof of claim in the case is deemed to have waived sovereign immunity with respect to a claim against such governmental unit that is property of the estate and that arose out of the same transaction or occurrence out of which the claim of such governmental unit arose.

(c) Notwithstanding any assertion of sovereign immunity by a governmental unit, there shall be offset against a claim or interest of a governmental unit any claim against such governmental unit that is property of the estate.

11 U.S.C. § 365

(a) Except as provided in sections 765 and 766 of this title and in subsections (b), (c), and (d) of this section, the trustee, subject to the court's approval, may assume or reject any executory contract or unexpired lease of the debtor.

(b)(1) If there has been a default in an executory contract or unexpired lease of the debtor, the trustee may not assume such contract or lease unless, at the time of assumption of such contract or lease, the trustee--

(A) cures, or provides adequate assurance that the trustee will promptly cure, such default other than a default that is a breach of a provision relating to the satisfaction of any provision (other than a penalty rate or penalty provision) relating to a default arising from any failure to perform nonmonetary obligations under an unexpired lease of real property, if it is impossible for the trustee to cure such default by performing nonmonetary acts at and after the time of assumption, except that if such default arises from a failure to operate in accordance with a nonresidential real property lease, then such default shall be cured by performance at and after the time of assumption in accordance with such lease, and pecuniary losses resulting from such default shall be compensated in accordance with the provisions of this paragraph;

(B) compensates, or provides adequate assurance that the trustee will promptly compensate, a party other than the debtor to such contract or lease, for any actual pecuniary loss to such party resulting from such default; and

(C) provides adequate assurance of future performance under such contract or lease.

(2) Paragraph (1) of this subsection does not apply to a default that is a breach of a provision relating to--

(A) the insolvency or financial condition of the debtor at any time before the closing of the case;

(B) the commencement of a case under this title;

(C) the appointment of or taking possession by a trustee in a case under this title or a custodian before such commencement; or

(D) the satisfaction of any penalty rate or penalty provision relating to a default arising from any failure by the debtor to perform nonmonetary obligations under the executory contract or unexpired lease.

...

11 U.S.C. § 541

(a) The commencement of a case under section 301, 302, or 303 of this title creates an estate. Such estate is comprised of all the following property, wherever located and by whomever held:

(1) Except as provided in subsections (b) and (c)(2) of this section, all legal or equitable interests of the debtor in property as of the commencement of the case.

...

(b) Property of the estate does not include--

(1) any power that the debtor may exercise solely for the benefit of an entity other than the debtor;

(2) any interest of the debtor as a lessee under a lease of nonresidential real property that has terminated at the expiration of the stated term of such lease before the commencement of the case under this title, and ceases to include any interest of the debtor as a lessee under a lease of nonresidential real property that has terminated at the expiration of the stated term of such lease during the case;

(3) any eligibility of the debtor to participate in programs authorized under the Higher Education Act of 1965 (20 U.S.C. 1001 et seq.; 42 U.S.C. 2751 et seq.), or any accreditation status or State licensure of the debtor as an educational institution;

(4) any interest of the debtor in liquid or gaseous hydrocarbons to the extent that--

(A)(i) the debtor has transferred or has agreed to transfer such interest pursuant to a farmout agreement or any written agreement directly related to a farmout agreement; and

(ii) but for the operation of this paragraph, the estate could include the interest referred to in clause (i) only by virtue of section 365 or 544(a)(3) of this title; or

(B)(i) the debtor has transferred such interest pursuant to a written conveyance of a production payment to an entity that does not participate in the operation of the property from which such production payment is transferred; and

(ii) but for the operation of this paragraph, the estate could include the interest referred to in clause (i) only by virtue of section 365 or 542 of this title;

(5) funds placed in an education individual retirement account (as defined in section 530(b)(1) of the Internal Revenue Code of 1986) not

later than 365 days before the date of the filing of the petition in a case under this title, but--

(A) only if the designated beneficiary of such account was a child, stepchild, grandchild, or stepgrandchild of the debtor for the taxable year for which funds were placed in such account;

(B) only to the extent that such funds--

(i) are not pledged or promised to any entity in connection with any extension of credit; and

(ii) are not excess contributions (as described in section 4973(e) of the Internal Revenue Code of 1986); and

(C) in the case of funds placed in all such accounts having the same designated beneficiary not earlier than 720 days nor later than 365 days before such date, only so much of such funds as does not exceed \$6,225¹;

(6) funds used to purchase a tuition credit or certificate or contributed to an account in accordance with section 529(b)(1)(A) of the Internal Revenue Code of 1986 under a qualified State tuition program (as defined in section 529(b)(1) of such Code) not later than 365 days before the date of the filing of the petition in a case under this title, but--

-

(A) only if the designated beneficiary of the amounts paid or contributed to such tuition program was a child, stepchild, grandchild, or stepgrandchild of the debtor for the taxable year for which funds were paid or contributed;

(B) with respect to the aggregate amount paid or contributed to such program having the same designated beneficiary, only so much of such amount as does not exceed the total contributions permitted under section 529(b)(6) of such Code with respect to such beneficiary, as adjusted beginning on the date of the filing of the petition in a case under this title by the annual increase or decrease (rounded to the nearest tenth of 1 percent) in the education expenditure category of the Consumer Price Index prepared by the Department of Labor; and

(C) in the case of funds paid or contributed to such program having the same designated beneficiary not earlier than 720 days nor later than 365 days before such date, only so much of such funds as does not exceed \$6,225¹;

(7) any amount--

(A) withheld by an employer from the wages of employees for payment as contributions--

(i) to--

(I) an employee benefit plan that is subject to title I of the Employee Retirement Income Security Act of 1974 or under an employee benefit plan which is a governmental plan under section 414(d) of the Internal Revenue Code of 1986;

(II) a deferred compensation plan under section 457 of the Internal Revenue Code of 1986; or

(III) a tax-deferred annuity under section 403(b) of the Internal Revenue Code of 1986;

except that such amount under this subparagraph shall not constitute disposable income as defined in section 1325(b)(2); or

(ii) to a health insurance plan regulated by State law whether or not subject to such title; or

(B) received by an employer from employees for payment as contributions--

(i) to--

(I) an employee benefit plan that is subject to title I of the Employee Retirement Income Security Act of 1974 or under an employee benefit plan which is a governmental plan under section 414(d) of the Internal Revenue Code of 1986;

(II) a deferred compensation plan under section 457 of the Internal Revenue Code of 1986; or

(III) a tax-deferred annuity under section 403(b) of the Internal Revenue Code of 1986; except that such amount under this subparagraph shall not constitute disposable income, as defined in section 1325(b)(2); or

(ii) to a health insurance plan regulated by State law whether or not subject to such title;

(8) subject to subchapter III of chapter 5, any interest of the debtor in property where the debtor pledged or sold tangible personal property (other than securities or written or printed evidences of indebtedness or title) as collateral for a loan or advance of money given by a person licensed under law to make such loans or advances, where--

(A) the tangible personal property is in the possession of the pledgee or transferee;

(B) the debtor has no obligation to repay the money, redeem the collateral, or buy back the property at a stipulated price; and

- (C) neither the debtor nor the trustee have exercised any right to redeem provided under the contract or State law, in a timely manner as provided under State law and section 108(b);
- (9) any interest in cash or cash equivalents that constitute proceeds of a sale by the debtor of a money order that is made--
 - (A) on or after the date that is 14 days prior to the date on which the petition is filed; and
 - (B) under an agreement with a money order issuer that prohibits the commingling of such proceeds with property of the debtor (notwithstanding that, contrary to the agreement, the proceeds may have been commingled with property of the debtor), unless the money order issuer had not taken action, prior to the filing of the petition, to require compliance with the prohibition; or
- (10) funds placed in an account of a qualified ABLE program (as defined in section 529A(b) of the Internal Revenue Code of 1986) not later than 365 days before the date of the filing of the petition in a case under this title, but--
 - (A) only if the designated beneficiary of such account was a child, stepchild, grandchild, or stepgrandchild of the debtor for the taxable year for which funds were placed in such account;
 - (B) only to the extent that such funds--
 - (i) are not pledged or promised to any entity in connection with any extension of credit; and
 - (ii) are not excess contributions (as described in section 4973(h) of the Internal Revenue Code of 1986); and
 - (C) in the case of funds placed in all such accounts having the same designated beneficiary not earlier than 720 days nor later than 365 days before such date, only so much of such funds as does not exceed \$6,225.

Paragraph (4) shall not be construed to exclude from the estate any consideration the debtor retains, receives, or is entitled to receive for transferring an interest in liquid or gaseous hydrocarbons pursuant to a farmout agreement.

- (c)(1) Except as provided in paragraph (2) of this subsection, an interest of the debtor in property becomes property of the estate under subsection (a)(1), (a)(2), or (a)(5) of this section notwithstanding any provision in an agreement, transfer instrument, or applicable nonbankruptcy law--
 - (A) that restricts or conditions transfer of such interest by the debtor; or

(B) that is conditioned on the insolvency or financial condition of the debtor, on the commencement of a case under this title, or on the appointment of or taking possession by a trustee in a case under this title or a custodian before such commencement, and that effects or gives an option to effect a forfeiture, modification, or termination of the debtor's interest in property.

(2) A restriction on the transfer of a beneficial interest of the debtor in a trust that is enforceable under applicable nonbankruptcy law is enforceable in a case under this title.

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28 U.S.C. § 157

(a) Each district court may provide that any or all cases under title 11 and any or all proceedings arising under title 11 or arising in or related to a case under title 11 shall be referred to the bankruptcy judges for the district.

(b)(1) Bankruptcy judges may hear and determine all cases under title 11 and all core proceedings arising under title 11, or arising in a case under title 11, referred under subsection (a) of this section, and may enter appropriate orders and judgments, subject to review under section 158 of this title.

(2) Core proceedings include, but are not limited to--

(A) matters concerning the administration of the estate;

(B) allowance or disallowance of claims against the estate or exemptions from property of the estate, and estimation of claims or interests for the purposes of confirming a plan under chapter 11, 12, or 13 of title 11 but not the liquidation or estimation of contingent or unliquidated personal injury tort or wrongful death claims against the estate for purposes of distribution in a case under title 11;

(C) counterclaims by the estate against persons filing claims against the estate;

(D) orders in respect to obtaining credit;

(E) orders to turn over property of the estate;

(F) proceedings to determine, avoid, or recover preferences;

(G) motions to terminate, annul, or modify the automatic stay;

(H) proceedings to determine, avoid, or recover fraudulent conveyances;

(I) determinations as to the dischargeability of particular debts;

(J) objections to discharges;

(K) determinations of the validity, extent, or priority of liens;

- (L) confirmations of plans;
 - (M) orders approving the use or lease of property, including the use of cash collateral;
 - (N) orders approving the sale of property other than property resulting from claims brought by the estate against persons who have not filed claims against the estate;
 - (O) other proceedings affecting the liquidation of the assets of the estate or the adjustment of the debtor-creditor or the equity security holder relationship, except personal injury tort or wrongful death claims; and
 - (P) recognition of foreign proceedings and other matters under chapter 15 of title 11.
- (3) The bankruptcy judge shall determine, on the judge's own motion or on timely motion of a party, whether a proceeding is a core proceeding under this subsection or is a proceeding that is otherwise related to a case under title 11. A determination that a proceeding is not a core proceeding shall not be made solely on the basis that its resolution may be affected by State law.
- (4) Non-core proceedings under section 157(b)(2)(B) of title 28, United States Code, shall not be subject to the mandatory abstention provisions of section 1334(c)(2).
- (5) The district court shall order that personal injury tort and wrongful death claims shall be tried in the district court in which the bankruptcy case is pending, or in the district court in the district in which the claim arose, as determined by the district court in which the bankruptcy case is pending.
- (c)(1) A bankruptcy judge may hear a proceeding that is not a core proceeding but that is otherwise related to a case under title 11. In such proceeding, the bankruptcy judge shall submit proposed findings of fact and conclusions of law to the district court, and any final order or judgment shall be entered by the district judge after considering the bankruptcy judge's proposed findings and conclusions and after reviewing de novo those matters to which any party has timely and specifically objected.
- (2) Notwithstanding the provisions of paragraph (1) of this subsection, the district court, with the consent of all the parties to the proceeding, may refer a proceeding related to a case under title 11 to a bankruptcy judge to hear and determine and to enter appropriate orders and judgments, subject to review under section 158 of this title.
- (d) The district court may withdraw, in whole or in part, any case or proceeding referred under this section, on its own motion or on timely motion

of any party, for cause shown. The district court shall, on timely motion of a party, so withdraw a proceeding if the court determines that resolution of the proceeding requires consideration of both title 11 and other laws of the United States regulating organizations or activities affecting interstate commerce.

(e) If the right to a jury trial applies in a proceeding that may be heard under this section by a bankruptcy judge, the bankruptcy judge may conduct the jury trial if specially designated to exercise such jurisdiction by the district court and with the express consent of all the parties.

28 U.S.C. § 1331

The district courts shall have original jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States.

28. U.S.C. § 1332

(a) The district courts shall have original jurisdiction of all civil actions where the matter in controversy exceeds the sum or value of \$75,000, exclusive of interest and costs, and is between--

- (1) citizens of different States;
- (2) citizens of a State and citizens or subjects of a foreign state, except that the district courts shall not have original jurisdiction under this subsection of an action between citizens of a State and citizens or subjects of a foreign state who are lawfully admitted for permanent residence in the United States and are domiciled in the same State;
- (3) citizens of different States and in which citizens or subjects of a foreign state are additional parties; and
- (4) a foreign state, defined in section 1603(a) of this title, as plaintiff and citizens of a State or of different States.

(b) Except when express provision therefor is otherwise made in a statute of the United States, where the plaintiff who files the case originally in the Federal courts is finally adjudged to be entitled to recover less than the sum or value of \$75,000, computed without regard to any setoff or counterclaim to which the defendant may be adjudged to be entitled, and exclusive of interest and costs, the district court may deny costs to the plaintiff and, in addition, may impose costs on the plaintiff.

...

28 U.S.C. § 1334

(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) Except as provided in subsection (e)(2), and 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) Except with respect to a case under chapter 15 of title 11, 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 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.

(d) Any decision to abstain or not to abstain made under subsection (c) (other than a decision not to abstain in a proceeding described in subsection (c)(2)) is not reviewable by appeal or otherwise by the court of appeals under section 158(d), 1291, or 1292 of this title or by the Supreme Court of the United States under section 1254 of this title. Subsection (c) and 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.

(e) The district court in which a case under title 11 is commenced or is pending shall have exclusive jurisdiction--

(1) of all the property, wherever located, of the debtor as of the commencement of such case, and of property of the estate; and

(2) over all claims or causes of action that involve construction of section 327 of title 11, United States Code, or rules relating to disclosure requirements under section 327.

28 U.S.C. § 1346

(a) The district courts shall have original jurisdiction, concurrent with the United States Court of Federal Claims, of:

(1) Any civil action against the United States for the recovery of any internal-revenue tax alleged to have been erroneously or illegally assessed or collected, or any penalty claimed to have been collected without authority or any sum alleged to have been excessive or in any manner wrongfully collected under the internal-revenue laws;

(2) Any other civil action or claim against the United States, not exceeding \$10,000 in amount, founded either upon the Constitution, or any Act of Congress, or any regulation of an executive department, or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases not sounding in tort, except that the district courts shall not have jurisdiction of any civil action or claim against the United States founded upon any express or implied contract with the United States or for liquidated or unliquidated damages in cases not sounding in tort which are subject to sections 7104(b)(1) and 7107(a)(1) of title 41. For the purpose of this paragraph, an express or implied contract with the Army and Air Force Exchange Service, Navy Exchanges, Marine Corps Exchanges, Coast Guard Exchanges, or Exchange Councils of the National Aeronautics and Space Administration shall be considered an express or implied contract with the United States.

(b)(1) Subject to the provisions of chapter 171 of this title, the district courts, together with the United States District Court for the District of the Canal Zone and the District Court of the Virgin Islands, shall have exclusive jurisdiction of civil actions on claims against the United States, for money damages, accruing on and after January 1, 1945, for injury or loss of property, or personal injury or death caused by the negligent or wrongful act or omission of any employee of the Government while acting within the scope of his office or employment, under circumstances where the United States, if a private person, would be liable to the claimant in accordance with the law of the place where the act or omission occurred.

(2) No person convicted of a felony who is incarcerated while awaiting sentencing or while serving a sentence may bring a civil action against the United States or an agency, officer, or employee of the Government, for mental or emotional injury suffered while in custody without a prior showing of physical injury or the commission of a sexual act (as defined in section 2246 of Title 18).

(c) The jurisdiction conferred by this section includes jurisdiction of any set-off, counterclaim, or other claim or demand whatever on the part of the United States against any plaintiff commencing an action under this section.

(d) The district courts shall not have jurisdiction under this section of any civil action or claim for a pension.

(e) The district courts shall have original jurisdiction of any civil action against the United States provided in section 6226, 6228(a), 7426, or 7428 (in the case of the United States district court for the District of Columbia) or section 7429 of the Internal Revenue Code of 1986.

(f) The district courts shall have exclusive original jurisdiction of civil actions under section 2409a to quiet title to an estate or interest in real property in which an interest is claimed by the United States.

(g) Subject to the provisions of chapter 179, the district courts of the United States shall have exclusive jurisdiction over any civil action commenced under section 453(2) of title 3, by a covered employee under chapter 5 of such title.

42 U.S.C. § 405(g)

(g) Judicial review

Any individual, after any final decision of the Commissioner of Social Security made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Commissioner of Social Security may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides, or has his principal place of business, or, if he does not reside or have his principal place of business within any such judicial district, in the United States District Court for the District of Columbia. As part of the Commissioner's answer the Commissioner of Social Security shall file a certified copy of the transcript of the record including the evidence upon which the findings and decision complained of are based. The court shall have power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Commissioner of Social Security, with or without remanding the cause for a rehearing. The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive, and where a claim has been denied by the Commissioner of Social Security or a decision is rendered under subsection (b) of this section which is adverse to an individual who was a party to the

hearing before the Commissioner of Social Security, because of failure of the claimant or such individual to submit proof in conformity with any regulation prescribed under subsection (a) of this section, the court shall review only the question of conformity with such regulations and the validity of such regulations. The court may, on motion of the Commissioner of Social Security made for good cause shown before the Commissioner files the Commissioner's answer, remand the case to the Commissioner of Social Security for further action by the Commissioner of Social Security, and it may at any time order additional evidence to be taken before the Commissioner of Social Security, but only upon a showing that there is new evidence which is material and that there is good cause for the failure to incorporate such evidence into the record in a prior proceeding; and the Commissioner of Social Security shall, after the case is remanded, and after hearing such additional evidence if so ordered, modify or affirm the Commissioner's findings of fact or the Commissioner's decision, or both, and shall file with the court any such additional and modified findings of fact and decision, and, in any case in which the Commissioner has not made a decision fully favorable to the individual, a transcript of the additional record and testimony upon which the Commissioner's action in modifying or affirming was based. Such additional or modified findings of fact and decision shall be reviewable only to the extent provided for review of the original findings of fact and decision. 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. Any action instituted in accordance with this subsection shall survive notwithstanding any change in the person occupying the office of Commissioner of Social Security or any vacancy in such office.

42 U.S.C. § 405(h)

(h) Finality of Commissioner's decision

The findings and decision of the Commissioner of Social Security after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Commissioner of Social Security shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Commissioner of Social Security, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

42 U.S.C. § 1307

(a) Whoever, with the intent to defraud any person, shall make or cause to be made any false representation concerning the requirements of this chapter, of chapter 2, 21, or 23 of the Internal Revenue Code of 1986, or of any provision of subtitle F of such Code which corresponds (within the meaning of section 7852(b) of such Code) to a provision contained in subchapter E of chapter 9 of the Internal Revenue Code of 1939, or of any rules or regulations issued thereunder, knowing such representations to be false, shall be deemed guilty of a misdemeanor, and, upon conviction thereof, shall be punished by a fine not exceeding \$1,000, or by imprisonment not exceeding one year, or both.

(b) Whoever, with the intent to elicit information as to the social security account number, date of birth, employment, wages, or benefits of any individual (1) falsely represents to the Commissioner of Social Security or the Secretary that he is such individual, or the wife, husband, widow, widower, divorced wife, divorced husband, surviving divorced wife, surviving divorced husband, surviving divorced mother, surviving divorced father, child, or parent of such individual, or the duly authorized agent of such individual, or of the wife, husband, widow, widower, divorced wife, divorced husband, surviving divorced wife, surviving divorced husband, surviving divorced mother, surviving divorced father, child, or parent of such individual, or (2) falsely represents to any person that he is an employee or agent of the United States, shall be deemed guilty of a felony, and, upon conviction thereof, shall be punished by a fine not exceeding \$10,000 for each occurrence of a violation, or by imprisonment not exceeding 5 years, or both.

42 U.S.C. § 1320a-7

(a) Mandatory exclusion

The Secretary shall exclude the following individuals and entities from participation in any Federal health care program (as defined in section 1320a-7b(f) of this title):

(1) Conviction of program-related crimes

Any individual or entity that has been convicted of a criminal offense related to the delivery of an item or service under subchapter XVIII of this chapter or under any State health care program.

(2) Conviction relating to patient abuse

Any individual or entity that has been convicted, under Federal or State law, of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service.

(3) Felony conviction relating to health care fraud

Any individual or entity that has been convicted for an offense which occurred after August 21, 1996, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program (other than those specifically described in paragraph (1)) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.

(4) Felony conviction relating to controlled substance

Any individual or entity that has been convicted for an offense which occurred after August 21, 1996, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

(b) Permissive exclusion

The Secretary may exclude the following individuals and entities from participation in any Federal health care program (as defined in section 1320a-7b(f) of this title):

(1) Conviction relating to fraud

Any individual or entity that has been convicted for an offense which occurred after August 21, 1996, under Federal or State law--

(A) of a criminal offense consisting of a misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct--

(i) in connection with the delivery of a health care item or service, or

(ii) with respect to any act or omission in a health care program (other than those specifically described in subsection (a)(1) of this section) operated by or financed in whole or in part by any Federal, State, or local government agency; or

(B) of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct with respect to any act or omission in a program (other than a health care program) operated by or financed in whole or in part by any Federal, State, or local government agency.

- (2) Conviction relating to obstruction of an investigation or audit
Any individual or entity that has been convicted, under Federal or State law, in connection with the interference with or obstruction of any investigation or audit related to--
- (i) any offense described in paragraph (1) or in subsection (a); or
 - (ii) the use of funds received, directly or indirectly, from any Federal health care program (as defined in section 1320a-7b(f) of this title).
- (3) Misdemeanor conviction relating to controlled substance
Any individual or entity that has been convicted, under Federal or State law, of a criminal offense consisting of a misdemeanor relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.
- (4) License revocation or suspension
Any individual or entity--
- (A) whose license to provide health care has been revoked or suspended by any State licensing authority, or who otherwise lost such a license or the right to apply for or renew such a license, for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity, or
 - (B) who surrendered such a license while a formal disciplinary proceeding was pending before such an authority and the proceeding concerned the individual's or entity's professional competence, professional performance, or financial integrity.
- (5) Exclusion or suspension under Federal or State health care program
Any individual or entity which has been suspended or excluded from participation, or otherwise sanctioned, under--
- (A) any Federal Program, including programs of the Department of Defense or the Department of Veterans Affairs, involving the provision of health care, or
 - (B) a State health care program, for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity.
- (6) Claims for excessive charges or unnecessary services and failure of certain organizations to furnish medically necessary services
Any individual or entity that the Secretary determines--
- (A) has submitted or caused to be submitted bills or requests for payment (where such bills or requests are based on charges or cost) under subchapter XVIII of this chapter or a State health

care program containing charges (or, in applicable cases, requests for payment of costs) for items or services furnished substantially in excess of such individual's or entity's usual charges (or, in applicable cases, substantially in excess of such individual's or entity's costs) for such items or services, unless the Secretary finds there is good cause for such bills or requests containing such charges or costs;

(B) has furnished or caused to be furnished items or services to patients (whether or not eligible for benefits under subchapter XVIII of this chapter or under a State health care program) substantially in excess of the needs of such patients or of a quality which fails to meet professionally recognized standards of health care;

(C) is--

(i) a health maintenance organization (as defined in section 1396b(m) of this title) providing items and services under a State plan approved under subchapter XIX of this chapter, or

(ii) an entity furnishing services under a waiver approved under section 1396n(b)(1) of this title,

and has failed substantially to provide medically necessary items and services that are required (under law or the contract with the State under subchapter XIX of this chapter) to be provided to individuals covered under that plan or waiver, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals; or

(D) is an entity providing items and services as an eligible organization under a risk-sharing contract under section 1395mm of this title and has failed substantially to provide medically necessary items and services that are required (under law or such contract) to be provided to individuals covered under the risk-sharing contract, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals.

(7) Fraud, kickbacks, and other prohibited activities

Any individual or entity that the Secretary determines has committed an act which is described in section 1320a-7a, 1320a-7b, or 1320a-8 of this title.

(8) Entities controlled by a sanctioned individual

Any entity with respect to which the Secretary determines that a person--

(A)(i) who has a direct or indirect ownership or control interest of 5 percent or more in the entity or with an ownership or control interest (as defined in section 1320a-3(a)(3) of this title) in that entity,

(ii) who is an officer, director, agent, or managing employee (as defined in section 1320a-5(b) of this title) of that entity; or

(iii) who was described in clause (i) but is no longer so described because of a transfer of ownership or control interest, in anticipation of (or following) a conviction, assessment, or exclusion described in subparagraph (B) against the person, to an immediate family member (as defined in subsection (j)(1) of this section) or a member of the household of the person (as defined in subsection (j)(2) of this section) who continues to maintain an interest described in such clause--

is a person--

(B)(i) who has been convicted of any offense described in subsection (a) of this section or in paragraph (1), (2), or (3) of this subsection;

(ii) against whom a civil monetary penalty has been assessed under section 1320a-7a or 1320a-8 of this title; or

(iii) who has been excluded from participation under a program under subchapter XVIII of this chapter or under a State health care program.

(9) Failure to disclose required information

Any entity that did not fully and accurately make any disclosure required by section 1320a-3 of this title, section 1320a-3a of this title, or section 1320a-5 of this title.

(10) Failure to supply requested information on subcontractors and suppliers

Any disclosing entity (as defined in section 1320a-3(a)(2) of this title) that fails to supply (within such period as may be specified by the Secretary in regulations) upon request specifically addressed to the entity by the Secretary or by the State agency administering or supervising the administration of a State health care program--

(A) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with

whom the entity has had, during the previous 12 months, business transactions in an aggregate amount in excess of \$25,000, or

(B) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between the entity and any wholly owned supplier or between the entity and any subcontractor.

(11) Failure to supply payment information

Any individual or entity furnishing, ordering, referring for furnishing, or certifying the need for items or services for which payment may be made under subchapter XVIII of this chapter or a State health care program that fails to provide such information as the Secretary or the appropriate State agency finds necessary to determine whether such payments are or were due and the amounts thereof, or has refused to permit such examination of its records by or on behalf of the Secretary or that agency as may be necessary to verify such information.

(12) Failure to grant immediate access

Any individual or entity that fails to grant immediate access, upon reasonable request (as defined by the Secretary in regulations) to any of the following:

(A) To the Secretary, or to the agency used by the Secretary, for the purpose specified in the first sentence of section 1395aa(a) of this title (relating to compliance with conditions of participation or payment).

(B) To the Secretary or the State agency, to perform the reviews and surveys required under State plans under paragraphs (26), (31), and (33) of section 1396a(a) of this title and under section 1396b(g) of this title.

(C) To the Inspector General of the Department of Health and Human Services, for the purpose of reviewing records, documents, and other data necessary to the performance of the statutory functions of the Inspector General.

(D) To a State medicaid fraud control unit (as defined in section 1396b(q) of this title), for the purpose of conducting activities described in that section.

(13) Failure to take corrective action

Any hospital that fails to comply substantially with a corrective action required under section 1395ww(f)(2)(B) of this title.

(14) Default on health education loan or scholarship obligations

Any individual who the Secretary determines is in default on repayments of scholarship obligations or loans in connection with health professions education made or secured, in whole or in part, by the Secretary and with respect to whom the Secretary has taken all reasonable steps available to the Secretary to secure repayment of such obligations or loans, except that (A) the Secretary shall not exclude pursuant to this paragraph a physician who is the sole community physician or sole source of essential specialized services in a community if a State requests that the physician not be excluded, and (B) the Secretary shall take into account, in determining whether to exclude any other physician pursuant to this paragraph, access of beneficiaries to physician services for which payment may be made under subchapter XVIII or XIX of this chapter.

(15) Individuals controlling a sanctioned entity

(A) Any individual--

(i) who has a direct or indirect ownership or control interest in a sanctioned entity and who knows or should know (as defined in section 1320a-7a(i)(6)1 of this title) of the action constituting the basis for the conviction or exclusion described in subparagraph (B); or

(ii) who is an officer or managing employee (as defined in section 1320a-5(b) of this title) of such an entity.

(B) For purposes of subparagraph (A), the term “sanctioned entity” means an entity--

(i) that has been convicted of any offense described in subsection (a) of this section or in paragraph (1), (2), or (3) of this subsection; or

(ii) that has been excluded from participation under a program under subchapter XVIII of this chapter or under a State health care program.

(16) Making false statements or misrepresentation of material facts

Any individual or entity that knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, agreement, bid, or contract to participate or enroll as a provider of services or supplier under a Federal health care program (as defined in section 1320a-7b(f) of this title), including Medicare Advantage organizations under part C of subchapter XVIII of this chapter, prescription drug plan sponsors under part D of subchapter XVIII of this chapter, medicaid managed care organizations under subchapter XIX of this chapter, and entities that apply to participate as

providers of services or suppliers in such managed care organizations and such plans.

(c) Notice, effective date, and period of exclusion

(1) An exclusion under this section or under section 1320a-7a of this title shall be effective at such time and upon such reasonable notice to the public and to the individual or entity excluded as may be specified in regulations consistent with paragraph (2).

(2)(A) Except as provided in subparagraph (B), such an exclusion shall be effective with respect to services furnished to an individual on or after the effective date of the exclusion.

(B) Unless the Secretary determines that the health and safety of individuals receiving services warrants the exclusion taking effect earlier, an exclusion shall not apply to payments made under subchapter XVIII of this chapter or under a State health care program for--

(i) inpatient institutional services furnished to an individual who was admitted to such institution before the date of the exclusion, or

(ii) home health services and hospice care furnished to an individual under a plan of care established before the date of the exclusion,

until the passage of 30 days after the effective date of the exclusion.

(3)(A) The Secretary shall specify, in the notice of exclusion under paragraph (1) and the written notice under section 1320a-7a of this title, the minimum period (or, in the case of an exclusion of an individual under subsection (b)(12) of this section or in the case described in subparagraph (G), the period) of the exclusion.

(B) Subject to subparagraph (G), in the case of an exclusion under subsection (a) of this section, the minimum period of exclusion shall be not less than five years, except that, upon the request of the administrator of a Federal health care program (as defined in section 1320-7b(f) of this title) who determines that the exclusion would impose a hardship on beneficiaries (as defined in section 1320a-7a(i)(5)) of this title) of that program the Secretary may, after consulting with the Inspector General of the Department of Health and Human Services, waive the exclusion under subsection (a)(1), (a)(3), or (a)(4) of this section with respect to that program in the case of an individual or entity

that is the sole community physician or sole source of essential specialized services in a community. The Secretary's decision whether to waive the exclusion shall not be reviewable.

(C) In the case of an exclusion of an individual under subsection (b)(12) of this section, the period of the exclusion shall be equal to the sum of--

(i) the length of the period in which the individual failed to grant the immediate access described in that subsection, and

(ii) an additional period, not to exceed 90 days, set by the Secretary.

(D) Subject to subparagraph (G), in the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b) of this section, the period of the exclusion shall be 3 years, unless the Secretary determines in accordance with published regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.

(E) In the case of an exclusion of an individual or entity under subsection (b)(4) or (b)(5) of this section, the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B) of this section, the period of the exclusion shall be not less than 1 year.

(G) In the case of an exclusion of an individual under subsection (a) of this section based on a conviction occurring on or after August 5, 1997, if the individual has (before, on, or after August 5, 1997) been convicted--

(i) on one previous occasion of one or more offenses for which an exclusion may be effected under such subsection, the period of the exclusion shall be not less than 10 years, or

(ii) on 2 or more previous occasions of one or more offenses for which an exclusion may be effected under such subsection, the period of the exclusion shall be permanent.

(d) Notice to State agencies and exclusion under State health care programs

(1) Subject to paragraph (3), the Secretary shall exercise the authority under this section and section 1320a-7a of this title in a manner that

results in an individual's or entity's exclusion from all the programs under subchapter XVIII of this chapter and all the State health care programs in which the individual or entity may otherwise participate.

(2) The Secretary shall promptly notify each appropriate State agency administering or supervising the administration of each State health care program (and, in the case of an exclusion effected pursuant to subsection (a) of this section and to which section 824(a)(5) of Title 21 may apply, the Attorney General)--

(A) of the fact and circumstances of each exclusion effected against an individual or entity under this section or section 1320a-7a of this title, and

(B) of the period (described in paragraph (3)) for which the State agency is directed to exclude the individual or entity from participation in the State health care program.

(3)(A) Except as provided in subparagraph (B), the period of the exclusion under a State health care program under paragraph (2) shall be the same as any period of exclusion under subchapter XVIII of this chapter.

(B)(i) The Secretary may waive an individual's or entity's exclusion under a State health care program under paragraph (2) if the Secretary receives and approves a request for the waiver with respect to the individual or entity from the State agency administering or supervising the administration of the program.

(ii) A State health care program may provide for a period of exclusion which is longer than the period of exclusion under subchapter XVIII of this chapter.

(e) Notice to State licensing agencies

The Secretary shall--

(1) promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of an individual or entity excluded (or directed to be excluded) from participation under this section or section 1320a-7a of this title, of the fact and circumstances of the exclusion,

(2) request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and

(3) request that the State or local agency or authority keep the Secretary and the Inspector General of the Department of Health and Human Services fully and currently informed with respect to any actions taken in response to the request.

(f) Notice, hearing, and judicial review

(1) Subject to paragraph (2), any individual or entity that is excluded (or directed to be excluded) from participation under this section is entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title, except that, in so applying such sections and section 405(l) of this title, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

(2) Unless the Secretary determines that the health or safety of individuals receiving services warrants the exclusion taking effect earlier, any individual or entity that is the subject of an adverse determination under subsection (b)(7) of this section shall be entitled to a hearing by an administrative law judge (as provided under section 405(b) of this title) on the determination under subsection (b)(7) of this section before any exclusion based upon the determination takes effect.

(3) The provisions of section 405(h) of this title shall apply with respect to this section and sections 1320a-7a, 1320a-8, and 1320c-5 of this title to the same extent as it is applicable with respect to subchapter II of this chapter, except that, in so applying such section and section 405(l) of this title, any reference therein to the Commissioner of Social Security shall be considered a reference to the Secretary.

(4) The provisions of subsections (d) and (e) of section 405 of this title shall apply with respect to this section to the same extent as they are applicable with respect to subchapter II of this chapter. The Secretary may delegate the authority granted by section 405(d) of this title (as made applicable to this section) to the Inspector General of the Department of Health and Human Services for purposes of any investigation under this section.

(g) Application for termination of exclusion

(1) An individual or entity excluded (or directed to be excluded) from participation under this section or section 1320a-7a of this title may apply to the Secretary, in the manner specified by the Secretary in regulations and at the end of the minimum period of exclusion provided under subsection (c)(3) of this section and at such other times as the Secretary may provide, for termination of the exclusion effected under this section or section 1320a-7a of this title.

(2) The Secretary may terminate the exclusion if the Secretary determines, on the basis of the conduct of the applicant which occurred after the date of the notice of exclusion or which was unknown to the Secretary at the time of the exclusion, that--

(A) there is no basis under subsection (a) or (b) of this section or section 1320a-7a(a) of this title for a continuation of the exclusion, and

(B) there are reasonable assurances that the types of actions which formed the basis for the original exclusion have not recurred and will not recur.

(3) The Secretary shall promptly notify each appropriate State agency administering or supervising the administration of each State health care program (and, in the case of an exclusion effected pursuant to subsection (a) of this section and to which section 824(a)(5) of Title 21 may apply, the Attorney General) of the fact and circumstances of each termination of exclusion made under this subsection.

(h) "State health care program" defined

For purposes of this section and sections 1320a-7a and 1320a-7b of this title, the term "State health care program" means--

(1) a State plan approved under subchapter XIX of this chapter,

(2) any program receiving funds under subchapter V of this chapter or from an allotment to a State under such subchapter,

(3) any program receiving funds under division A of subchapter XX of this chapter or from an allotment to a State under such division, or

(4) a State child health plan approved under subchapter XXI of this chapter.

(i) "Convicted" defined

For purposes of subsections (a) and (b) of this section, an individual or entity is considered to have been "convicted" of a criminal offense--

(1) when a judgment of conviction has been entered against the individual or entity by a Federal, State, or local court, regardless of whether there is an appeal pending or whether the judgment of conviction or other record relating to criminal conduct has been expunged;

(2) when there has been a finding of guilt against the individual or entity by a Federal, State, or local court;

(3) when a plea of guilty or nolo contendere by the individual or entity has been accepted by a Federal, State, or local court; or

(4) when the individual or entity has entered into participation in a first offender, deferred adjudication, or other arrangement or program where judgment of conviction has been withheld.

(j) Definition of immediate family member and member of household

For purposes of subsection (b)(8)(A)(iii) of this section:

(1) The term “immediate family member” means, with respect to a person--

(A) the husband or wife of the person;

(B) the natural or adoptive parent, child, or sibling of the person;

(C) the stepparent, stepchild, stepbrother, or stepsister of the person;

(D) the father-, mother-, daughter-, son-, brother-, or sister-in-law of the person;

(E) the grandparent or grandchild of the person; and

(F) the spouse of a grandparent or grandchild of the person.

(2) The term “member of the household” means, with respect to any person, any individual sharing a common abode as part of a single family unit with the person, including domestic employees and others who live together as a family unit, but not including a roomer or boarder.

42 U.S.C. § 1395cc(b)(2)

(b) Termination or nonrenewal of agreement.

...

(2) The Secretary may refuse to enter into an agreement under this section or, upon such reasonable notice to the provider and the public as may be specified in regulations, may refuse to renew or may terminate such an agreement after the Secretary--

(A) has determined that the provider fails to comply substantially with the provisions of the agreement, with the provisions of this subchapter and regulations thereunder, or with a corrective action required under section 1395ww(f)(2)(B) of this title,

(B) has determined that the provider fails substantially to meet the applicable provisions of section 1395x of this title,

(C) has excluded the provider from participation in a program under this subchapter pursuant to section 1320a-7 of this title or section 1320a-7a of this title, or

(D) has ascertained that the provider has been convicted of a felony under Federal or State law for an offense which the Secretary determines is detrimental to the best interests of the program or program beneficiaries.

42 U.S.C. § 1396 a(a)(39)

(a) Contents

A State plan for medical assistance must--

...

(39) provide that the State agency shall exclude any specified individual or entity from participation in the program under the State plan for the period specified by the Secretary, when required by him to do so pursuant to section 1320a-7 or section 1320a-7a of this title, terminate the participation of any individual or entity in such program if (subject to such exceptions as are permitted with respect to exclusion under sections 1320a-7(c)(3)(B) and 1320a-7(d)(3)(B) of this title) participation of such individual or entity is terminated under subchapter XVIII of this chapter or any other State plan under this subchapter, and provide that no payment may be made under the plan with respect to any item or service furnished by such individual or entity during such period;

98 Stat. 1162, § 2663(a)(4)(D)

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, Unites States Code,”.

98 Stat. 1165, § 2663(a)(15)(C)

Section 222(b)(4) of such Act is amended by striking out “full-time student” and inserting in lieu thereof “full-time elementary or secondary school student”.

98 Stat. 1168, § 2663(e)(2)(B)(3)

Section 1107(b) of such Act is amended by striking out "former wife divorced," each place it appears and inserting in lieu thereof "divorced wife, divorced husband, surviving divorced wife, surviving divorced husband, surviving divorced mother, surviving divorced father,".

98 Stat. 1171-72, § 2664

(a) Except as otherwise specifically provided, the amendments made by sections 2661 and 2662 shall be effective as though they had been included in the enactment of the Social Security Amendments of 1983 (Public Law 98-21).

(b) 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.

Fla Stat. 409.907(2)

The agency may make payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a provider agreement in effect with the agency, who is performing services or supplying goods in accordance with federal, state, and local law, and who agrees that no person shall, on the grounds of handicap, race, color, or national origin, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from the agency.

...

(2) Each provider agreement shall be a voluntary contract between the agency and the provider, in which the provider agrees to comply with all laws and rules pertaining to the Medicaid program when furnishing a service or goods to a Medicaid recipient and the agency agrees to pay a sum, determined by fee schedule, payment methodology, or other manner, for the service or goods provided to the Medicaid recipient. Each provider agreement shall be effective for a stipulated period of time, shall be terminable by either party after reasonable notice, and shall be renewable by mutual agreement.

42 C.F.R. 488.456(c)

(c) Notice of termination

Before terminating a provider agreement, CMS does and the State must notify the facility and the public—

- (1) At least 2 calendar days before the effective date of termination for a facility with immediate jeopardy deficiencies; and
- (2) At least 15 calendar days before the effective date of termination for a facility with non- immediate jeopardy deficiencies that constitute noncompliance.

Fed. R. Bankr. P. 3020(e)

(e) Stay of confirmation order. An order confirming a plan is stayed until the expiration of 14 days after the entry of the order, unless the court orders otherwise.

COMMITTEE NOTES ON RULE – 1999 AMENDMENT

Subdivision (e) is added to provide sufficient time for a party to request a stay pending appeal of an order confirming a plan under chapter 9 or chapter 11 of the Code before the plan is implemented and an appeal becomes moot. Unless the court orders otherwise, any transfer of assets, issuance of securities, and cash distributions provided for in the plan may not be made before the expiration of the 10-day period. The stay of the confirmation order under subdivision (e) does not affect the time for filing a notice of appeal from the confirmation order in accordance with Rule 8002.

The court may, in its discretion, order that Rule 3020(e) is not applicable so that the plan may be implemented and distributions may be made immediately. Alternatively, the court may order that the stay under Rule 3020(e) is for a fixed period less than 10 days.

[PUBLISH]

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 15-13731

D.C. Docket Nos. 8:14-bk-09521-MGW; 8:14-cv-02816-JSM

In Re: BAYOU SHORES SNF, LLC,

Debtor.

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION,
UNITED STATES OF AMERICA, on behalf of the Secretary of the
United States Department of Health and Human Services,

Plaintiffs - Appellees,

versus

BAYOU SHORES SNF, LLC,

Defendant - Appellant.

Appeal from the United States District Court
for the Middle District of Florida

(July 11, 2016)

Before HULL, JULIE CARNES, and CLEVINGER,^{*} Circuit Judges.

CLEVINGER, Circuit Judge:

Bayou Shores SNF, LLC (“Bayou Shores”) operates a skilled nursing facility in St. Petersburg, Florida. Most of Bayou Shores’ patients are on Medicare or Medicaid, and over ninety percent of its revenue is derived from Medicare and Medicaid patients. It receives compensation for Medicare and Medicaid services through provider agreements entered into with the federal and state governments. Bayou Shores’ entitlement to participate in the provider agreements depends on its continued compliance with qualification requirements for such facilities that are established by the Secretary of the Department of Health and Human Services. After an unchallenged exercise of her statutory oversight authority, the Secretary determined that Bayou Shores was not in substantial compliance with the Medicare program participation requirements, and that conditions in its facility constituted an immediate jeopardy to residents’ health and safety. By letter dated July 22, 2014, the Secretary notified Bayou Shores that its Medicare provider agreement “will be terminated at 11:59 pm on August 3, 2014.” The termination of Bayou Shores’ Medicare provider agreement triggered the termination of its Medicaid provider agreement as well.

^{*} Honorable Raymond C. Clevenger, III, United States Circuit Judge for the Federal Circuit, sitting by designation.

To avoid the consequences of termination of its provider agreements, Bayou Shores sought protection in the United States Bankruptcy Court for the Middle District of Florida. Rejecting the jurisdictional challenge from the Secretary, the bankruptcy court assumed authority over the Medicare and Medicaid provider agreements as part of the debtor's estate, enjoined the Secretary from terminating the provider agreements, determined for itself that Bayou Shores was qualified to participate in the provider agreements, required the Secretary to maintain the stream of monetary benefit under the agreements, reorganized the debtor's estate, and finally issued its Confirmation Order on December 31, 2014.

On appeal, in a June 26, 2015, Order, the United States District Court for the Middle District of Florida upheld the Secretary's jurisdictional challenge and reversed the Confirmation Order with respect to the assumption of the debtor's Medicare and Medicaid provider agreements. *See In re Bayou Shores SNF, LLC*, 533 B.R. 337, 343 (M.D. Fla. 2015).

Bayou Shores timely appeals the decision of the district court. The appeal turns on the jurisdictional question. From the Social Security Amendments of 1939 until 1984, it is undisputed that bankruptcy courts lacked jurisdiction over Medicare claims. The statute barring such jurisdiction was finally recodified in 1984 to reflect an earlier recodification of the Judicial Code. In cases involving the interpretation of statutory language changed in a recodification, it has long been

established that no change in the previous recodified law is recognized unless Congress's intention to make a substantive change is "clearly expressed." *United States v. Ryder*, 110 U.S. 729, 740 (1884). Now the central question is whether the statutory revision in this case demonstrated Congress's clear intention to vest the bankruptcy courts with jurisdiction over Medicare claims. We think it is abundantly clear that Congress expressed no such intention.

Therefore, after careful review of the record and the parties' briefs, and with the benefit of oral argument, and for the reasons set forth below, we affirm the district court's Order.

I. BACKGROUND

The relevant facts of this case are generally undisputed and ably set out by the district court in the opinion below. *See In re Bayou Shores SNF, LLC*, 533 B.R. 337, 338-40 (M.D. Fla. 2015). A brief summary follows.

A. Bayou Shores' "Skilled Nursing Facility"

As noted above, Bayou Shores operates a "skilled nursing facility"¹ in St. Petersburg, Florida, and approximately ninety percent of Bayou Shores' revenue is derived from caring for Medicare and Medicaid patients. To be eligible for the Medicare/Medicaid program, Bayou Shores entered into so-called "provider agreements" with the federal and Florida state governments, respectively, which

¹ A "skilled nursing facility" is statutorily defined at 42 U.S.C. § 1395i-3(a).

provide reimbursement to Bayou Shores for the provision of medical services to Bayou Shores' Medicare/Medicaid patients. As a condition of payment under these agreements Bayou Shores must comply with certain regulatory requirements pertaining to skilled nursing facilities.² The Plaintiffs in this case are the government agencies primarily tasked with monitoring Bayou Shores' compliance with these regulations: the Florida Agency for Health Care Administration ("AHCA") and the United States Department of Health and Human Services ("HHS") (collectively, "the Government"). AHCA is responsible for conducting surveys of skilled nursing facilities in Florida and administering the state's Medicaid program. HHS administers Medicare nationally, and uses AHCA's surveys to decide whether skilled nursing facilities in Florida are compliant with the regulations, and if not, what remedial action to take. When conditions at a skilled nursing facility pose immediate jeopardy to the health or safety of the facility's patients, the law requires the Secretary to select and execute an appropriate remedy.³

² See e.g. 42 C.F.R. Part 483, Subsection B.

³ The Secretary of HHS's duty to take remedial action in the face of immediate jeopardy to a facility's patients is explained in 42 U.S.C. § 1395i-3(h)(2), where Congress specified that the Secretary "shall" take remedial action in response to immediate jeopardy. See 42 U.S.C. § 1395i-3(h)(2)(A)-(B) (statutorily defined remedies include termination from program, denial of payments, civil monetary penalties, and appointment of temporary management); see also *id.* at (f)(1) ("It is the duty and responsibility of the Secretary to assure that requirements which govern the provision of care in skilled nursing facilities under this subchapter, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.").

On February 10, 2014, AHCA conducted such a survey at Bayou Shores' skilled nursing facility. As a result of the survey, AHCA reported to HHS that Bayou Shores was not compliant with the relevant regulations. The survey noted a number of problems including failing to correctly track residents' "Do Not Resuscitate" orders, poor patient hygiene, and unsecured expired medications. AHCA determined that at least some of these deficiencies posed a threat of immediate jeopardy to Bayou Shores' patients.⁴ Bayou Shores was given an opportunity to remedy these deficiencies. In a follow-up survey on March 20, 2014, AHCA again found a number of deficiencies. These included Bayou Shores placing a "known sexual offender" in a room with a disabled patient without informing that patient, and subsequently failing to appropriately handle an alleged sexual assault by the "known sexual offender" reported by the disabled patient. As with the previous survey, AHCA found that at least some of these deficiencies posed a threat of immediate jeopardy to Bayou Shores' patients. Bayou Shores was again given the opportunity to remedy the deficiencies.

The proverbial "last straw" was a final survey on July 11, 2014, in which further deficiencies were identified, including allowing a mentally impaired

⁴ Immediate jeopardy exists if the nursing home's noncompliance has caused or is likely to cause "serious injury, harm, impairment or death to a resident." 42 C.F.R. § 488.301. The regulation only requires that the nursing home's noncompliance is likely to cause harm to "a resident." Though correctly quoting the regulation, the bankruptcy court appears to have incorrectly believed that actual harm is required for a finding of "immediate jeopardy." See *In re Bayou Shores SNF, LLC*, 525 B.R. 160, 163 (Bankr. M.D. Fla. 2014). However, actual harm is not a prerequisite for a finding of immediate jeopardy.

resident to leave the facility unaccompanied on a hot Florida day (he was later found at a bus station). AHCA again determined that at least some of these deficiencies placed Bayou Shores' residents in immediate jeopardy. After the third finding of non-compliance, HHS sent Bayou Shores a letter on July 22, 2014 notifying Bayou Shores that its non-compliance posed an "immediate jeopardy to [Bayou Shores'] residents' health and safety," and that HHS was exercising its regulatory discretion to terminate Bayou Shores' Medicare provider agreement. HHS's letter stated that the "Medicare provider agreement will be terminated at 11:59 pm on August 3, 2014."⁵ The termination of Bayou Shores' Medicare provider agreement triggered the termination of Bayou Shores' Medicaid provider agreement.⁶

B. Bankruptcy Court Proceedings

Two days before this looming deadline, on August 1, 2014, Bayou Shores sought emergency injunctive relief from the U.S. District Court for the Middle

⁵ The statute permits HHS to terminate a provider agreement in light of a finding of immediate jeopardy without a pre-termination hearing for the provider. *See* 42 U.S.C. § 1395i-3(h)(2)(a); *see also Cathedral Rock of N. Coll. Hill, Inc. v. Shalala*, 223 F.3d 354, 366 (6th Cir. 2000) (no pre-termination hearing required under Due Process Clause); *Northlake Cmty. Hosp. v. United States*, 654 F.2d 1234, 1241-43 (7th Cir. 1981) (same).

⁶ Though Bayou Shores disputes whether Florida has followed the correct procedure to "finalize" the termination of their Medicaid provider agreement, Bayou Shores does not appear to dispute that such termination will be the end result of the termination of the Medicare provider agreement. *See e.g.* 42 U.S.C. § 1396a(a)(39); Fla. Stat. § 409.913(14); *see also Livingston Care Ctr., Inc. v. United States*, 934 F.2d 719, 720 (6th Cir. 1991) ("The Secretary of Health and Human Services's termination of the plaintiffs' Medicare certification automatically triggered termination of plaintiffs' Medicaid certification as well").

District of Florida to prevent the termination of the provider agreements. The district court initially granted Bayou Shores' request for a temporary restraining order. However, on motion of HHS, the district court dismissed Bayou Shores' complaint for lack of subject matter jurisdiction. On August 15, 2014, the court found that Bayou Shores had not exhausted its administrative remedies, and thus Medicare's jurisdictional bar (42 U.S.C. § 405(h)) prevented the district court from exercising jurisdiction over the termination of the provider agreements. *See Bayou Shores SNF, LLC v. Burwell*, No. 8:14-CV-1849-T-33MAP, 2014 WL 4059900,*6-8 (M.D. Fla. Aug. 15, 2014). Approximately an hour after issuance of the district court's order, Bayou Shores filed a Voluntary Petition for Chapter 11 bankruptcy, and sought an emergency injunction from the bankruptcy court preventing HHS and AHCA from terminating the provider agreements. The Government, at each opportunity, challenged the bankruptcy court's jurisdiction to order assumption of the provider agreements.

On August 25, 2014, the bankruptcy court issued the preliminary injunction sought by Bayou Shores. The bankruptcy court reasoned that it had jurisdiction pursuant to 28 U.S.C. § 1334,⁷ the provider agreements were property of the estate, and an automatic stay preventing HHS and AHCA from terminating the agreements was thus proper. At a subsequent evidentiary hearing on August 26,

⁷ 28 U.S.C. § 1334, titled "Bankruptcy cases and proceedings," generally defines the original and exclusive jurisdiction of district courts over bankruptcy proceedings.

the bankruptcy court heard testimony from doctors, patients, and other Bayou Shores witnesses. Concluding that in its view Bayou Shores' patients did not appear to be in any immediate jeopardy, the bankruptcy court issued an order on September 5, 2014 that (among other things) forbade HHS and AHCA from terminating Bayou Shores' provider agreements.

After further proceedings, on December 31, 2014 the bankruptcy court issued its Confirmation Order. *See In re Bayou Shores SNF, LLC*, 525 B.R. 160 (Bankr. M.D. Fla. 2014). In the Confirmation Order, the bankruptcy court again stated its belief that jurisdiction was proper under 28 U.S.C § 1334, and rejected HHS and AHCA's argument that the same 42 U.S.C. § 405(h) bar applied to the bankruptcy court as applied to the district court. The bankruptcy court reasoned that the plain language of § 405(h), which refers only to 28 U.S.C §§ 1331 and 1346, did not prevent the bankruptcy court from exercising jurisdiction over the assumption of the provider agreements under § 1334. *Id.* at 166. The bankruptcy court further concluded that because Bayou Shores appeared to have remedied the deficiencies it was originally cited for, Bayou Shores had provided adequate assurances of future performance under the provider agreements, and thus was eligible to assume them. Finding the remainder of the statutory requirements fulfilled, the bankruptcy court confirmed Bayou Shore's Chapter 11 plan. The

bankruptcy court also ordered the dissolution of the automatic stay and preliminary injunction.⁸

C. District Court Proceedings

HHS and AHCA separately appealed both the bankruptcy court's September 5, 2014 Order, and the Confirmation Order. The appeals were consolidated by the district court. As they had argued to the bankruptcy court, HHS and AHCA asserted to the district court that 42 U.S.C. § 405(h) denied the bankruptcy court jurisdiction over the provider agreements. The district court agreed. While acknowledging that the bankruptcy court's reading of § 405(h) was an issue that the Eleventh Circuit had not squarely addressed, the district court noted that the majority of other circuit courts addressing the issue "have examined Congress' intent when it enacted the jurisdictional bar and concluded that the omission of section 1334 and other jurisdictional grants (like section 1332) was inconsistent with that intent." *In re Bayou Shores*, 533 B.R. at 342. The district court reviewed the relevant statutory language and legislative history, as well as decisions from other courts examining the same. In particular, the district court noted that the absence of § 1334 in the recodified 42 U.S.C. § 405(h) appeared to be the result of a codification error. Based on that analysis, the district court held that it

⁸ See Bankr. ECF No. 285 at 12-13 (ordering that "all injunctions and stays previously provided for in this case pursuant to sections 105 and/or 362 of the Bankruptcy Code shall remain in full force and effect until the Effective Date."). As explained further *infra*, the parties dispute what effect this dissolution has on the issues in this case.

“respectfully disagree[d] [with the bankruptcy court] and align[ed] itself with the majority view” in finding that § 405(h) must be understood to bar jurisdiction under § 1334. *Id.* at 343.

Because it was undisputed that Bayou Shores had yet to exhaust its administrative remedies, and “no other independent basis for jurisdiction existed to enjoin and order the assumption of the Medicare and Medicaid provider agreements,” the district court reversed the orders of the bankruptcy court (with respect to the provider agreements). *Id.*

The district court also noted that a hotly contested issue on appeal was “the exact timing of any termination of the provider agreements.” *Id.* However, the district court found that it did not need to resolve that issue, because the timing was irrelevant to whether or not the bankruptcy court lacked jurisdiction to hear the case in the first place. *Id.*⁹

Bayou Shores timely appealed the district court’s order.

II. STANDARD OF REVIEW

In a bankruptcy case, this Court sits as a second court of review and thus examines independently the factual and legal determinations of the bankruptcy court and employs the same standards of review as the district court. *See Brown v.*

⁹ The Government argues that the provider agreements terminated prior to Bayou Shores filing their bankruptcy petition, thus depriving the bankruptcy court of jurisdiction over the provider agreements. Bayou Shores (for various reasons) contests that argument. For reasons we explain below, we do not find it necessary to resolve this dispute.

Gore (In re Brown), 742 F.3d 1309, 1315 (11th Cir. 2014). We review the bankruptcy court's factual findings for clear error and its legal conclusions de novo. *Id.* The district court's legal determinations are also reviewed de novo. *See Dionne v. Simmons (In re Simmons)*, 200 F.3d 738, 741 (11th Cir. 2000).

III. BANKRUPTCY COURT JURISDICTION OVER MEDICARE CLAIMS

The primary dispute in this case is purely legal: does 42 U.S.C. § 405(h) bar a bankruptcy court from exercising 28 U.S.C. § 1334 jurisdiction over claims that arise under the Medicare Act? Bayou Shores' primary argument is that the plain text of § 405(h) precludes district court jurisdiction under 28 U.S.C. §§ 1331 and 1346 only. The Government argues that the lack of a reference to § 1334 is merely a result of a codification error, and that properly construed the statute requires exhaustion of administrative remedies before bringing a Medicare claim before any district court.

Because we conclude that the lack of a reference to § 1334 in § 405(h) is the result of a codification error, we agree with the Government that the bankruptcy court lacked jurisdiction over the termination of the provider agreements. To see why, we turn first to an examination of the history of § 405(h).

A. Legislative history of § 405(h)

The relevant text of the 42 U.S.C. § 405(h) currently reads (emphasis added):

(h) Finality of Commissioner's decision

The findings and decision of the Commissioner of Social Security after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Commissioner of Social Security shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Commissioner of Social Security, or any officer or employee thereof shall be brought *under section 1331 or 1346 of Title 28* to recover on any claim arising under this subchapter.¹⁰

Bayou Shores argues that the third sentence of § 405(h) forbids only an “action” brought under “section 1331 [*i.e.* federal question jurisdiction] or 1346 [*i.e.* suits against the federal government] of Title 28.” Because Bayou Shores’ action was brought under section 1334 of Title 28 (*i.e.* bankruptcy jurisdiction), Bayou Shores argues that § 405(h) does not apply. To understand why Bayou Shores is incorrect however requires a thorough examination of the history of § 405(h), which reveals that the issue is not as straightforward as Bayou Shores suggests.

The original text of § 405(h) when passed in 1939 was largely the same as it is today, with the crucial difference for this case emphasized below:

(h) 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

¹⁰ § 405(h) applies to Medicare via 42 U.S.C. § 1395ii, which states that “any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.”

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 24 of the Judicial Code of the United States* to recover on any claim arising under this title.

See Social Security Amendments of 1939, Pub. L. No. 76-379, 53 Stat. 1360 (1939) (emphasis added). In 1939, “section 24 of the Judicial Code” defined the original jurisdiction granted to district courts, including jurisdiction over bankruptcy claims (*see* Judicial Code, Pub. L. No. 61-475, 36 Stat. 1087, § 24(19) (1911)), diversity and federal question claims (*id.* at § 24(1)), and claims against the United States (*id.* at § 24(20)). With few exceptions then, section 24 of the Judicial Code originally “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 [Medicare] statutes.” *See Weinberger v. Salfi*, 422 U.S. 749, 756, n. 3 (1975). It is thus undisputed that under the original text of § 405(h), bankruptcy court jurisdiction over Medicare claims was barred.

In 1948, however, Congress recodified section 24 of the Judicial Code under title 28 of the U.S. Code.¹¹ As part of that revision, Congress split the district

¹¹ Codification refers generally to the process of arranging and organizing the Statutes at Large into the U.S. Code. *See generally* Proceedings of the Fifty-First Annual Meeting of the American Association of Law Libraries, Fifth General Session, 51 Law Libr. J. 388 (1958) (remarks of Dr. Charles Zinn, Law Revision Counsel, explaining the process of codification); *see also* William W. Barron, *The Judicial Code*, 8 F.R.D. 439 (1949) (the “Chief Reviser, Title 28, U.S. Code, Judiciary and Judicial Procedure, and Title 18, U.S. Code, Crime and Criminal Procedure” explaining generally the 1948 Judicial Code revisions).

courts' jurisdictional grants into multiple sections under Title 28. *See* U.S. Code, Title 28, Pub. L. No. 80-773, 62 Stat. 869 (1948). Among other things, federal question jurisdiction was re-codified to 28 U.S.C. § 1331, diversity jurisdiction to § 1332, suits against the government to § 1346, and bankruptcy jurisdiction to § 1334. *See id.* at Ch. 85, §§ 1331-1359 (“District Courts; Jurisdiction”).

After the 1948 re-codification however, the text of § 405(h) continued to incorrectly refer to “section 24 of the Judicial Code” for approximately the next thirty years. Indeed, the Supreme Court noted this issue in its 1975 *Salfi* decision. The text in the body of the Court’s opinion replaced the reference in § 405(h) to “section 24 of the Judicial Code” with “[§ 1331 et seq.] of Title 28.” *See Salfi*, 422 U.S. at 756. A footnote in the opinion acknowledged the apparent error created by the 1948 Judicial Code recodification. *See id.* at n. 3.

By 1976 (after the *Weinberger* decision), the Office of the Law Revision Counsel appears to have recognized the error.¹² In the edition of the U.S. Code published that year, the revisers substituted the phrase “section 24 of the Judicial Code of the United States” in § 405(h) with the now current language, “sections 1331 or 1346 of title 28.” A “Codification” note included in the 1976 revision indicates the following about the change:

¹² The Office of the Law Revision Counsel, created in 1974, is a body within the U.S. House of Representatives whose principal purpose is to codify the laws of the U.S. and periodically publish updates to the U.S. Code. *See* 2 U.S.C. §§ 285 *et. seq.*

In subsec. (h), “sections 1331 or 1346 of title 28” was substituted for “section 24 of the Judicial Code of the United States” on authority of act June 25, 1948, ch. 646, 62 Stat. 869, section 1 of which enacted Title 28, Judiciary and Judicial Procedure. Prior to the enactment of Title 28, section 24 of the Judicial Code was classified to section 41 of Title 28.

See 42 U.S.C. § 405 (1976). The revisers expanded somewhat on this note in the 1982 version of the code (added text emphasized):

In subsec. (h), “sections 1331 or 1346 of title 28” was substituted for “section 24 of the Judicial Code of the United States” on authority of act June 25, 1948, ch. 646, 62 Stat. 869, section 1 of which enacted Title 28, Judiciary and Judicial Procedure. Prior to the enactment of Title 28, section 24 of the Judicial Code was classified to section 41 of Title 28. *Jurisdictional provisions previously covered by section 41 of Title 28 are covered by sections 1331 to 1348, 1350 to 1357, 1359, 1397, 1399, 2361, 2401, and 2402 of Title 28.*

See 42 U.S.C. § 405 (1982).

A year later, H.R. 3805, the “Technical Corrections Act of 1983” was introduced to the floor of the House. 129 Cong. Rec. 23,439 (1983) (statement of Rep. Rostenkowski). A report on the bill describes its derivation and purpose as follows:

The technical amendments made by the Technical Corrections Act of 1983 are intended to clarify and conform various provisions adopted by the acts listed above. The bill is based on a review by the staffs of the Joint Committee on Taxation and the Committee on Ways and Means, taking into account the comments submitted to the Congress that concerned changes that would be technical in nature. The bill was developed with the assistance of the Treasury Department, the Social Security Administration, and the Health Care Financing Administration.

See STAFF OF J. COMM. ON TAXATION, 98TH CONG., DESCRIPTION OF H.R. 3805 (TECHNICAL CORRECTIONS ACT OF 1983), at 1 (J. Comm. Print 1983) (“H.R. 3805 Rept.”).

Among the numerous “technical amendments” was an amendment to § 405(h), proposing to enact the prior codification into positive law:

(D) 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,”.

See Technical Corrections Act of 1983: Hearing on H.R. 3805 Before the H.

Comm. on Ways and Means, 98th Cong. 79 (1984) (draft text of H.R. 3805).¹³

That section of the act, titled “Sec. 403. Other Technical Corrections in [old age, survivors, and disability insurance] Provisions,”¹⁴ was followed by this in “Sec. 404. Effective Dates”:

(b)(1) Except to the extent otherwise specifically provided in this title, the amendments made by section 403 shall be effective on the date of 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.*

¹³ The U.S. Code is not necessarily “positive law.” Rather, the text of the U.S. Code is *prima facie* evidence of the law of the United States; where the code conflicts with the Statutes at Large however, the Statutes at Large trump. See *U.S. Nat. Bank of Oregon v. Indep. Ins. Agents of Am., Inc.*, 508 U.S. 439, 448 (1993). Additionally, some parts of the code have been enacted into positive law; when this happens, the text of the code becomes evidence of the law. See *id.* at 448 n. 3 (citing to 1 U.S.C. § 204(a)); see generally Alice I. Youmans, et. al., *Questions & Answers*, 78 Law. Libr. J. 585, 590 (1986) (explaining the relationship between the U.S. Code, Statutes at Large, and positive law).

¹⁴ See e.g. H.R. 3805 Rept. at 20.

See id. at 89-90 (emphasis added). The legislative history of H.R. 3805 appears to characterize this and other “technical corrections” as “certain corrections of spelling, punctuation, and cross-references in title XVIII of the Social Security Act and in cross-references to the Internal Revenue Code.” *See* H.R. 3805 Rept. at 37.¹⁵ Moreover, the bill’s sponsor, Rep. Dan Rostenkowski, noted when the bill was introduced: “I would like to emphasize that this bill intends simply to correct technical errors and to better reflect the policies established by the Congress in enacting the original legislation.” 129 Cong. Rec. 23321, 23440 (1983). H.R. 3805 did not contain any provisions relating to the jurisdiction of bankruptcy courts.

Although H.R. 3805 did not become law, in 1984 it was merged into another bill, H.R. 4170, which Congress passed as The Deficit Reduction Act of 1984, Pub. L. No. 98-369, 98 Stat. 494 (1984) (hereinafter, the “DRA”).¹⁶ As noted in the bill itself, the general purpose of the DRA was “to provide for tax reform, and for deficit reduction.” *See* 98 Stat. at 494. The DRA did not contain any provisions relating to the scope of bankruptcy court jurisdiction.

The amendment to § 405(h) is located in “DIVISION V – SPENDING REDUCTION ACT OF 1984”, “TITLE VI — OASDI, SSI, AFDC, AND OTHER

¹⁵ The report similarly notes that where no descriptions are provided, the amendments are “clerical in nature.” *Id.* at 1.

¹⁶ *See* H.R. Rep. No. 98-432, pt. 2, at 1027 (1984) (explaining that “Title VI – Technical Corrections” of H.R. 4170 originated as the amended H.R. 3805).

PROGRAMS,” “Subtitle D — Technical Corrections,” “Sec. 2663. Other technical corrections in the Social Security Act and related provisions.” Consistent with the 1976 and 1982 codification (and the amendment originally proposed in H.R. 3805), section 2663(a)(4)(D) ordered that “Section 205(h) of [the Social Security 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,’.” *See* 98 Stat. at 1162. Section 2664 of the DRA further requires that “[e]xcept 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.” *See id.* at 1171-72.

The House committee report on the DRA explains the reasons for the “technical corrections” of certain sections in the bill, but does not specifically address the amendments to § 405(h). The report generally states that the “bill makes certain corrections of spelling, punctuation, cross-references and other clerical amendments to the Social Security Act and related provisions in the Internal Revenue Code.” *See* H.R. Rep. No. 98-432, pt. 2, at 1663 (1984). Nothing in the report or elsewhere in the legislative history, in so far as we have been able to determine, expresses any intention to change the jurisdiction of bankruptcy

courts, let alone to grant bankruptcy courts parallel authority with HHS over Medicare claims.

It thus appears that the current text of § 405(h) is the result of the Office of the Law Revision Counsel's mistaken codification, an error enacted into positive law by the DRA. While the Supreme Court has yet to speak on this precise issue, the Court has had reason to interpret § 405(h) in a number of cases that are helpful in resolving the current dispute. We thus turn to an examination of those cases before turning back to the codification issue.

B. Supreme Court cases interpreting § 405(h)

The earliest relevant Supreme Court decision, *Salfi*, was decided prior to the DRA amendment to § 405(h). In *Salfi* the plaintiff brought suit to challenge the Social Security Administration's "duration-of-relationship requirements" as unconstitutional. 422 U.S. at 752-53. The district court exercised jurisdiction over the case pursuant to 28 U.S.C. § 1331. *Id.* at 755. While deciding the constitutional question against the plaintiff, more relevant for our purposes is the Court's analysis of the "serious question as to whether the District Court had jurisdiction over this suit" to begin with. *See Salfi, Id.* at 756.

In examining the requirements of § 405(h), the Court found that the third sentence, "No action against the United States, the Secretary, or any officer or employee thereof shall be brought under (§ 1331 et seq.) of Title 28 to recover on

any claim arising under (Title II of the Social Security Act)”¹⁷ should be read as more than merely a “codified requirement of administrative exhaustion” because the first two sentences of § 405(h) already require administrative exhaustion. *Id.* at 757.¹⁸ Those first two sentences prevent review of any decision of the Secretary other than as set out in § 405(g), which prescribes “typical requirements for review of matters before an administrative agency, including administrative exhaustion.” *Id.* at 758. The Court thus explained that the third sentence of § 405(h) acted to bar actions under § 1331, even where administrative remedies had been exhausted. *Id.* at 757.

Somewhat less than a decade later, the Court again considered § 405(h) again in *Heckler v. Ringer*, 466 U.S. 602 (1984). In *Ringer*, the underlying factual dispute involved “challenges to the policy of the Secretary of Health and Human Services (Secretary) as to the payment of Medicare benefits for a surgical procedure known as bilateral carotid body resection (BCBR).” *Id.* at 604-05. The focus of the case was whether the plaintiff’s claims “arose” under the Medicare Act. *See e.g. id.* at 612-613. But in characterizing § 405(h) and its own holding in

¹⁷ As noted previously, the third sentence of § 405(h) at the time incorrectly referred to title 24 of the Judicial Code, and the Court’s opinion inserted the correct cross-reference to the relevant section of Title 28 of the U.S. Code. *See id.* at 756 n. 3. While surely strong evidence of how the Supreme Court reads § 405(h), *Salfi* did not raise the interpretive issue at the heart of this case, and thus does not dispose of the issue.

¹⁸ The first two sentences read: “The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided.” 42 U.S.C. § 405(h).

Salfi, the Court held that “[t]he 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.” *Id.* at 614-15.

Perhaps most instructive is a more recent case, decided long after the 1984 DRA amendments to § 405(h), *Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1 (2000). The plaintiffs in *Illinois Council* were an association of nursing homes challenging the legality and constitutionality of certain Medicare-related regulations. *Id.* at 5. As in *Ringer*, the key issue in *Illinois Council* was whether the plaintiff’s claims “arose” under the Medicare Act (and were thus subject to the § 405(h) jurisdictional bar). *Id.* at 9-10.

However, in explaining the application of § 405(h) to the case, the Court again emphasized that the effect of § 405(h) was to reach beyond normal principles of “administrative exhaustion” and “ripeness,” and prevent even the application of normal exceptions to those doctrines. *Id.* at 12. The Court held that § 405(h) “demands the ‘channeling’ of *virtually all legal attacks* through the agency.” *Id.* at 13 (emphasis added). Moreover, the Court explained the balancing policy interests inherent in such a scheme:

[I]t assures the agency greater opportunity to apply, interpret, or revise policies, regulations, or statutes without possibly premature interference by different individual courts applying “ripeness” and “exhaustion” exceptions case by case. But this assurance comes at

a price, namely, occasional individual, delay-related hardship. In the context of a massive, complex health and safety program such as Medicare, embodied in hundreds of pages of statutes and thousands of pages of often interrelated regulations, any of which may become the subject of a legal challenge in any of several different courts, paying this price may seem justified.

Id. at 13. As the Court noted, whatever one may think of such a policy, it was clearly that chosen by Congress in creating § 405(h).¹⁹

A few salient points about § 405(h) are thus clear from the relevant Supreme Court cases. *Salfi* makes clear that the first two sentences of § 405(h) require standard administrative exhaustion of remedies prior to bringing Medicare claims before a district court. *See Salfi*, 422 U.S. at 757. Moreover, § 405(h) “demands the ‘channeling’ of virtually all legal attacks through the agency,” making § 405(g) the “sole avenue for judicial review for all ‘claim[s] arising under’ the Medicare Act.” *See Illinois Council*, 529 U.S. at 13; *Ringer*, 466 U.S. at 615-14. However, we must acknowledge a common thread running through all three cases: each involved a suit brought under 28 U.S.C. § 1331, a jurisdictional grant that all parties agree was barred by § 405(h) prior to the 1984 amendments and continues to be barred after the amendments.²⁰ Thus, none of these cases answers the

¹⁹ *See id.* at 13 (noting that “[i]n any event, such was the judgment of Congress as understood in *Salfi* and *Ringer*”).

²⁰ Similarly, to the extent our Court has addressed the reach of the jurisdictional bar of § 405(h) since the 1984 DRA amendments, it appears that the cases have been § 1331 cases. *See e.g. Dial v. Healthspring of Alabama, Inc.*, 541 F.3d 1044, 1047-48 (11th Cir. 2008); *Cochran v. U.S. Health Care Fin. Admin.*, 291 F.3d 775, 778-79 (11th Cir. 2002); *United States v. Blue Cross & Blue Shield of Alabama, Inc.*, 156 F.3d 1098, 1101 (11th Cir. 1998); *Am. Acad. of Dermatology*

question before us, namely, does § 405(h) bar jurisdiction under § 1334? To further examine the question, we turn to the decisions of our sister circuits.

C. Courts split over the application of § 405(h) to district courts

The decisions of our sister circuits (and the lower courts) fall into two categories. The first group of cases holds that the jurisdictional bar of § 405(h) applies to cases brought under § 1332 jurisdiction (*i.e.* diversity jurisdiction), notwithstanding the fact that § 1332 (like § 1334) is not mentioned in the statute. The second group of cases directly considers whether § 1334 jurisdiction can lie in the face of § 405(h).

1. Cases holding that § 405(h) bars jurisdiction

The primary case among the first category of § 1332 decisions is from the Seventh Circuit in *Bodimetric Health Servs., Inc. v. Aetna Life & Cas.*, 903 F.2d 480 (7th Cir. 1990). In determining whether a review of plaintiff's claims in a district court was precluded by § 405(h), the Seventh Circuit noted the “curious” fact that § 405(h) on its face appears to bar “actions brought pursuant to federal

v. Dep't of Health & Human Servs., 118 F.3d 1495, 1499 n. 8 (11th Cir. 1997); *Am. Fed'n of Home Health Agencies, Inc. v. Heckler*, 754 F.2d 896, 897-98 (11th Cir. 1984). Both parties cite and discuss *V.N.A. of Greater Tift Cty., Inc. v. Heckler*, 711 F.2d 1020 (11th Cir. 1983). Though *V.N.A.* was decided before the 1984 amendments, it appears the Court in that case cited to the Law Revision Counsel's 1976 (or 1982) re-codified version of the statute in its opinion. See *V.N.A.*, 711 F.2d at 1024. In a footnote of the opinion, the Court notes that “[t]here can be no question that § 405(h) fully applies to the present case, because the district court's jurisdiction is founded on 28 U.S.C. § 1331.” *Id.* at n. 5. We also note *Lifestar Ambulance Serv., Inc. v. United States*, 365 F.3d 1293, 1295 n. 3 (11th Cir. 2004), in which this Court assumed, but did not decide, that mandamus jurisdiction under § 1361 was not barred under § 405(h). These cases do not address the issue of whether actions brought under § 1334 are barred by § 405(h).

question jurisdiction and actions brought against the United States but appears to permit actions brought pursuant to diversity jurisdiction.” *See id.* at 488.

However, the Seventh Circuit then analyzed the codification history described *supra*, holding that in § 2664(b) of the DRA Congress had “clearly expressed” its intent not to substantively change the scope of § 405(h). *Id.* at 489. Thus, because the statute prior to amendment had clearly barred diversity jurisdiction, the revised statute continued to bar diversity jurisdiction. *Id.*

Both the Third and Eighth circuits have subsequently adopted the holding and analysis of *Bodimetric*. See *Nichole Med. Equip. & Supply, Inc. v. TriCenturion, Inc.*, 694 F.3d 340, 346-47 (3d Cir. 2012); *Midland Psychiatric Associates, Inc. v. United States*, 145 F.3d 1000, 1004 (8th Cir. 1998). An earlier Third Circuit case, *In re Univ. Med. Ctr., Inc.*, 973 F.2d 1065, 1073-74 (3d Cir. 1992), appears to suggest (but not hold) that § 405(h) may not apply to bankruptcy courts. However, that case involved a claim that HHS had violated an automatic bankruptcy stay. The court’s opinion hinged on its holding that such a claim did not “arise” under the Medicare act. *Id.* at 1073. In *Nichole Med. Equip.*, the Third Circuit explicitly adopted *Bodimetric*, noting that “Congress clearly prohibited federal courts from exercising subject matter jurisdiction or diversity jurisdiction over claims arising under the [Medicare] Act.” *See* 694 F.3d at 347.

Several circuits have thus addressed the question of whether § 405(h) bars districts court jurisdiction other than pursuant only to §§ 1331 and 1346. Those circuits read the history of § 405(h) to conclude that the codification error acts to carry forward the original § 405(h)'s jurisdictional restrictions.²¹

2. Cases holding that § 405(h) does not bar § 1334 jurisdiction

The second category of cases come first from the Ninth Circuit and begin with *In re Town & Country Home Nursing Servs.*, 963 F.2d 1146 (9th Cir. 1991). The court there was asked to determine if the failure to exhaust administrative remedies precluded a bankruptcy court from exercising jurisdiction over state law tort and contract claims “arising out of the government’s setoff of Medicare overpayments.” *Id.* at 1154. The Ninth Circuit held that “Section 405(h) only bars actions under 28 U.S.C. §§ 1331 and 1346; it in no way prohibits an assertion of jurisdiction under section 1334.” *Id.* at 1155. The Ninth Circuit appears to have placed great weight on “section 1334’s broad jurisdictional grant over all matters conceivably having an effect on the bankruptcy estate.” *Id.* However, the court did not discuss or analyze the legislative history relied on in the *Bodimetric* line of cases.

²¹ Although not squarely deciding the issue, a number of other circuit court decisions have suggested that § 405(h) bars jurisdictions other than pursuant to only §§ 1331 and 1346. *See BP Care, Inc. v. Thompson*, 398 F.3d 503, 515 n. 11 (6th Cir. 2005) (citing favorably to *Bodimetric* analysis); *St. Vincent's Med. Ctr. v. United States*, 32 F.3d 548, 550 (Fed. Cir. 1994) (holding that Court of Federal claims jurisdiction barred by § 405(h)). The First Circuit has recognized the issue, but declined to address it. *See In re Ludlow Hosp. Soc., Inc.*, 124 F.3d 22, 25 n. 7 (1st Cir. 1997) (recognizing, but avoiding, § 405(h) jurisdictional issue by deciding case on merits).

A later Ninth Circuit case, *Kaiser v. Blue Cross of California*, 347 F.3d 1107, 1114 (9th Cir. 2003), cites favorably to both *Bodimetric* and *Midland Psychiatric* for what those cases say about a claim that “arises under Medicare.” It appears that the court in *Kaiser* assumed that the plaintiffs were proceeding under federal-question jurisdiction (which is indisputably precluded by § 405(h)), and thus the only relevant question was whether their claims “arose” under Medicare. But in a dicta discussion of whether there had been a waiver of sovereign immunity, the court noted that “11 U.S.C. § 106(a), which refers to waivers of sovereign immunity in bankruptcy proceedings, could not apply since any consideration of claims against the government in [debtor]'s bankruptcy would likely require consideration of the merits of the Medicare claims, again invoking 42 U.S.C. § 405(g).” *Id.* at 1117. Thus, *Kaiser* at least hints that the court would have come to the opposite conclusion of *In re Town & Country*, *i.e.* by holding that bankruptcy jurisdiction could not trump the exhaustion requirements of §§ 405(g) and (h).

A more recent Ninth Circuit decision, *Do Sung Uhm v. Humana, Inc.*, 620 F.3d 1134 (9th Cir. 2010) attempted to address what it characterized as a possible conflict between *Kaiser* and *In re Town & Country*. The *Do Sung Uhm* court cites *Kaiser* for the proposition that “[j]urisdiction over cases ‘arising under’ Medicare exists only under 42 U.S.C. § 405(g), which requires an agency decision in

advance of judicial review.” *Id.* at 1140-41. In a footnote though, the court acknowledges the tension between *Kaiser*’s broad reading of § 405(h) and *In re Town & Country*’s more narrow reading, but reconciles the two on the grounds that *In re Town & Country* relied on the “special status” of bankruptcy court jurisdiction over bankruptcy issues. *Id.* at 1141 n. 11. The court concludes that *In re Town & Country*’s reading of 42 U.S.C. § 405(h) applies “only to actions brought under § 1334, while not bearing on the relationship between § 405(h) and other jurisdictional provisions such as § 1332.” *Id.* The Ninth Circuit thus joins the other circuit courts in unanimously opining that § 405(h) bars diversity jurisdiction under § 1332, notwithstanding the omission of § 1332 from the text of § 405(h).

However, the Ninth Circuit is alone among circuit court decisions in reading § 405(h) to permit bankruptcy court jurisdiction over Medicare claims under § 1334. Many lower courts have also considered the issue of § 1334 jurisdiction. These lower courts have split, with some assuming jurisdiction,²² and others

²² See e.g. *In re Nurses' Registry & Home Health Corp.*, 533 B.R. 590, 593-97 (Bankr. E.D. Ky. 2015); *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); *In re Healthback, L.L.C.*, 226 B.R. 464, 472-74 (Bankr. W.D. Okla. 1998), *vacated*, *In re HealthBack, L.L.C.*, Case No. 97-22616-BH, 1999 WL 35012949 (Bankr. W.D. Okla. May 28, 1999); *First Am. Health Care of Georgia Inc. v. Dep't of Health & Human Servs.*, 208 B.R. 985, 988-90 (Bankr. S.D. Ga. 1996), *vacated and superseded sub nom.*, *First Am. Health Care of Georgia, Inc. v. U.S. Dep't of Health & Human Servs.*, Case No. 96-2007, 1996 WL 282149 (Bankr. S.D. Ga. Mar. 11, 1996); *In re Healthmaster Home Health Care, Inc.*, Case No. 95-10548, 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, 557-60 (Bankr. N.D. Ga. 1987).

deciding jurisdiction was barred.²³ Case going both ways have recognized and analyzed the codification error that led to the present omission of § 1334 from the text of § 405(h). *Compare e.g. In re Nurses' Registry & Home Health Corp.*, 533 B.R. 590, 593-97 (Bankr. E.D. Ky. 2015) (assuming jurisdiction under § 1334) *to In re St. Johns Home Health Agency, Inc.*, 173 B.R. 238, 245-46 (Bankr. S.D. Fla. 1994) (holding that § 1334 jurisdiction is barred).

We also note some limited scholarship addressing this issue as well. Articles written by members of the bankruptcy bar argue that under the “plain meaning” doctrine, bankruptcy courts’ § 1334 jurisdiction is not barred by § 405(h). *See* Samuel R. Maizel & Michael B. Potere, *Killing the Patient to Cure the Disease: Medicare's Jurisdictional Bar Does Not Apply to Bankruptcy Courts*, 32 Emory Bankr. Dev. J. 19, 66 (2015); Peter R. Roest, *Recovery of Medicare and Medicaid Overpayments in Bankruptcy*, 10 Annals Health L. 1, 1 (2001). Conversely, an article written by current and former counsel for HHS argues that, based on the

²³ *Excel Home Care, Inc. v. U.S. Dep't of Health & Human Servs.*, 316 B.R. 565, 572-574 (D. Mass. 2004); *In re Hodges*, 364 B.R. 304, 305-6 (Bankr. N.D. Ill. 2007); *In re House of Mercy, Inc.*, 353 B.R. 867, 869-73 (Bankr. W.D. La. 2006); *In re Fluellen*, Case No. 05-40336 (ALG), 2006 WL 687160, at *1 (Bankr. S.D.N.Y. Mar. 13, 2006); *U.S., Dep't of Health & Human Servs. v. James*, 256 B.R. 479, 481-82 (W.D. Ky. 2000); *In re Hosp. Staffing Servs., Inc.*, 258 B.R. 53, 57-58 (S.D. Fla. 2000); *In re Mid-Delta Health Sys., Inc.*, 251 B.R. 811, 814-15 (Bankr. N.D. Miss. 1999); *In re Tri Cty. Home Health Servs., Inc.*, 230 B.R. 106, 108 n. 1 (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 Home Comp Care, Inc.*, 221 B.R. 202, 206 (N.D. Ill. 1998); *In re AHN Homecare, LLC*, 222 B.R. 804, 807-10 (Bankr. N.D. Tex. 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, 117-20 (Bankr. W.D. Mo. 1991); *In re St. Mary Hosp.*, 123 B.R. 14, 16-18 (E.D. Pa. 1991).

legislative history, the amended § 405(h) should have the same effect as the prior version, *i.e.* barring bankruptcy court jurisdiction. *See* John Aloysius Cogan Jr. & Rodney A. Johnson, *Administrative Channeling Under the Medicare Act Clarified: Illinois Council, Section 405(h), and the Application of Congressional Intent*, 9 Annals Health L. 125, 125 (2000).

3. Mandamus jurisdiction and § 405(h)

We note in passing a related issue: whether § 405(h) bars mandamus jurisdiction exercised pursuant to 28 U.S.C. § 1361. As noted *supra*, n. 20, this circuit has not decided that issue. *See Lifestar Ambulance Serv., Inc. v. United States*, 365 F.3d 1293, 1295 n. 3 (11th Cir. 2004). The Supreme Court has also repeatedly declined to decide whether mandamus jurisdiction is prohibited by § 405(h). *See e.g. Your Home Visiting Nurse Servs., Inc. v. Shalala*, 525 U.S. 449, 456 n. 3 (1999). However, the great weight of authority from other circuits has almost uniformly found that § 405(h) does not necessarily deprive district courts of mandamus jurisdiction over Medicare claims.²⁴

Superficially at least, there is some commonality between the issue in those cases regarding § 1361, and the issue in our case involving § 1334, because both

²⁴ *See e.g. Randall D. Wolcott, M.D., P.A. v. Sebelius*, 635 F.3d 757, 766 (5th Cir. 2011); *Cordoba v. Massanari*, 256 F.3d 1044, 1047 (10th Cir. 2001); *Buchanan v. Apfel*, 249 F.3d 485, 491–92 (6th Cir. 2001); *Briggs v. Sullivan*, 886 F.2d 1132, 1142 (9th Cir. 1989); *Burnett v. Bowen*, 830 F.2d 731, 738 (7th Cir. 1987); *Ganem v. Heckler*, 746 F.2d 844, 851–52 (D.C. Cir. 1984); *Kuehner v. Schweiker*, 717 F.2d 813, 819 (3d Cir. 1983), *judgment vacated sub. nom. on other grounds*, *Heckler v. Kuehner*, 469 U.S. 977 (1984); *Belles v. Schweiker*, 720 F.2d 509, 513 (8th Cir. 1983); *Ellis v. Blum*, 643 F.2d 68, 81 (2d Cir. 1981).

jurisdictional provisions are not listed in the text of § 405(h). The commonality is just that though, superficial. As Judge Friendly of the Second Circuit accurately explained, when § 405(h) was passed in 1939, mandamus jurisdiction was not one of the jurisdictional provisions contained in Section 24 of the Judicial Code. *See Ellis v. Blum*, 643 F.2d 68, 81 (2d Cir. 1981).²⁵ Thus, unlike § 1334, there is no argument to be made that the codification of section 24 into Title 28 had any impact on the availability of mandamus relief under § 1361. *See id.*; *see also Ganem v. Heckler*, 746 F.2d 844, 851 (D.C. Cir. 1984) (noting that absence of § 1361 was unrelated to codification error because even in original version of § 405(h), § 24 of the Judicial Code did not include District of Columbia's common law jurisdiction to issue mandamus writs).

However, the issue of whether a district court can exercise mandamus jurisdiction related to Medicare claims, notwithstanding the § 405(h) bar, is neither in front of the court, nor necessary to resolve the current dispute. As previously,

²⁵ In fact, at that time only district courts in the District of Columbia could exercise mandamus jurisdiction, pursuant to an uncodified grant of authority dating back to the early nineteenth century and the District of Columbia's adoption of Maryland law. *See id.* District courts elsewhere in the country were granted mandamus jurisdiction explicitly when Congress passed the Mandamus and Venue Act, Pub. L. No. 87-748, 76 Stat. 744 (1962). Judge Friendly reasoned that Congress likely did not intend to bar District of Columbia courts' mandamus jurisdiction when it passed § 405(h) because that uncodified jurisdiction was not specifically excluded, and Congress similarly did not intend mandamus jurisdiction to suddenly become subject to § 405(h) when mandamus jurisdiction was extended to other courts in 1962. *See Ellis*, 643 F.2d at 81.

we thus decline to decide the issue. *See Lifestar Ambulance Serv.*, 365 F.3d at 1295 n. 3.

D. The Bankruptcy Court Lacked Jurisdiction Under § 405(h)

With that considerable background in mind, we turn now to the issue in this case: did 42 U.S.C. § 405(h) bar the bankruptcy court below from taking jurisdiction over Bayou Shore’s Medicare provider agreement under 28 U.S.C. § 1334? Because we are persuaded that the 1984 amendments to § 405(h) were a codification and not a substantive change, we align ourselves with the Seventh, Eighth, and Third Circuits and hold that § 405(h) bars § 1334 jurisdiction over claims that “arise under [the Medicare Act].”

1. The Deficit Reduction Act of 1984 amendment to § 405(h) was a codification and did not substantively change the law.

Bayou Shores’ primary argument, and the primary argument of courts holding that § 1334 jurisdiction is not barred § 405(h), is relatively straightforward: the text of the third sentence of § 405(h) does not mention § 1334, and thus, under the “plain meaning” of the statute § 1334 jurisdiction is not barred by § 405(h). Bayou Shores is certainly correct that “when [a] statute’s language is plain, the sole function of the courts—at least where the disposition required by the text is not absurd—is to enforce it according to its terms.” *Lamie v. U.S. Tr.*, 540 U.S. 526, 534 (2004) (internal quotation marks and citations removed); *see also Owner-*

Operator Indep. Drivers Ass'n, Inc. v. Landstar Sys., Inc., 622 F.3d 1307, 1327 (11th Cir. 2010) (holding that “[t]here is no reason for this Court to rewrite a statute because of an alleged scrivener error unless a literal interpretation would lead to an absurd result.”)

But that is not the end of the analysis because this case is governed by a particular canon in statutory construction regarding the codification of law, *i.e.* the process of converting and organizing the Statutes at Large into the U.S. Code. Since virtually the founding of the Republic, it has been recognized that when legislatures codify the law, courts should presume that no substantive change was intended absent a clear indication otherwise. For example, in the oldest case we have been able to locate,²⁶ *Taylor v. Delancy*, 2 Cai. Cas. 143, 151 (N.Y. Sup. Ct. 1805), the New York Supreme Court of Judicature²⁷ held “that where the law, antecedently to the revision was settled, either by clear expressions in the statutes, or adjudications on them, the mere change of phraseology shall not be deemed or construed a change of the law, unless such phraseology evidently purports an intention in the legislature to work a change.”

²⁶ The difficulties inherent in codifying and organizing the law are older still, and plagued even the earliest democracy. Aristotle notes that after the Athenian statesmen Solon “had organized the [Athenian] constitution in the manner stated, people kept coming to him and worrying him about his laws, criticizing some points and asking questions about others,” causing him to leave Greece for Egypt for the next ten years. *See* ARISTOTLE, *THE ATHENIAN CONSTITUTION*, Ch. 11 (H. Rackham trans., Cambridge, MA, Harvard University Press 1952).

²⁷ The Supreme Court of Judicature was the “highest common-law” state court in New York at that time. *See William J. Jenack Estate Appraisers & Auctioneers, Inc. v. Rabizadeh*, 22 N.Y.3d 470, 478 (2013).

The Supreme Court appears to have recognized the canon at least as early as *Stewart v. Kahn*, 78 U.S. 493, 502 (1870), where the Court held that “[a] change of language in a revised statute will not change the law from what it was before, unless it be apparent that such was the intention of the legislature.” The Court reiterated the principle in *United States v. Ryder*, 110 U.S. 729, 740 (1884), holding that “[i]t will not be inferred that the legislature, in revising and consolidating the laws, intended to change their policy, unless such intention be clearly expressed.” This canon of statutory construction has remained undisturbed since that time. See e.g. *McDonald v. Hovey*, 110 U.S. 619, 629 (1884); *Logan v. United States*, 144 U.S. 263, 302 (1892), *abrogated on other grounds*, *Witherspoon v. State of Ill.*, 391 U.S. 510 (1968); *Holmgren v. United States*, 217 U.S. 509, 520 (1910); *Anderson v. Pac. Coast S.S. Co.*, 225 U.S. 187, 199 (1912); *United States v. Sisco*, 262 U.S. 165, 168-69 (1923); *Hale v. Iowa State Bd. of Assessment & Review*, 302 U.S. 95, 102 (1937); *Fourco Glass Co. v. Transmirra Products Corp.*, 353 U.S. 222, 227 (1957); *United States v. FMC Corp.*, 84 S. Ct. 4, 7 (Goldberg, Circuit Justice 1963); *United States v. Welden*, 377 U.S. 95, 98 n. 4 (1964); *Tidewater Oil Co. v. United States*, 409 U.S. 151, 162 (1972); *Cass v. United States*, 417 U.S. 72, 82 (1974); *Aberdeen & Rockfish R. Co. v. Students Challenging Regulatory Agency Procedures (S.C.R.A.P.)*, 422 U.S. 289, 309 n. 12 (1975); *Muniz v. Hoffman*, 422 U.S. 454, 470 (1975); *Fulman v. United States*, 434

U.S. 528, 538 (1978); *Walters v. Nat'l Ass'n of Radiation Survivors*, 473 U.S. 305, 318 (1985); *Finley v. United States*, 490 U.S. 545, 554 (1989); *Ankenbrandt v. Richards*, 504 U.S. 689, 700 (1992); *Keene Corp. v. United States*, 508 U.S. 200, 209 (1993); *Scheidler v. Nat'l Org. for Women, Inc.*, 547 U.S. 9, 20 (2006); *John R. Sand & Gravel Co. v. United States*, 552 U.S. 130, 136 (2008).

As it happens, a number of these cases from the 20th century arise from an event that directly touches on the issues in our case: the 1948 recodification of the Judicial Code.²⁸

In one of the earlier cases to examine the 1948 recodification, *Fourco Glass Co. v. Transmirra Products Corp.*, 353 U.S. 222 (1957), the Court considered whether the recodification had substantively changed venue rules in patent cases. The issue was whether or not the specific patent venue statute, 28 U.S.C. § 1400(b) was supplemented by the more general (and more expansive) civil suit venue statute, 28 U.S.C. § 1391. *Id.* at 222. The Court first noted that in a pre-1948 recodification case, *Stonite Products Co. v. Melvin Lloyd Co.*, 315 U.S. 561 (1942), the Court had already determined that the more specific patent venue provisions in the old Judicial Code of 1911 trumped more general venue provisions

²⁸ The 1948 recodification moved “section 24 of the Judicial Code” to Title 28 of the U.S. Code, but 42 U.S.C. § 405(h) continued to refer to “section 24 of the Judicial Code” until the DRA amendment in 1984.

for civil suits.²⁹ The only issue therefore was whether the 1948 recodification (which recodified § 48 of the Judicial Code to 28 U.S.C. § 1400(b)) had substantively changed the patent venue statute. *Fourco Glass*, 353 U.S. at 225. Noting that neither the legislative history, nor the Reviser's Notes, indicated that any substantive change was intended, the Court reasoned that "[t]he change of arrangement, which placed portions of what was originally a single section in two separated sections cannot be regarded as altering the scope and purpose of the enactment. For it will not be inferred that Congress, in revising and consolidating the laws, intended to change their effect, unless such intention is clearly expressed." *Id.* at 227 (internal quotation marks and citations omitted) (quoting from *Anderson v. Pac. Coast S.S. Co.*, 225 U.S. 187, 198 (1912)). The Court thus held that no substantive change to 28 U.S.C. § 1400(b) had occurred during the 1948 recodification and the result in *Stonite Products* dictated the outcome of the case. *Id.* at 227-28.

Similarly, in *Tidewater Oil Co. v. United States*, 409 U.S. 151, 162 (1972), the Court rejected the argument that the 1948 Judicial Code revisions substantively changed the existing law concerning appellate court jurisdiction over interlocutory appeals in Government civil antitrust cases. The 1948 revision to 28 U.S.C. § 1292(a)(1) allowed interlocutory appeals of district court order to the courts of

²⁹ Compare Judicial Code, Pub. L. No. 61-475, 36 Stat. 1087, § 48 (1911) with *id.* at § 52.

appeals, “except where a direct review may be had in the Supreme Court.” *Id.* Under then-existing law, appellate courts had no jurisdiction over any appeals in Government civil antitrust cases (which were appealed directly to the Supreme Court), and interlocutory appeals to the Supreme Court in Government civil antitrust cases were not permitted. *Id.* at 154-56, 160. The Court thus reasoned that a possible interpretation of the new language added by the 1948 revisions, “except where a direct review may be had in the Supreme Court,” was that appellate court jurisdiction over interlocutory appeals in Government civil anti-trust cases was now available (contrary to prior law) because “direct review” in the Supreme Court of an interlocutory appeal could not “be had.” *Id.* at 162.

Citing to *Fourco Glass*, the Court rejected that interpretation because no such change to existing law had been “clearly expressed” by the 1948 revisions. “To the contrary, the Revisers' Notes fail to reveal any intention to expand the scope of the pre-existing jurisdiction of the courts of appeals over interlocutory appeals; the new § 1292 is described merely as a consolidation of a number of previously separate code provisions—including the general interlocutory appeals provision—‘with necessary changes in phraseology to effect the consolidation.’” *Id.* at 162-63. The Court thus concluded that the 1948 revisions did not substantively expand the jurisdiction of appellate courts. *Id.* at 163.

Muniz v. Hoffman, 422 U.S. 454, 456-57 (1975) arose out of a labor dispute between the San Francisco Typographical Union and a local daily newspaper, in which the union and its officers had been cited for criminal contempt in violating certain court orders and subsequently denied a jury trial in the criminal contempt proceedings. A key issue in the case was whether the Wagner and Taft-Hartley Acts,³⁰ which authorized courts to grant certain injunctions, permitted jury trials to those found in contempt of the injunctions. *Id.* at 461. The parties appeared to agree that prior to the 1948 revisions of the Criminal Code,³¹ a contemnor had no right to a jury trial in contempt actions to enforce injunctions issued under the Wagner and Taft-Hartley Acts, notwithstanding the jury requirements in § 11 of the earlier passed Norris-LaGuardia Act.³² Petitioners argued however that in recodifying § 11 of Norris-LaGuardia as 18 U.S.C. § 3692 in 1948, Congress had overruled its prior policy of not permitting jury trials in contempt actions to enforce injunctions issued under the Wagner and Taft-Hartley Acts. *Id.* at 467.

³⁰ National Labor Relations Act, Pub. L. No. 74-198, 49 Stat. 449 (1935) (the “Wagner Act”); Labor Management Relations Act, Pub. L. No. 80-101, 61 Stat. 136 (1947) (the “Taft-Harley Act”).

³¹ As the Court notes, the 1948 revision to the Criminal Code followed a “parallel course” to the revision to the Judicial Code, and was prepared by the same staff of experts. *See Muniz*, 422 U.S. at 470 n. 10.

³² Injunctions in Labor Disputes, Pub. L. No. 72-65, 47 Stat. 70 (1932) (the “Norris-LaGuardia Act”). §11 of the Norris-LaGuardia Act provided jury trials in certain contempt actions, but unquestionably did not provide a jury right in contempt actions arising out of injunctions issued pursuant to the Wagner or Taft-Harley Acts. *See Muniz*, 422 U.S. at 462-463.

The Court rejected this argument, holding that “[w]e cannot accept the proposition that Congress, without expressly so providing, intended in § 3692 to change the rules for enforcing injunctions,” which rules existed when § 11 was originally passed. *See Muniz*, 422 U.S. at 468. The Court examined the legislative history of the recodification and the Reviser’s Notes, which consistently expressed that no substantive change was intended by the revision. *Id.* at 467-469. Citing *Fourco Glass*, the Court reiterated the longstanding rule that “[n]o changes of law or policy...are to be presumed from changes of language in the revision unless an intent to make such changes is clearly expressed.” *Id.* at 472 (internal quotation marks omitted). The Court thus expressed some incredulity at the proposition that the major policy change petitioners argued for could be effected by Congress without any mention of it in any of the legislative history or notes:

In view of the express disavowals in the House and Senate Reports on the revisions of both the Criminal Code and the Judicial Code, it would seem difficult at best to argue that a change in the substantive law could nevertheless be effected by a change in the language of a statute without any indication in the Revisers’ Note of that change. It is not tenable to argue that the Revisers’ Note to § 3692, although it explained in detail what words were deleted from and added to what had been § 11 of the Norris-LaGuardia Act, simply did not bother to explain at all, much less in detail, that an admittedly substantial right was being conferred on potential contemnors that had been rejected in the defeat of the Ball amendment the previous year and that, historically, contemnors had never enjoyed.

See id. at 472.

Finley v. United States, 490 U.S. 545, 553-54 (1989), involved a question of whether the 1948 recodification of the Judicial Code substantively created new “pendent-party” jurisdiction when it recodified the Federal Tort Claims Act, 28 U.S.C. § 1346(b) (the “FTCA”).³³ Writing for the Court, Justice Scalia rejected that argument, holding that “[u]nder established canons of statutory construction, it will not be inferred that Congress, in revising and consolidating the laws, intended to change their effect unless such intention is clearly expressed.” *Id.* at 554 (internal quotation marks omitted) (quoting from *Anderson v. Pac. Coast S.S. Co.*, 225 U.S. 187, 199 (1912) and citing to *United States v. Ryder*, 110 U.S. 729, 740 (1884)). Finding “no suggestion, much less a clear expression, that the minor rewording at issue here imported a substantive change,” the Court held that the pre-codification interpretation of the statute continued to hold (*i.e.* no “pendent-party” jurisdiction under the FTCA). *Id.* at 554-56.

Finally, our own court has recently applied this canon in *Koch Foods, Inc. v. Sec’y, U.S. Dep’t of Labor*, 712 F.3d 476 (11th Cir. 2013). There we held that certain amendments to 49 U.S.C. § 31105 enacted by the Revision of Title 49, United States Code Annotated, “Transportation”, Pub. L. No. 103-272, 108 Stat. 745 (1994) were simply revisions and codifications, and thus did not change the

³³ “Pendent-party” jurisdiction is “jurisdiction over parties not named in any claim that is independently cognizable by [a] federal court.” See *Finley*, 490 U.S. at 549. As opposed to “pendent-claim” jurisdiction, which is “jurisdiction over nonfederal claims between parties litigating other matters properly before the court.” *Id.* at 548.

pre-amendment scope of the law. *Koch Foods*, 712 F.3d at 485. We noted in *Koch Foods* that (much like § 2664(b) of the DRA amendments here) the recodification statute cautioned that the revisions and codifications were enacted “without substantive change,” and that the legislative history (like the legislative history of the DRA here) emphasized that the changes were not substantive. *Id.* The interpretive canon used in *Koch Foods* is the one we use in this case: “As the Supreme Court has observed, ‘it will not be inferred that Congress, in revising and consolidating the laws, intended to change their effect unless such intention is clearly expressed.’” *Id.* at 486 (quoting from *Finley*, 490 U.S. at 554).

We turn then to applying the recodification canon of statutory construction to our case. It is clear that the Office of the Law Revision Counsel made an error in revising § 405(h) in 1976 (and again in 1982). Rather than include the full range of jurisdictional grants that were clearly forbidden under the prior law,³⁴ the Law Revision Counsel (who it must be recalled has no authority to pass laws or alter the jurisdiction of federal district courts)³⁵ mistakenly decided to update the cross-reference only to § 1346 and § 1331 of the new Title 28. We find no indication whatsoever, let alone a “clear indication,” in the Law Revision Counsel’s

³⁴ *I.e.* each district court jurisdictional grant listed in Section 24 of the Judicial Code of 1911.

³⁵ *See e.g. N. Dakota v. United States*, 460 U.S. 300, 311 n. 13 (1983) (noting that the editorial decisions made by a codifier without the approval of Congress should be given no weight in interpreting a statute).

Codification note that the revisers intended or were suggesting an expansion of district court jurisdiction to review Medicare and Social Security claims, thereby reversing forty years of Congressional policy. On the contrary, the title of the note (“Codification”) and its contents indicate that the change was a mere codification (*i.e.* updating the cross-reference to “section 24 of the Judicial code” to its new location in Title 28 of the U.S. Code), and not a substantive change. One would expect that if the revisers intended the kind of fundamental change in policy and expansion of the jurisdiction of bankruptcy courts that Bayou Shores suggests, it would merit *some* mention. *See Muniz*, 422 U.S. at 472 (“It is not tenable to argue that the Revisers’ Note ..., although it explained in detail what words were deleted ... and added ..., simply did not bother to explain at all, much less in detail, that an admittedly substantial right was being conferred...”).

Moreover we do not find it significant, contrary to Bayou Shores’ suggestion, that Congress enacted the error into positive law when it passed the DRA in 1984. There is no evidence in the DRA that Congress “clearly expressed” an intention to reverse decades of Medicare and Social Security Act policy and give bankruptcy courts parallel jurisdiction with HHS to adjudicate Medicare claims (and parallel jurisdiction with the Social Security Administration to adjudicate Social Security claims). Again, if Congress intended such an important expansion of bankruptcy court jurisdiction to be enacted in a recodification, one

would expect to find some indication in the statute or legislative history stating as much. *See Tidewater Oil*, 409 U.S. at 162-63 (finding no indication in Reviser's Notes or legislative history that Congress intended recodification to expand federal appellate court jurisdiction). Bayou Shores points to no such indication, nor are we able to find one.

To the contrary, the *statute itself* tells us that the amendment in question is not to be interpreted as making any substantive change to the law: “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.” *See* DRA, § 2664(b); *see also Koch Foods*, 712 F.3d at 485 (noting that the statute “expressly states that no substantive change is intended by the revisions to the language”).³⁶ The legislative history of the bill similarly emphasizes that the amendments in § 2663 (including the amendment to § 405(h)) were not intended to be substantive. *See* H.R. Rep. No. 98-432, pt. 2, at 1663 (1984) (noting that the bill “makes certain corrections of spelling, punctuation, cross-references and other clerical amendments to the Social Security Act and related provisions in the Internal Revenue Code”). Rep. Dan Rostenkowski (the original sponsor of H.R.

³⁶ The bankruptcy court referred to § 2664(b) as “legislative history.” *See In re Bayou Shores*, 525 B.R. at 167. Strictly speaking, that is not correct. “Legislative history” refers to “proceedings leading to the enactment of a statute, including hearings, committee reports, and floor debates.” *Black's Law Dictionary* (10th ed. 2014). Conversely, § 2664(b) of the DRA is positive law: it is part of a statute that was passed by Congress and signed into law by the President.

3805, containing the “technical corrections” that were merged into the DRA) “emphasize[d] that this bill intends simply to correct technical errors and to better reflect the policies established by the Congress in enacting the original legislation.” 129 Cong. Rec. 23321, 23440 (1983).

Per long standing Supreme Court precedent, we “will not ... infer[] that the legislature, in revising and consolidating [§ 405(h)] intended to change their policy, unless such intention be clearly expressed.” *See United States v. Ryder*, 110 U.S. 729, 740 (1884). Here, we find no clear expression of any intent to change Congressional policy with respect to bankruptcy court jurisdiction over Medicare claims. To the contrary, the statute and legislative history detailed above expresses an intent *not* to substantively amend § 405(h).³⁷

In reply, Bayou Shores attempts to downplay the mandate of § 2664(b) in the DRA by arguing that despite the statute’s command that the amendments are not to be interpreted as substantive, certain of the amendments were in fact substantive. *See Appellant’s Reply Br.* at 2-9. We are not persuaded by this argument. As an initial matter, Bayou Shores essentially asks us to ignore § 2664(b) and Congress’s command that the amendments are not substantive, which

³⁷ The Seventh Circuit’s *Bodimetric* decision (and thus the decisions of the Third and Eighth Circuits adopting *Bodimetric*) recognized and correctly applied this recodification canon of statutory interpretation. *See Bodimetric*, 903 F.2d at 489 (citing to *Muniz* and *U.S. v. Ryder*). Conversely, the cases holding that § 405(h) does not bar jurisdiction under § 1334 do not appear to have recognized the existence of the canon, let alone analyzed whether it applies to this issue. It is clear that in ignoring a canon of statutory construction that courts have been applying for more than a century, these latter courts erred.

we are clearly not free to do. In *Muniz* the Supreme Court indicated that “[t]he nature of the revision process itself requires the courts, including this Court, to give particular force to the many express disavowals in the House and Senate Reports of any intent to effect substantive changes in the law.” *See Muniz*, 422 U.S. at 472 n.

11. Here we think it most reasonable to give force to Congress’s express disavowals in the DRA itself and in the legislative history “of any intent to effect substantive changes in the law.”

Moreover, the two examples that Bayou Shores cites as “substantive” amendments in § 2663 of the DRA are, on closer review, at least arguably non-substantive. First, Bayou Shores argues that § 2663(e)(3) of the DRA expanded criminal liability for impersonating certain persons in order to obtain information about their Social Security benefits. Appellant’s Reply Br. at 3-4. The language in § 2663(e)(3) orders that “Section 1107(b) of [the Social Security Act] is amended by striking out ‘former wife divorced,’ each place it appears and inserting in lieu thereof ‘divorced wife, divorced husband, surviving divorced wife, surviving divorced husband, surviving divorced mother, surviving divorced father,’.” The House committee report on the bill indicates that this amendment was intended to bring Section 1107(b) into conformity with an earlier amendment eliminating

gender-based distinctions in the Social Security Act.³⁸ Thus, arguably the earlier amendment had already eliminated gender distinctions in Section 1107(b), and the DRA amendments merely revised the text of Section 1107(b) to correctly reflect those earlier amendments.³⁹

Second, Bayou Shores points to §2663(a)(15)(C), and characterizes it as denying certain benefits to college students that they otherwise would have received under the prior version of the statute. Appellant's Reply Br. at 5. The relevant text of the amendment orders that "(C) Section 222(b)(4) of such Act is amended by striking out 'full-time student' and inserting in lieu thereof 'full-time elementary or secondary school student'." See DRA at §2663(a)(15)(C). A close reading of the legislative history suggests that Bayou Shores is mistaken about this provision as well. Section 222(b)(4) of the Social Security Act (codified at 42

³⁸ See H.R. Rep. No. 98-432, pt. 2, at 1659 (1984) ("While the Social Security Amendments of 1983 sought to eliminate all gender-based distinctions in the Social Security Act, this gender-based distinction was not eliminated by those amendments. In order to assure that the Social Security Act provides the same penalty for fraud regardless of sex, the bill provides that the penalty for fraud would also apply to an individual who falsely represents that he is the divorced husband of a worker or beneficiary.")

³⁹ Even assuming Bayou Shores is correct that this provision substantively changed existing law, it would not change the result in this case. The House report indicates the "clear intent" behind the amendment to Section 1107(b) (whether substantive or not), whereas nothing in the legislative history indicates a "clear intent" to change the jurisdiction of bankruptcy courts with the amendment to § 405(h). Thus, the amendment to Section 1107(b) is not analogous to the amendment to § 405(h). It is certainly possible that Congress intended to make substantive amendments in the codification and revision section of the DRA. However, under *United States v. Ryder* and its progeny we require *some* indication that a substantive change in the revision was intended. See e.g. *Ex parte Collett*, 337 U.S. 55, 65-71 (1949) (explaining that reviser's notes and legislative history made clear that addition of 28 U.S.C. § 1404(a), which made forum non conveniens transfers available in any district court civil action, was a substantive amendment enacted by the 1948 Judicial Code revision).

U.S.C. § 422) was added by Congress in 1965.⁴⁰ At the time § 222(b)(4) was added to the larger section, the term “full-time student” was “as defined and determined under section 202(d).”⁴¹ Turning then to Section 202(d), that section was amended in 1981 (prior to the DRA in 1984) in a section titled “Elimination of child’s insurance benefits in the case of children age 18 through 22 who attend postsecondary schools.”⁴² The 1981 amendment makes clear that “full time student” was to be defined as elementary and high-school students, not college students.⁴³ A Senate report issued the following year noted that under the prior law children beneficiaries could receive benefits until they were 22 as long as they were in school, while the 1981 amendments eliminated those benefits for anyone over 18 attending post-secondary schooling.⁴⁴ It thus appears that the 1984 amendment in the DRA referenced by Bayou Shores was a “technical correction” because it simply updated § 222(b)(4) of the statute to be consistent with the definitions in the earlier amended § 202(d).

⁴⁰ See Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 at § 306(14) (1965).

⁴¹ Section 202 of the Social Security Act is codified at 42 U.S.C. § 402. The current statute continues to refer to section 202 for its definition of “full-time elementary or secondary school student.”

⁴² See Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, 95 Stat. 357 at §2210 (1981).

⁴³ See *id.* (“SEC. 2210. (a)(1) Section 202(d) of the Social Security Act is amended ... by striking out ‘full-time student’ each place it appears and inserting in lieu thereof ‘full-time elementary or secondary school student’.”)

⁴⁴ See S. Rep. No. 97-314, Vol. I, at 106 (1982).

Finally, even if we assume for the sake of argument that Bayou Shores has correctly identified two substantive changes in § 2663, the examples Bayou Shores relies on are minor substantive amendments at best, compared to the massive shift in policy that giving bankruptcy courts parallel authority to adjudicate Medicare disputes would represent. This is akin to finding a few hidden firecrackers in the bill and thus inferring the presence of an atomic bomb. In other words, the presence of two minor substantive changes in § 2663 (assuming they are substantive), can hardly justify interpreting the amendment to § 405(h) as enacting a significant change in Congressional policy by creating bankruptcy court jurisdiction over Medicare claims.

Therefore, we conclude that because the previous version of § 405(h) precluded bankruptcy court review of Medicare claims under § 1334, so too must the newly revised § 405(h) bar such actions.

2. § 1334 does not give bankruptcy courts special jurisdiction over Medicare claims

In light of the above explanation, this Court is constrained to disagree with the Ninth Circuit's *In re Town & Country* opinion, and thus holds that § 405(h) bars a bankruptcy court acting pursuant to § 1334 from exercising jurisdiction over Medicare claims. However, both the Ninth Circuit in *Do Sung Uhm v. Humana, Inc.*, 620 F.3d 1134 (9th Cir. 2010) and Bayou Shores here argue that § 1334 has a

“special status” that is different and distinct from other jurisdictional provisions (such as § 1332).⁴⁵ In particular, Bayou Shores argues that the text of § 1334(b) itself defines the expansive nature of bankruptcy court jurisdiction:

“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.” *See* 28 U.S.C. § 1334(b). However, we read the Supreme Court’s opinion in *Bd. of Governors of Fed. Reserve Sys. v. MCorp Fin., Inc.*, 502 U.S. 32 (1991) as effectively foreclosing that argument.

In *MCorp Fin.*, the Court held that bankruptcy law’s automatic stay provision (11 U.S.C. § 362) could not stay an administrative proceeding by the Board of Governors of the Federal Reserve System against MCorp Financial. The Court first found that the administrative proceeding fell squarely into the exception in § 362 for proceedings to enforce a “governmental unit’s police or regulatory power.” *Id.* at 39-40.⁴⁶ The Court rejected MCorp Financial’s argument that for the exception to apply, the bankruptcy court would need to determine in the first instance whether the exercise of regulatory power was legitimate; the Court held that such a reading “would require bankruptcy courts to scrutinize the validity of

⁴⁵ *See e.g.* Appellant’s Reply Br. at 9-12.

⁴⁶ The parties dispute a similar question on appeal. However, our decision that the bankruptcy court lacked subject matter jurisdiction over the provider agreements renders moot the question of whether HHS’s actions fall in § 362’s exceptions. We thus decline to decide that issue.

every administrative or enforcement action brought against a bankrupt entity,” and that “[s]uch a reading is problematic, both because it conflicts with the broad discretion Congress has expressly granted many administrative entities and because it is inconsistent with *the limited authority Congress has vested in bankruptcy courts.*” *Id.* at 40 (emphasis added).

Importantly, the Court rejected MCorp’s broad reading of 28 U.S.C. § 1334(b), holding that “[s]ection 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.’” *Id.* at 41-42. That is precisely the situation here: Bayou Shores’ provider agreement was terminated by the Centers for Medicare & Medicaid Services (“CMS”), which is an administrative agency within HHS and not a “court.” Thus, § 1334(b) does not concern the allocation of jurisdiction between the bankruptcy court and HHS, and cannot trump the § 405(h) jurisdictional bar.

Bayou Shores raises an additional argument relating to the 1984 amendments to § 1334. Bayou Shores points out that the Bankruptcy Amendments and Federal Judgeship Act of 1984, Pub. L. No. 98-353, 98 Stat 333 (July 10, 1984) (the “Bankruptcy Act”) was passed only eight days prior to passage of the DRA, and among other things significantly enlarged the scope of bankruptcy court

jurisdiction.⁴⁷ According to Bayou Shores, because “28 U.S.C. § 1334 was enacted first, and 42 U.S.C. § 405(h) was enacted days later,” Congress’s failure to include § 1334 in § 405(h) indicates a positive intent to expand the scope of bankruptcy court jurisdiction. Appellant’s Br. at 45. We disagree. *See N. L. R. B. v. Plasterers' Local Union No. 79, Operative Plasterers' & Cement Masons' Int'l Ass'n, AFL-CIO*, 404 U.S. 116, 129-30 (1971) (“The Court has frequently cautioned that it is at best treacherous to find in Congressional silence alone the adoption of a controlling rule of law.”) (quotation marks omitted).

As an initial matter, reading too much into the significance of the timing of the passage of these acts is at best speculative, particularly since the DRA had nothing to do with bankruptcy court jurisdiction, nor does Bayou Shores point to any evidence suggesting that Congress had the Bankruptcy Act in mind when passing the DRA.⁴⁸ Moreover Bayou Shores’ timing argument also cuts the opposite way: one would equally expect that if Congress were inclined to expand the jurisdiction of bankruptcy courts to include hearing Medicare and Social Security claims, it would have done that in the Bankruptcy Act that it had just

⁴⁷ The Bankruptcy Act added subsection 1334(b), discussed *supra*. *See* Bankruptcy Act at § 101(a).

⁴⁸ Approximately forty-some public laws were passed by Congress in July of 1984. *See* <https://www.congress.gov/public-laws/98th-congress>. We are skeptical of the suggestion that the temporal proximity between any one of these laws and the Bankruptcy Act, standing alone, has any particular significance in interpreting any of these laws.

passed, rather than burying it as a “Technical Correction” in a bill wholly unrelated to bankruptcy courts (*i.e.* the DRA).

3. Barring bankruptcy court jurisdiction is consistent with Congressional Medicare policy

The bankruptcy court also relied on what was essentially a policy argument about the wisdom of allowing a bankruptcy court rather than HHS to adjudicate Medicare claims:

Consider the following hypothetical: a debtor that operates a skilled nursing facility has its Medicare provider agreement terminated because it was improperly cited for noncompliance. The debtor immediately appeals the finding of noncompliance. But because CMS stops payment for Medicare residents, the debtor is forced to file for bankruptcy. If the Court were to adopt HHS's view, the debtor in that hypothetical scenario could never assume its Medicare provider agreement since it is highly unlikely the appeals process will be complete before the debtor files for bankruptcy.

See In re Bayou Shores, 525 B.R. at 169.⁴⁹ In other words, unless the bankruptcy court can take jurisdiction over the provider agreements, Bayou Shores would

⁴⁹ See also Samuel R. Maizel & Michael B. Potere, *Killing the Patient to Cure the Disease: Medicare's Jurisdictional Bar Does Not Apply to Bankruptcy Courts*, 32 Emory Bankr. Dev. J. 19, 27-29 (2015) (noting that because of the length of the HHS appeals process, a hospital could be faced with the “fatal dilemma” of being put out of business before being able to challenge an adverse HHS decision); *but see Oakland Med. Grp., P.C. v. Sec'y of Health & Human Servs., Health Care Fin. Admin.*, 298 F.3d 507, 511 (6th Cir. 2002) (“[T]he government has a strong interest in expediting provider-termination procedures because: (1) the Secretary’s responsibility for insuring the safety and care of elderly and disabled Medicare patients is of primary importance, and (2) the government has a strong interest in minimizing the expenses of administering the Medicare program.”) (internal quotation marks and citations omitted); *Northlake Cmty. Hosp. v. United States*, 654 F.2d 1234, 1242 (7th Cir. 1981) (explaining that “a

cease to exist as a going concern long before the HHS administrative appeals process could complete.⁵⁰

While we are not unsympathetic to this argument, the choice of whether the bankruptcy court or HHS is best positioned to adjudicate Medicare claims is a policy decision that the bankruptcy court was not empowered to make. As explained at length above, § 405(h) and (g) restricts the role of district courts to a limited review of final HHS decisions, thus reflecting Congressional policy to let HHS adjudicate those claims in the first instance. The Supreme Court explained in *Illinois Council* that the review provisions of § 405(h) and (g) give HHS a greater opportunity to “apply, interpret, or revise policies, regulations, or statutes without possibly premature interference by different individual courts.” *See* 529 U.S. at 13.

Indeed, the bankruptcy court’s actions here illustrate the kind of “premature interference” that *Illinois Council* had in mind. While the bankruptcy court went to great length to deny that it was reviewing the merits of HHS’s findings or decisions (*see e.g. In re Bayou Shores SNF*, 525 B.R. at 168), that is effectively what the bankruptcy court did. After holding an evidentiary hearing on the

provider’s financial need to be subsidized for the care of its Medicare patients is only incidental to the purpose and design of the (Medicare) program.”) (internal quotation marks and citations omitted).

⁵⁰ This assumes of course that Bayou Shores will be successful in regaining the provider agreements in the administrative appeals process. That in turn is a dubious proposition as an administrative law judge in that appeal has already granted summary judgment against Bayou Shores on the issue of the termination of the provider agreements. *See* Bankr. ECF No. 261-1, Administrative Law Judge Ruling on Motion for Partial Summary Judgement (Dec. 16, 2015).

conditions at Bayou Shores' facility, the bankruptcy court apparently decided that the three deficiencies Bayou Shores was cited for were not particularly serious. *Id.* at 163. The court also decided that Bayou Shores had corrected each of the deficiencies it was cited for and provided adequate assurances that it would be in compliance with the Medicare regulations in the future. *Id.* at 170-171.

Notwithstanding HHS's determination to the contrary, the bankruptcy court deemed the health and safety of Bayou Shores' patients free of immediate jeopardy. The practical outcome of the bankruptcy court's decision was thus a reversal of HHS's decision: the bankruptcy court rolled back the termination, gave Bayou Shores back its provider agreements, and effectively prevented HHS from terminating Bayou Shores from the Medicare/Medicaid program for its repeated deficiencies. That was functionally a decision on the merits of the underlying HHS decision, and an interference with HHS's role in deciding who is eligible to participate in Medicare/Medicaid.⁵¹

The Government for its part disputes the bankruptcy court's version of the facts. With respect to the three violations, the picture painted by the Government suggests far more serious issues with the care provided by Bayou Shores to its

⁵¹ We have explained previously that where both parties to a Medicare claim dispute "engage in extensive discovery and presentation of their whole cases on the merits, the district court does exactly what [HHS] is expected to do," and therefore "[i]t is simply not realistic to say that the district court in such a case does not address and decide the merits of the case." *V.N.A. of Greater Tift Cty., Inc. v. Heckler*, 711 F.2d 1020, 1032 (11th Cir. 1983). Such a merits-review is contrary to the policy embodied by the Medicare Act's limited judicial review provisions. *See id.*

patients. Federal Appellee Br. at 14-16; State Appellee's Br. at 3-4.⁵² Moreover, the Government argues that simply coming back into compliance after each violation was not the issue. Rather, terminating repeat offenders like Bayou Shores was a key part of Congress's overhaul of nursing home regulations, and was intended to stop "instances in which substandard providers had avoided termination from Medicare by claiming that they had cured serious violations of safety standards, only to lapse back into noncompliance after the threat of administrative sanction was removed." Federal Appellee's Br. at 50-51.

In any event, we do not need to decide whose version of the facts is correct, nor do we need decide whether the bankruptcy court's decision on the merits of HHS's action was correct. HHS, not the bankruptcy court, has been charged by Congress with administering the Medicare Act and regulating Medicare providers. Indeed, the bankruptcy court's action here stymied the direct statutory mandate from Congress to HHS to take appropriate action (including potentially terminating a provider agreement) when, as here, a survey determines that a nursing home's condition "immediately jeopardize[s] the health or safety of its residents." *See* 42

⁵² Most disturbingly perhaps, the bankruptcy court's opinion describes the result of the second incident somewhat innocuously: "[T]he patient with the history of abuse—who was in the facility for less than 24 hours—did not touch or otherwise harm the other resident." *In re Bayou Shores SNF*, 525 B.R. at 163. But the Government contends that the "patient with the history of abuse" "sexually molest[ed]" his roommate during those 24 hours. Federal Appellee Br. at 14-16; State Appellee's Br. at 3-4. According to the underlying report, the roommate reported in an interview that the patient with the history of abuse "put his hand under the curtain and moved his hand on the sheet to about ¼ inch from my private parts." *See In re Bayou Shores*, Bankr. ECF No. 42-2 at 17.

U.S.C. § 1395i-3(h)(2).⁵³ And though charged with broad jurisdiction to deal with issues related to a debtor's bankruptcy estate, bankruptcy courts generally lack the institutional competence or technical expertise of HHS to oversee the health and welfare of nursing home patients or to interpret and administer a "massive, complex health and safety program such as Medicare." *See Illinois Council*, 529 U.S. at 13. Or at least, that is the judgment of Congress we derive from the enactment of § 405(h) in 1939 (and the recodification in 1984).

4. § 405(h) clearly requires administrative exhaustion

Finally, while much of the above dispute concerns the third sentence of § 405(h) and whether it completely bars bankruptcy jurisdiction under § 1334, we do not overlook the effect of the first two sentences as well. The bankruptcy court dismissed the second sentence as merely limiting "the ability of federal courts to review the findings of fact or an agency decision." *In re Bayou Shores SNF*, 525 B.R. at 167. Though correct in a minimalist sense, we think that is an overly narrow understanding of the statute. The Supreme Court made clear in *Salfi* that the first two sentences of § 405(h) "assure that administrative exhaustion will be required" and "prevent review of decisions of the Secretary save as provided in the

⁵³ If the deficiencies immediately jeopardize the health and safety of a facility's residents, "the Secretary *shall take immediate action* to remove the jeopardy and correct the deficiencies through the remedy specified in subparagraph (B)(iii), *or terminate the facility's participation under this subchapter* and may provide, in addition, for one or more of the other remedies described in subparagraph (B))." 42 U.S.C. § 1395i-3(h)(2) (emphasis added).

Act, which provision is made in § 405(g).” 422 U.S. at 757. The third sentence, according to the Court in *Salfi*, means that no action may be brought pursuant to any jurisdiction other than § 405(g), even where administrative remedies have been exhausted. *Id.*; see also *Illinois Council*, 529 U.S. at 13.

Bayou Shores does not dispute that its claims have not been administratively exhausted; in fact, as of the date of the oral argument, Bayou Shores’ administrative appeal was still pending in front of an administrative law judge at HHS. See Oral Argument, March 29, 2016. Putting aside the jurisdictional question then, neither Bayou Shores nor the bankruptcy court has explained why standard principles of administrative exhaustion should not prevent a district court from hearing Bayou Shores’ case. See e.g. *In re Rodriguez*, No. 09-93431-JB, 2010 WL 2035733, at *3-5 (Bankr. N.D. Ga. Mar. 23, 2010) (relying on § 405(g) and (h) to hold that bankruptcy court would not entertain non-administratively exhausted Social Security claims). Bayou Shores has also not shown that any exception to standard administrative exhaustion principles should apply here. See *McCarthy v. Madigan*, 503 U.S. 140, 146-149 (1992) (explaining the “three broad sets of circumstances” in which exceptions to administrative exhaustion may apply).

Thus, even if we were to assume that § 405(h) does not bar jurisdiction under § 1334, the bankruptcy court erred by not dismissing Bayou Shores' claim for failure to exhaust Bayou Shores' administrative remedies first.

IV. OTHER ARGUMENTS

Bayou Shores raises a number of other issues that it contends warrant reversal of the district court's Order. For the reasons below, we do not find these arguments persuasive.

A. Mootness

Bayou Shores argues that this dispute is either constitutionally moot or equitably moot. With respect to constitutional mootness, Bayou Shores contends that because the bankruptcy court's injunction and automatic stay have been dissolved, no live controversy between the parties remains. The Government contends that at least two live issues remain. First, the bankruptcy court's stay and injunction (even if now dissolved) prevented the Government from stopping payments to Bayou Shores during the pendency of the bankruptcy case. The Government argues that it intends to seek recoupment of these payments if the bankruptcy court's orders are found to be invalid. Second, contrary to Bayou Shores' contention that the injunction and stay have dissolved, the Government

contends that the bankruptcy court's Confirmation Order continues to indefinitely enjoin the Government from terminating the provider agreements.⁵⁴

A case is constitutionally moot when “when the issues presented are no longer ‘live’ or the parties lack a legally cognizable interest in the outcome.” *Powell v. McCormack*, 395 U.S. 486, 496 (1969). Put another way, “[a] case is moot when it no longer presents a live controversy with respect to which the court can give meaningful relief.” *Florida Ass'n of Rehab. Facilities, Inc. v. State of Fla. Dep't of Health & Rehab. Servs.*, 225 F.3d 1208, 1216-17 (11th Cir. 2000) (internal quotations and citations omitted). Here, a holding that the bankruptcy court lacked subject matter jurisdiction would allow the Government to go forward with its efforts to terminate Bayou Shores from the Medicare/Medicaid program, as well as allow the Government to try and recover payments made to Bayou Shores since the filing of the bankruptcy court action.⁵⁵ Meaningful relief is thus available, and this case is not constitutionally moot.

⁵⁴ For example, we note that the Confirmation Order contains the following: “Nothing set forth in the Amended Plan or this Order shall limit the power and authority of AHCA to take action related to the renewal or revocation of the Debtor's license necessary to protect public health, safety and welfare, ***provided however, that any such actions related to the renewal or revocation of the license may not be based upon the termination of the Medicare and Medicaid provider agreements that have been assumed by the Debtor.***” *In re Bayou Shores*, Bankr. ECF No. 285 at 14. At oral argument, Bayou Shores conceded that this second issue was not constitutionally moot.

⁵⁵ Bayou Shores argues that the Government has no claim to damages because the Government “would be required to pay for the care of Bayou's patients, if not at Bayou, somewhere, because the vast majority of Bayou's patients are indigent.” Appellant's Reply Br. at 28. That argument misses the mark though. The Government is not seeking to claw back the money merely to pocket the funds or to avoid paying for the care of Bayou Shores' patients. Rather, the

Bayou Shores argues alternatively that the case is equitably moot because its Chapter 11 plan has been substantially consummated. Equitable mootness is a discretionary doctrine that permits courts sitting in bankruptcy appeals to dismiss challenges (typically to confirmation plans) when effective relief would be impossible. *See In re Nica Holdings, Inc.*, 810 F.3d 781, 786 (11th Cir. 2015). Central to a finding of mootness is a determination by an appellate court that it cannot grant effective judicial relief. *Id.* (quoting from *First Union Real Estate Equity & Mortg. Invs. v. Club Assocs. (In re Club Assocs.)*, 956 F.2d 1065, 1069 (11th Cir.1992)). The equitable mootness doctrine seeks to avoid an appellate decision that “would knock the props out from under the authorization for every transaction that has taken place and create an unmanageable, uncontrollable situation for the Bankruptcy Court.” *Id.* at 787 (citing *Miami Ctr., Ltd. P'ship v. Bank of NY*, 838 F.2d 1547, 1555 (11th Cir.1988)).

Here however, we are reviewing whether the district court was correct in dismissing for lack of subject matter jurisdiction. “Subject-matter jurisdiction properly comprehended ... refers to a tribunal’s power to hear a case, *a matter that can never be forfeited or waived.*” *See Union Pac. R. Co. v. Bhd. of Locomotive*

Government (as required by statute) will not pay a facility such as Bayou Shores that fails to comply with health and safety regulations. In other words, while the Government may be required to pay for the care of Bayou Shores’ patients, it reasonably wants to pay someone other than Bayou Shores for that service.

Engineers & Trainmen Gen. Comm. of Adjustment, Cent. Region, 558 U.S. 67, 81, 130 (2009) (internal quotation marks omitted; citations omitted; emphasis added). Because we agree with the district court that the bankruptcy court lacked subject matter jurisdiction over the assumption of Bayou Shores' provider agreements, that must end the inquiry. When the lower court "lack[s] jurisdiction, we have jurisdiction on appeal, not of the merits but merely for the purpose of correcting the error of the lower court in entertaining the suit." *See Bender v. Williamsport Area Sch. Dist.*, 475 U.S. 534, 541 (1986). "Without jurisdiction the court cannot proceed at all in any cause. Jurisdiction is power to declare the law, and when it ceases to exist, the only function remaining to the court is that of announcing the fact and dismissing the cause." *Steel Co. v. Citizens for a Better Env't*, 523 U.S. 83, 94 (1998). The Supreme Court in *Steel Co.* characterized this threshold inquiry as "inflexible and without exception." *See id.* at 94-95 (quoting from *Mansfield, C. & L.M.R. Co. v. Swan*, 111 U.S. 379, 382 (1884)).

Thus, even assuming for the sake of argument that Bayou Shores is correct that this situation justifies the application of equitable mootness, the absence of jurisdiction precludes the exercise of that discretionary authority. Our only role

here is to correct the bankruptcy court's error by affirming the district court's Order.⁵⁶

B. Bayou Shores' claims "arise" under the Medicare Act

Bayou Shores additionally argues that its claims do not "arise" under the Medicare Act, and thus are not subject to the § 405(h) jurisdictional bar. According to Bayou Shores, "[n]either the September 5 Order nor the Confirmation Orders had anything to do with recovering a claim (a right to payment) arising under the Medicare Act." Appellant's Br. at 58.

Bayou Shores' position however has already been rejected by the Supreme Court. In *Illinois Council* the Court rejected the argument that claims "arising under" the Medicare Act were limited to monetary claims:

Nor can we accept a distinction that limits the scope of § 405(h) to claims for monetary benefits. Claims for money, claims for other benefits, *claims of program eligibility*, and *claims that contest a*

⁵⁶ Of course, we are addressing only the issue of the bankruptcy court's authority to adjudicate Bayou Shores' claim to ownership of the provider agreements terminated by the Government. To the extent Bayou Shores has other property in its bankruptcy estate, nothing in this opinion addresses or reaches the bankruptcy court's actions with respect to that property.

Further, while we do not rule on the equitable mootness issue, we note that the limited factual record in front of us suggests it would not be appropriate to do so in this situation. Although the Government did not obtain a stay, it appears from our review of the record that it was not for lack of trying. *See In re Nica Holdings*, 810 F.3d at 787 ("On this record, we cannot fault [appellant] for not getting a stay."). Moreover, the simplicity of the transactions and amounts of money involved here appear more akin to the "simpler" transactions in *In re Nica Holdings*, 810 F.3d at 788 (no equitable mootness) than in the complex multi-million dollar transactions that justified equitable mootness in *In re Club Assocs.*, 956 F.2d 1065 and *Miami Ctr., Ltd. P'ship v. Bank of NY*, 820 F.2d 376 (11th Cir.1987). Finally, the reliance interests of Bayou Shores' creditors, who we must presume understood they were lending money to a nursing home that the Government was attempting to shut down for violating health and safety regulations, also do not weigh much in favor of applying equitable mootness.

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 provisions. *There is no reason to distinguish among them in terms of the language or in terms of the purposes of § 405(h)...* Nor for similar reasons can we here limit those provisions to claims that involve “amounts.”

Id. at 14 (emphasis added).

Here, the determination of whether Bayou Shores is allowed to keep its provider agreements could be characterized as either a “claim[] of program eligibility” (*i.e.* whether Bayou Shore is eligible to participate in Medicare) or a “claim[] that contest[s] a sanction or remedy” (*i.e.* the sanction of terminating Bayou Shores from the Medicare program). In either case, the Supreme Court made clear in *Illinois Council* that Bayou Shores’ claims fall within the ambit of § 405(h)’s “claim[s] arising under” the Medicare Act.

C. Bayou Shores’ Medicaid claims rise and fall with its Medicare claims

The parties also dispute whether the termination of Bayou Shores’ Medicare provider agreement resulted in the termination of Bayou Shores’ Medicaid provider agreement. In its briefing, Bayou Shores contends that AHCA failed to use the required procedures under Florida state law to terminate a Medicaid agreement. The Government argues that Medicaid agreements terminate by operation of law when Medicare agreements terminate. *See* 42 U.S.C. § 1396a(a)(39).

Without resolving this dispute, we note that the only issue necessary to decide is whether the bankruptcy court was barred by § 405(h) from taking jurisdiction over Bayou Shores' Medicaid provider agreements. Courts have held that the Medicare and Medicaid statutory and regulatory provisions "provide that when a dually certified facility challenges a determination that it is not in substantial compliance with the common Medicaid and Medicare regulations and a termination of its participation in both programs, the facility must seek review of this determination through the Medicare administrative appeals procedure." *Cathedral Rock of N. Coll. Hill, Inc. v. Shalala*, 223 F.3d 354, 366 (6th Cir. 2000); *see also Michigan Ass'n of Homes & Servs. for Aging, Inc. v. Shalala*, 127 F.3d 496, 503 (6th Cir. 1997) ("The Medicaid Act's inclusion of § 405(g) is clear textual support for the proposition that Congress intended the exhaustion of administrative remedies to apply in cases [involving dual Medicare/Medicaid providers]); *Health Equity Res. Urbana, Inc. v. Sullivan*, 927 F.2d 963, 967 (7th Cir. 1991).

Bayou Shores cannot avoid the jurisdictional bar in § 405(h) by attempting to re-characterize its claim to the Medicaid provider agreement as separate from its claim to the Medicare provider agreement. *See Cathedral Rock*, 223 F.3d at 366-67. Indeed, it can hardly be said that Bayou Shores has a separate Medicaid claim, notwithstanding the two separate provider agreements: the sole reason for termination of Bayou Shores' Medicaid provider agreement was the termination of

its Medicare provider agreement for Bayou Shores' failure to comply with Medicare laws and regulations. Allowing Bayou Shores to go forward with only its Medicaid claims would thus put the bankruptcy court in the untenable position of adjudicating a dispute fundamentally about Medicare laws and regulations (*i.e.* whether Bayou Shores was in compliance with the relevant Medicare laws and regulations), despite being barred from adjudicating Bayou Shores' Medicare claims. *See Rhode Island Hosp. v. Califano*, 585 F.2d 1153, 1162 (1st Cir. 1978) (“Were we to assume § 1331 jurisdiction over the Hospital’s Medicaid claim we would find ourselves in the peculiar posture of hearing a case that consists entirely of a challenge to the limits promulgated under [the Medicare Act], when we are expressly barred by [the Medicare Act] from entertaining that challenge at this time.”).

Accordingly, Bayou Shores “cannot avoid the Medicare Act’s administrative channeling requirement simply because as a dual Medicare and Medicaid provider, its claims also fall under Medicaid Act.” *Cathedral Rock*, 223 F.3d at 367.⁵⁷

D. Termination of the provider agreements

On appeal, the parties continue to dispute whether the provider agreements in question terminated before or after the filing of Bayou Shores’ bankruptcy petition. Because we have determined that the bankruptcy court lacked jurisdiction

⁵⁷ We do not need to decide here whether a different result would accrue in a case where a party presents only Medicaid claims to a bankruptcy court.

over the termination of the provider agreements, we decline to rule on the issue of whether or not the agreements terminated prior to the filing of the bankruptcy petition.

V. Conclusion

We agree with the district court that the bankruptcy court erred as a matter of law when it exercised subject matter jurisdiction over the provider agreements in this case. The bankruptcy court was without § 1334 jurisdiction under the § 405(h) bar to issue orders enjoining the termination of the provider agreements and to further order the assumption of the provider agreements.

Thus, finding no reversible error in the district court's June 26, 2015, Order (*In re Bayou Shores*, 533 B.R. at 343) we AFFIRM.

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

ELBERT PARR TUTTLE COURT OF APPEALS BUILDING
56 Forsyth Street, N.W.
Atlanta, Georgia 30303

David J. Smith
Clerk of Court

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July 11, 2016

MEMORANDUM TO COUNSEL OR PARTIES

Appeal Number: 15-13731-FF

Case Style: Agency for Health Care Adminis, et al v. Bayou Shores SNF LLC

District Court Docket No: 8:14-cv-02816-JSM

Secondary Case Number: 8:14-bk-09521-MGW

This Court requires all counsel to file documents electronically using the Electronic Case Files ("ECF") system, unless exempted for good cause. Enclosed is a copy of the court's decision filed today in this appeal. Judgment has this day been entered pursuant to FRAP 36. The court's mandate will issue at a later date in accordance with FRAP 41(b).

The time for filing a petition for rehearing is governed by 11th Cir. R. 40-3, and the time for filing a petition for rehearing en banc is governed by 11th Cir. R. 35-2. Except as otherwise provided by FRAP 25(a) for inmate filings, a petition for rehearing or for rehearing en banc is timely only if received in the clerk's office within the time specified in the rules. Costs are governed by FRAP 39 and 11th Cir. R. 39-1. The timing, format, and content of a motion for attorney's fees and an objection thereto is governed by 11th Cir. R. 39-2 and 39-3.

Please note that a petition for rehearing en banc must include in the Certificate of Interested Persons a complete list of all persons and entities listed on all certificates previously filed by any party in the appeal. See 11th Cir. R. 26.1-1. In addition, a copy of the opinion sought to be reheard must be included in any petition for rehearing or petition for rehearing en banc. See 11th Cir. R. 35-5(k) and 40-1.

Counsel appointed under the CRIMINAL JUSTICE ACT must file a CJA voucher claiming compensation for time spent on the appeal no later than 60 days after either issuance of mandate or filing with the U.S. Supreme Court of a petition for a writ of certiorari (whichever is later).

Pursuant to Fed.R.App.P. 39, costs taxed against appellant.

The Bill of Costs form is available on the internet at www.ca11.uscourts.gov

For questions concerning the issuance of the decision of this court, please call the number referenced in the signature block below. For all other questions, please call Janet K. Mohler, FF at (404) 335-6178.

Sincerely,

DAVID J. SMITH, Clerk of Court

Reply to: Jeff R. Patch
Phone #: 404-335-6161

OPIN-1A Issuance of Opinion With Costs

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

*Samuel R. Maizel**

*Michael B. Potere***

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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The authors are grateful to Lori K. Mihalich-Levi, a Partner in Dentons US LLP's Washington, D.C. office, and to Andy Jinnah, an Associate in Dentons US LLP's Los Angeles office, for their assistance in the preparation of this article.

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).

2015]

KILLING THE PATIENT TO CURE THE DISEASE

21

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 Counsel¹⁵ 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

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).

2015]

KILLING THE PATIENT TO CURE THE DISEASE

25

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

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).

2015]

KILLING THE PATIENT TO CURE THE DISEASE

27

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

2015]

KILLING THE PATIENT TO CURE THE DISEASE

29

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 recoupment⁵⁶ 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

2015]

KILLING THE PATIENT TO CURE THE DISEASE

31

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 1978⁶⁶ 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).

2015]

KILLING THE PATIENT TO CURE THE DISEASE

33

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.*

2015]

KILLING THE PATIENT TO CURE THE DISEASE

35

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, nonpossessory, 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).

2015]

KILLING THE PATIENT TO CURE THE DISEASE

37

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).

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.*

2015]

KILLING THE PATIENT TO CURE THE DISEASE

39

4. *Bayou Shores's Appeal*

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

Bayou Shores presented ample evidence that absent a stay it and its patients, employees, and staff will suffer irreparable damage. The Court finds that if the stay is not continued, Bayou Shores will no longer be able to operate and will be forced to discharge its patients and terminate its staff. Notably, this evidence also relates to the public interest, an interest that is highly relevant here because it involves the patients and their family.

Medicare and Medicaid are required under both federal and state law to pay for the care of Bayou Shores' patients regardless of where they reside, whether it be at Bayou Shores or at any other nursing home.¹¹⁷

As Bayou Shores noted, *there is a significant factor of human dignity at issue here that this Court cannot ignore*. Bayou Shores' patients are comfortable, they know the staff, they have the same routines, and they retain some dignity and independence from this comfort and familiarity. It would be *draconian* to disrupt their dignity based on a jurisdictional debate that has resulted in significant contrary opinions among the circuit courts and the lower courts.¹¹⁸

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

The case is currently pending in the Eleventh Circuit.

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

¹¹⁸ *Id.* at *3 (emphasis added).

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

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

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

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

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.

2015]

KILLING THE PATIENT TO CURE THE DISEASE

41

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 determinations¹²⁹ 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 declaration¹³⁴ 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).

2015]

KILLING THE PATIENT TO CURE THE DISEASE

43

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.

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).

2015]

KILLING THE PATIENT TO CURE THE DISEASE

45

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 Third¹⁴⁸ and Ninth Circuits,¹⁴⁹ as well as by numerous district¹⁵⁰ 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.

2015]

KILLING THE PATIENT TO CURE THE DISEASE

47

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.

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

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.

2015]

KILLING THE PATIENT TO CURE THE DISEASE

51

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'être*."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.

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.

2015]

KILLING THE PATIENT TO CURE THE DISEASE

53

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).

2015]

KILLING THE PATIENT TO CURE THE DISEASE

55

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.

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 “trench[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).

2015]

KILLING THE PATIENT TO CURE THE DISEASE

57

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 absurd²⁰⁶ 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 1935²⁰⁸ 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.

2015]

KILLING THE PATIENT TO CURE THE DISEASE

59

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).

2015]

KILLING THE PATIENT TO CURE THE DISEASE

61

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.*

2015]

KILLING THE PATIENT TO CURE THE DISEASE

63

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 language²²⁸ 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)).

2015] KILLING THE PATIENT TO CURE THE DISEASE 65

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 Government¹ 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 Act⁹ 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. Magalliff,

MEDICARE PROVIDER AGREEMENTS

To be able to bill the Medicare program¹² 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 contractor¹⁵ 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 Act²⁷ 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 contract 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.”); *German-town 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.”); *Tornello 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, Kamy & 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 Medicaid⁹² 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 Agreement¹²⁰ 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 interests¹⁴⁰ 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

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 precedent¹⁷⁹ 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.



MSR:JClair

U.S. Department of Justice
Civil Division
Washington, DC 20530

March 30, 2016

Filed and Served via ECF

Hon. Amy C. Nerenberg
Acting Clerk
United States Court Of Appeals
For The Eleventh Circuit
56 Forsyth Street, N.W.
Atlanta, GA 30303

Re: Bayou Shores, SNF, LLC v. Fla. Agency for Health Care Adm., et al.,
No. 15-13731 (11th Cir.)

Dear Ms. Nerenberg:

Pursuant to FRAP 28(j), the federal appellees submit as supplemental authority *Cathedral Rock of North College Hill v. Shalala*, 223 F.3d 354 (6th Cir. 2000) and *Health Equity Resources Urbana, Inc. v. Sullivan*, 927 F.2d 963 (7th Cir. 1991) (copies attached).

At argument, the Court inquired as to whether the bankruptcy court could assume jurisdiction over Bayou Shores' challenge to the state's termination of its *Medicaid* provider agreement without exhausting administrative remedies. The above-cited authority holds that although 42 U.S.C. 405(h) does not apply to the Medicaid program, exhaustion of administrative remedies is nonetheless required before a court may assume jurisdiction.

Cathedral Rock thus holds, in the context of a nursing facility's challenge to the termination of its Medicare and Medicaid provider agreements, that "where a provider is dually certified and brings a claim that challenges determinations made under both the Medicare and Medicaid Acts, the provider cannot avoid the jurisdictional bar and administrative channeling of the Medicare Act simply by characterizing the claim as arising under the Medicaid Act." *Id.*, 223 F.3d at 367. Rather, "when a dually certified facility challenges a determination that it is not in substantial compliance with the common Medicaid and Medicare regulations and a termination of its participation in both programs, the facility must seek review of this determination through the

Medicare administrative appeals procedure.” *Id.* at 366, citing 42 C.F.R. 498.4; *see also* 42 C.F.R. 431.153(g).

Health Equity also holds that a nursing facility may not challenge a state’s termination of its Medicaid contract prior to exhaustion of administrative remedies, even though section 405(h) does not apply to the Medicaid program. 927 F.2d at 965.

Neither decision addresses whether exhaustion is required where a Medicaid termination turns wholly on questions of state law. *See Cathedral Rock*, 223 F.3d at 367 n.7. In this case, however, the bankruptcy court assumed jurisdiction to decide a wholly federal question arising under both the Medicaid and Medicare statutes: whether Bayou Shores meets federal standards for the care of its residents. *Cathedral Rock* and *Health Equity* hold that such jurisdiction is precluded prior to exhaustion of administrative remedies.

Respectfully submitted,

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misrepresentations and concealment not of information concerning the general health risks associated with smoking, *i.e.*, those risks that are common knowledge, but of information beyond the common knowledge of the ordinary person, *i.e.*, the manipulation of nicotine levels in cigarettes. Thus, Glassner must plead facts sufficient to support a finding that his decedent was injured not merely by one of those smoking-related diseases commonly known to the ordinary person, but as a proximate result of her reliance on Defendants' misrepresentations and concealment of information beyond the common knowledge of the ordinary person. He has failed to do so.

IV. Conspiracy

[14] Because the district court properly dismissed Glassner's substantive claims, his claim for conspiracy must fail. *See NPF IV, Inc., v. Transitional Health Servs.*, 922 F.Supp. 77, 83 (S.D.Ohio 1996) ("Conspiracy in and of itself does not normally establish a basis for recovery in a civil action in Ohio; rather, there must be an actionable wrong committed as a result of the conspiracy.") (citation omitted); *Akins v. Zeneca, Inc.*, 1995 WL 452087, at *3-*4 (6th Cir. July 27, 1995) (unpublished) (holding that conspiracy claim fails when underlying tort claim fails).

CONCLUSION

For the reasons set forth above, we AFFIRM the judgment of the district court.



CATHEDRAL ROCK OF NORTH COLLEGE HILL, INC., d/b/a Beechknoll Convalescent Center, Plaintiff-Appellant,

v.

Donna E. SHALALA, Secretary of Health and Human Services, Defendant-Appellee.

No. 99-4149.

United States Court of Appeals,
Sixth Circuit.

Submitted: May 5, 2000

Decided and Filed: Sept. 5, 2000

Nursing facility which was certified to participate in both Medicare and Medicaid programs brought suit challenging determination by Secretary of Health and Human Services (HHS) that it was not in substantial compliance with program regulations, and imposition of remedies by Secretary which included termination of its participation in programs. The United States District Court for the Southern District of Ohio, Herman J. Weber, J., dismissed action for lack of subject matter jurisdiction. Facility appealed. The Court of Appeals, Moore, Circuit Judge, held that: (1) facility was required to exhaust its administrative remedies before seeking judicial review of Secretary's determinations; (2) facility was not entitled under due process clause to pre-termination hearing; and (3) facility was required to obtain review of Secretary's actions through Medicare administrative appeals procedure.

Affirmed.

Batchelder, Circuit Judge, concurred in the judgment and filed opinion.

1. Federal Courts ¶776, 850.1

A district court's legal determinations in dismissing a complaint for lack of subject matter jurisdiction are reviewed de

CATHEDRAL ROCK OF NORTH COLLEGE HILL v. SHALALA 355

Cite as 223 F.3d 354 (6th Cir. 2000)

novo, while any factual findings are reviewed for clear error.

2. Social Security and Public Welfare
 ⇨241.30, 241.41

Provision of Medicare Act which incorporates administrative review provision for Social Security disability benefit claims channels most, if not all, Medicare claims through special review system of an administrative hearing, and purports to make exclusive the judicial review method set forth in provision. Social Security Act, §§ 205(g, h), 1872, as amended, 42 U.S.C.A. §§ 405(g, h), 1395ii.

3. Social Security and Public Welfare
 ⇨241.45

To obtain judicial review of determination by Secretary of Health and Human Services (HHS) under Medicare Act, a party must comply with (1) a nonwaivable requirement of presentation of any claim to the Secretary, and (2) a requirement of exhaustion of administrative review, which the Secretary may waive. Social Security Act, §§ 205(g), 1872, as amended, 42 U.S.C.A. §§ 405(g), 1395ii.

4. Social Security and Public Welfare
 ⇨241.45, 241.115

Nursing facility which participated in Medicare and Medicaid programs was required to exhaust its administrative remedies before seeking judicial review after Secretary of Health and Human Services (HHS) determined that facility was not in substantial compliance with Medicare and Medicaid requirements, and imposed remedies which included termination of facility's participation in programs, in which facility challenged termination on basis of absence of a finding of immediate jeopardy, and denial of a pre-termination hearing; facility's claims directly challenged Secretary's substantive determinations, and were not entirely collateral to a substantive claim for benefits, as no colorable claim under due process clause had been raised. U.S.C.A. Const.Amend. 5; Social Security Act, §§ 205(g, h), 1872, as amended, 42 U.S.C.A. §§ 405(g, h), 1395ii.

5. Social Security and Public Welfare
 ⇨241.30, 241.45

Where Secretary of Health and Human Services (HHS) terminates a provider's agreement to participate in Medicare program for failure to comply substantially with the agreement or the Medicare regulations, provider is entitled to a hearing, and then judicial review of the Secretary's final decision after the hearing. Social Security Act, §§ 205(g), 1866(h), as amended, 42 U.S.C.A. §§ 405(g), 1395cc(h).

6. Social Security and Public Welfare
 ⇨241.45, 241.115

A party's characterization of its challenge to the termination of a Medicare or Medicaid provider agreement by Secretary of Health and Human Services (HHS) as a purely legal or statutory question is not sufficient, by itself, to constitute a claim that is entirely collateral to a substantive claim for benefits, as will bring challenge within exception to exhaustion of administrative remedies requirement; rather, court must examine whether the allegedly collateral claim involves completely separate issues from the party's claim that it is entitled to benefits or continued participation in the Medicare program, or whether it is inextricably intertwined with its substantive claim to benefits or participation. Social Security Act, §§ 205(g, h), 1872, as amended, 42 U.S.C.A. §§ 405(g, h), 1395ii.

7. Constitutional Law ⇨251.6

Factors considered in determining whether procedural due process requires a pre-termination hearing are (1) the private interest that will be affected by the official action, (2) the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards, and (3) the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural re-

quirement would entail. U.S.C.A. Const. Amend. 5.

8. Constitutional Law ⚖️278.7(3)

Social Security and Public Welfare ⚖️241.30, 241.110

Nursing facility which participated in Medicare and Medicaid programs was not entitled under due process clause to hearing before Secretary of Health and Human Services terminated its participation in programs, based on finding that facility was not in substantial compliance with program regulations; private interest was not particularly strong, because providers are not intended beneficiaries of programs and facility would still receive payment from care of private patients, facility could likely present its position through documentary evidence and without a hearing, and government had strong interest in expeditious provider-terminations. U.S.C.A. Const. Amend. 5.

9. Social Security and Public Welfare ⚖️241.10, 241.110

Medicare and Medicaid Acts impose common certification and quality of care requirements on nursing facilities, and where Secretary of Health and Human Services (HHS) finds that a dually certified nursing facility is not in compliance with these requirements, it has authority to impose remedies on the facility, including termination, under both Acts. Social Security Act, §§ 1819(a)(3), (b-d), 1919(a)(3), (b-d), as amended, 42 U.S.C.A. §§ 1395i-3(a)(3), (b-d), 1396r(a)(3), (b-d); 42 C.F.R. § 483.1.

10. Social Security and Public Welfare ⚖️241.110

Applicable regulations provide that the appeals procedures set forth for reviewing determinations by Secretary of Health and Human Services (HHS) affecting participation in Medicare program also apply to Secretary's determination to terminate a nursing facility's Medicaid provider agreement. 42 C.F.R. §§ 498.3(a)(2)(i), 498.4.

11. Social Security and Public Welfare ⚖️241.30, 241.110

When a dually certified facility challenges a determination that it is not in substantial compliance with the common Medicaid and Medicare regulations, and a termination of its participation in both programs, the facility must seek review of this determination through the Medicare administrative appeals procedure. Social Security Act, §§ 1819(a)(3), (b-d), (h)(2-4), 1919(a)(3), (b-d), (h)(3-5), as amended, 42 U.S.C.A. §§ 1395i-3(a)(3), (b-d) (h)(2-4), 1396r(a)(3), (b-d), (h)(3-5); 42 C.F.R. §§ 483.1, 498.3(a)(2)(i), 498.4.

12. Social Security and Public Welfare ⚖️241.30, 241.110

Nursing facility whose participation in Medicare and Medicaid programs had been terminated by Secretary of Health and Human Services (HHS), based on finding that it was not in substantial compliance with program requirements, was required to obtain review of the Secretary's decision through the Medicare administrative appeals procedure. Social Security Act, §§ 1819(a)(3), (b-d), (h)(2-4), 1919(a)(3), (b-d), (h)(3-5), as amended, 42 U.S.C.A. §§ 1395i-3(a)(3), (b-d) (h)(2-4), 1396r(a)(3), (b-d), (h)(3-5); 42 C.F.R. §§ 483.1, 498.3(a)(2)(i), 498.4.

13. Social Security and Public Welfare ⚖️241.45, 241.115

Where a provider is dually certified under both Medicare and Medicaid programs, and brings a claim that challenges determinations made under both the Medicare and Medicaid Acts, the provider cannot avoid the jurisdictional bar and administrative channeling of the Medicare Act simply by characterizing the claim as arising under the Medicaid Act. Social Security Act, §§ 1819(a)(3), (b-d), (h)(2-4), 1919(a)(3), (b-d), (h)(3-5), as amended, 42 U.S.C.A. §§ 1395i-3(a)(3), (b-d) (h)(2-4), 1396r(a)(3), (b-d), (h)(3-5); 42 C.F.R. §§ 483.1, 498.3(a)(2)(i), 498.4.

CATHEDRAL ROCK OF NORTH COLLEGE HILL v. SHALALA 357

Cite as 223 F.3d 354 (6th Cir. 2000)

Geoffrey E. Webster (argued), J. Randall Richards (briefed), Columbus, OH, for Plaintiff–Appellant.

Jan M. Holtzman, Asst. U.S. Attorney, Office of the U.S. Attorney, Cincinnati, OH, Ted Yasuda (briefed), U.S. Department of Health & Human Services, Office of the General Counsel, Region V, Chicago, IL, for Defendants–Appellees.

Before: BATCHELDER, MOORE, and BEEZER,* Circuit Judges.

MOORE, J., delivered the opinion of the court, in which BEEZER, J., joined. BATCHELDER, J. (pp. 367–68), delivered a separate opinion concurring in the judgment.

OPINION

MOORE, Circuit Judge.

Cathedral Rock of North College Hill, Inc. d/b/a Beechknoll Convalescent Center (“Beechknoll”)¹ is a nursing facility appealing the dismissal of its complaint for lack of subject matter jurisdiction. In its complaint, Beechknoll challenges a determination of the Secretary of Health and Human Services that it is not in substantial compliance with the Medicare and Medicaid regulations and terminating its participation in the programs. Although Beechknoll did not exhaust its administrative remedies before seeking judicial review as required under the Medicare Act, it contends that it falls under an exception to this requirement established in *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667, 106 S.Ct. 2133, 90 L.Ed.2d 623 (1986), and also under an exception for claims that are “entirely collateral” to a substantive challenge of the Secretary’s determination. Alternatively, Beechknoll asserts that the district court had jurisdiction under the Medicaid Act. We **AFFIRM** the dismissal of Beechknoll’s

complaint for lack of subject matter jurisdiction because neither of the alleged exceptions to the Medicare Act’s exhaustion requirement applies in this case. In addition, Beechknoll cannot avoid this requirement by characterizing its claims as arising under the Medicaid Act when it is a dual provider subject to common certification, termination, and appeals procedures under the Medicare and Medicaid regulations.

I. FACTS AND PROCEDURE

Beechknoll is a 100–bed nursing facility located in Cincinnati, Ohio, that was certified to participate in both Medicare and Medicaid programs. The Ohio Department of Health (ODH) conducted several surveys of Beechknoll, which showed that it was not in substantial compliance with the federal Medicare and Medicaid certification and quality of care requirements. The Secretary of Health and Human Services then adopted the ODH’s recommendations and imposed the following remedies against Beechknoll: (1) denial of payment for new Medicare admissions effective June 25, 1999; (2) a civil monetary penalty; and (3) termination of Beechknoll’s participation in the Medicare and Medicaid programs effective July 19, 1999.

On July 19, 1999, Beechknoll filed a complaint for declaratory and injunctive relief in federal district court against the Secretary. Beechknoll alleges that the Secretary’s remedies violate the Medicare Act, 42 U.S.C. § 1395i–3(h)(2); the Medicaid Act, 42 U.S.C. § 1396(h)(3); the Due Process Clause of the Fifth Amendment; the Administrative Procedure Act, 5 U.S.C. §§ 553 et seq. and 706; and that they are contrary to law, arbitrary, capricious, and an abuse of discretion in violation 5 U.S.C. § 706(2). Beechknoll seeks a

* The Honorable Robert R. Beezer, Circuit Judge of the United States Court of Appeals for the Ninth Circuit, sitting by designation.

1. The appellant’s briefs and joint appendix also mistakenly refer to appellant as Cathedral Rock of North College Hill, Inc. d/b/a Beechknoll Community Center.

declaration that these remedies are in violation of the law and a permanent injunction to prevent the Secretary from “(a) terminating Plaintiff’s Medicare and Medicaid provider agreements and certification for and participation in the Medicare and Medicaid Program effective July 19, 1999, and (b) terminating or refusing to make payment to Plaintiff for covered services rendered to Medicare and Medicaid eligible residents who now reside at Beechknoll, pending the outcome of an administrative hearing.” J.A. at 10 (Complaint). In response, the Secretary filed a motion to dismiss for lack of subject matter jurisdiction because Beechknoll failed to exhaust its administrative remedies before seeking relief in federal district court.

On the same date, Beechknoll also filed a motion for a temporary restraining order asking the district court to restrain temporarily the Secretary from terminating its Medicare and Medicaid provider agreements and from refusing to make payment to Beechknoll for covered services rendered to its current Medicare and Medicaid patients, pending the outcome of an administrative hearing. The Secretary filed a memorandum in response to Beechknoll’s motion arguing that Beechknoll failed to show a strong likelihood of success on the merits or any of the other requirements for injunctive relief.

Beechknoll filed a formal request for an administrative hearing on July 20, 1999.

The district court entered an order issuing a temporary restraining order for ten days for the purpose of preserving the status quo pending its decision on whether subject matter jurisdiction exists. Within this period, the court held a hearing on the Secretary’s motion to dismiss and concluded that it lacked subject matter jurisdiction to review Beechknoll’s claims because the nursing facility had failed to exhaust its administrative remedies. After the district court entered judgment dismissing Beechknoll’s complaint without prejudice, Beechknoll filed a timely notice of appeal.

II. ANALYSIS

A. Standard of Review

[1] A district court’s legal determinations in dismissing a complaint for lack of subject matter jurisdiction are reviewed de novo, while any factual findings are reviewed for clear error. *See Michigan Ass’n of Indep. Clinical Labs. v. Shalala*, 52 F.3d 1340, 1346 (6th Cir.1994).

B. Jurisdiction under the Medicare Act

Under 42 U.S.C. § 1395cc(h)(1), an institution “dissatisfied with a determination by the Secretary . . . described in subsection (b)(2) of this section shall be entitled to a hearing thereon by the Secretary . . . and to judicial review of the Secretary’s final decision after such hearing as is provided in section 405(g) of this title.” The referenced subsection (b)(2) sets forth the Secretary’s power to terminate an agreement with a provider of services to participate in the Medicare program, including situations in which “the provider fails to comply substantially with the provisions of the agreement, [or] with the provisions of [the Medicare Act] and regulations thereunder.” 42 U.S.C. § 1395cc(b)(2)(A). The Secretary’s findings and decision to terminate participation in the Medicare program thus are subject to judicial review under § 405(g), which states:

Any individual, after any final decision of the [Secretary] made after a hearing to which he was a party . . . may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the [Secretary] may allow.

42 U.S.C. § 405(g).

[2] Under 42 U.S.C. § 1395ii, the Medicare Act incorporates 42 U.S.C. § 405(h), which provides that the Secretary’s findings and final decision after a hearing are binding on the parties to the hearing. This provision also limits judicial review as follows: “[n]o findings of fact or

CATHEDRAL ROCK OF NORTH COLLEGE HILL v. SHALALA 359

Cite as 223 F.3d 354 (6th Cir. 2000)

decision of the [Secretary] shall be reviewed by any person, tribunal, or governmental agency except as herein provided” and no action against the Secretary “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). This section “channels most, if not all, Medicare claims through [the] special review system” of an administrative hearing and “purports to make exclusive the judicial review method set forth in § 405(g).” *Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, —, 120 S.Ct. 1084, 1091, 146 L.Ed.2d 1 (2000); see also *Michigan Ass’n of Homes & Servs. for the Aging, Inc. v. Shalala*, 127 F.3d 496, 499 (6th Cir.1997); *Livingston Care Ctr., Inc. v. United States*, 934 F.2d 719, 721 (6th Cir.), cert. denied, 502 U.S. 1003, 112 S.Ct. 636, 116 L.Ed.2d 654 (1991).

[3] We have held that in order to obtain judicial review under § 405(g), a party must comply with “(1) a nonwaivable requirement of presentation of any claim to the Secretary, and (2) a requirement of exhaustion of administrative review, which the Secretary may waive.” *Michigan Ass’n of Homes & Servs.*, 127 F.3d at 499 (citing *Heckler v. Ringer*, 466 U.S. 602, 617, 104 S.Ct. 2013, 80 L.Ed.2d 622 (1984)). In *Ringer*, the Supreme Court held that a challenge of a Secretary’s decision not to provide reimbursement to individuals who receive a particular medical treatment is a claim that “arises under the Medicare Act,” and therefore § 405(h) is applicable and judicial review must be obtained through § 405(g), which requires the exhaustion of administrative remedies. See 466 U.S. at 615–17, 104 S.Ct. 2013. The Supreme Court recently examined and reaffirmed the *Ringer* decision, noting that it held that “all aspects” of a present or future claim for benefits must be “channeled” through the administrative process. See *Illinois Council*, 529 U.S. at —, 120 S.Ct. at 1093 (quoting *Ringer*, 466 U.S. at 614, 104 S.Ct. 2013). “As so interpreted,

the bar of § 405(h) reaches beyond ordinary administrative law principles of ‘ripeness’ and ‘exhaustion of administrative remedies’” where exceptions may apply and instead “demands the ‘channeling’ of virtually all legal attacks through the agency.” *Id.* This system “assures the agency greater opportunity to apply, interpret, or revise policies, regulations, or statutes without possibly premature interference by different individual courts,” although “this assurance comes at a price, namely, occasional individual, delay-related hardship.” *Id.* The Court concluded, however, that “[i]n the context of a massive, complex health and safety program such as Medicare, embodied in hundreds of pages of statutes and thousands of pages of often interrelated regulations . . . paying this price may seem justified.” *Id.* Based on this interpretation of § 405(h), virtually all legal challenges to an administrative determination must be channeled through the Secretary’s administrative process before judicial review is available as set forth in § 405(g), and any claimed exceptions to this requirement of exhaustion of administrative remedies must be examined critically.

1. Application of the *Michigan Academy* exception

[4] Although Beechknoll acknowledges that a party is required to exhaust its administrative remedies prior to seeking judicial review of a Secretary’s determination under § 405(g), it asserts that it is not subject to this requirement because § 1395ii, which incorporates § 405(h) and its jurisdictional limitation for Medicare challenges to § 405(g), only applies to challenges to “amount determinations.” Beechknoll relies on *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667, 106 S.Ct. 2133, 90 L.Ed.2d 623 (1986), for this proposition. In *Michigan Academy*, a group of physicians filed suit in federal district court challenging the validity of a regulation promulgated under Part B of the Medicare program establishing the method for calculating the payment of

benefits. Under Part B, the Secretary contracts with private insurance carriers to provide voluntary supplementary medical insurance. The Medicare statute in effect at that time simply required a “fair hearing” by private insurance carriers for disputes regarding “amount determinations” under Part B, and was silent regarding the proper procedure for a challenge to the method by which an amount is determined. *See id.* at 675–76, 106 S.Ct. 2133. An administrative hearing and judicial review through § 405(g) was not available for either type of determination. The Supreme Court held, “[c]areful analysis of the governing statutory provisions and their legislative history thus reveals that Congress intended to bar judicial review only of determinations of the amount of benefits to be awarded under Part B.” *Id.* at 678, 106 S.Ct. 2133. It then rejected the argument that § 405(h), as incorporated through § 1395ii, altogether barred judicial review of a challenge to the method used in amount determinations brought under 28 U.S.C. § 1331. The Court reasoned:

The legislative history of both the statute establishing the Medicare program and the 1972 amendments thereto provides specific evidence of Congress’ intent to foreclose review only of “amount determinations”—*i.e.*, those “quite minor matters,” remitted finally and exclusively to adjudication by private insurance carriers in a “fair hearing.” By the same token, matters which Congress did *not* delegate to private carriers, such as challenges to the validity of the Secretary’s instructions and regulations, are cognizable in courts of law. In the face of this persuasive evidence of legislative intent, we will not indulge the Government’s assumption that Congress contemplated review by carriers of “trivial”

monetary claims, but intended no review at all of substantial statutory and constitutional challenges to the Secretary’s administration of Part B of the Medicare program.

Id. at 680, 106 S.Ct. 2133 (citations and footnotes omitted). The Court thus allowed the physicians to bring their challenge to the methods used in calculating the amount of benefits under § 1331.

Although the Seventh Circuit interpreted *Michigan Academy* as limiting the application of § 1395ii and therefore § 405(h) to challenges to “amount determinations,” the Supreme Court expressly has rejected this interpretation. *See Illinois Council on Long Term Care, Inc. v. Shalala*, 143 F.3d 1072, 1075–76 (7th Cir.1998), *rev’d*, 529 U.S. 1, 120 S.Ct. 1084, 146 L.Ed.2d 1 (2000). Rather, the Court explained that § 1395ii did not apply § 405(h) in *Michigan Academy* “where its application to a particular category of cases, such as Medicare Part B ‘methodology’ challenges, would not lead to a channeling of review through the agency, but would mean no review at all.” *Illinois Council*, 529 U.S. at ———, 120 S.Ct. at 1095–96. The Court noted that the Seventh Circuit’s interpretation “would have overturned or dramatically limited this Court’s earlier precedents” involving Social Security and Medicare Part A cases and would have resulted in an unjustifiable distinction between the treatment of “amount determinations” and other similar determinations by the Secretary. *Id.* at ———, 120 S.Ct. at 1096. The Supreme Court thus limited its holding in *Michigan Academy*, restricting the application of § 1395ii and § 405(h) to those cases in which “application of § 405(h) would not simply channel review through the agency, but would mean no review at all.” *Id.* at ———, 120 S.Ct. at 1096–97.² This limitation applies

2. Beechknoll also cites to *McNary v. Haitian Refugee Center, Inc.*, 498 U.S. 479, 497–98, 111 S.Ct. 888, 112 L.Ed.2d 1005 (1991), for the proposition that a federal court may have jurisdiction under *Michigan Academy* over general pre-enforcement challenges to the

Medicare Act but not over individual benefit determination challenges. In *Haitian Refugee Center*, the Supreme Court held that the district court had subject matter jurisdiction to consider plaintiffs’ constitutional and statutory challenges to several INS procedures de-

CATHEDRAL ROCK OF NORTH COLLEGE HILL v. SHALALA 361

Cite as 223 F.3d 354 (6th Cir. 2000)

in the context of both Medicare Part A and Medicare Part B cases. *See id.* at —, 120 S.Ct. at 1097.³

In light of the Supreme Court's holding in *Illinois Council*, we must reject Beechknoll's argument that § 1395ii and § 405(h) and (g) only apply to challenges to "amount determinations." Rather, in order to determine whether the *Michigan Academy* exception is applicable, we must examine whether Beechknoll is simply being required to seek review first through the agency or is being denied altogether the opportunity for judicial review. *See Illinois Council*, 529 U.S. at — — —, 120 S.Ct. at 1096–97; *see also Michigan Ass'n of Homes & Servs.*, 127 F.3d at 500 (interpreting *Michigan Academy* and *Haitian Refugee Center* "to carve out an exception to the limitations of jurisdictional provisions similar to section 405(h) in cases of futility where plaintiffs would not otherwise be able to obtain judicial review of their claims").

[5] In its complaint, Beechknoll seeks declaratory relief challenging the lawfulness of the Secretary's termination of Beechknoll's Medicare and Medicaid provider agreements and imposition of additional remedies. Beechknoll also requests a "permanent[]" injunction preventing the Secretary from terminating its agreements and from refusing to pay for covered services to its eligible residents "pending the outcome of an administrative hearing." J.A. at 10 (Complaint). As Beechknoll concedes, where the Secretary terminates a provider's agreement to participate in

spite a provision limiting federal court jurisdiction because the plaintiffs otherwise would not be able to obtain any meaningful judicial review of the INS's determinations. *See id.* at 496–98, 111 S.Ct. 888. Therefore, this case involves the same reasoning and analysis as *Michigan Academy*: the court must examine whether the plaintiff is precluded from seeking judicial review altogether.

3. The government correctly points out that Congress amended the Medicare Act in 1986 so that Part B amount determinations now are entitled to both administrative and judi-

the Medicare program for failure to comply substantially with the agreement or the Medicare regulations, the provider is entitled to a hearing and then judicial review of the Secretary's final decision after the hearing. *See* § 1395cc(h) & § 405(g). A party may obtain judicial review of a Secretary's final decision by filing a civil suit in federal district court within sixty days after notice of the decision is mailed. *See* § 405(g). Accordingly, once the Secretary issues a final decision, Beechknoll may seek judicial review of the decision. Application of § 1395ii and § 405(h) in this case will not prevent judicial review altogether; Beechknoll simply must exhaust its administrative remedies before this review can take place. Therefore, we conclude that the *Michigan Academy* exception is not applicable in this case.

2. Application of the "Entirely Collateral" Exception

Beechknoll also argues that because its claims are "entirely collateral" to a substantive claim for benefits, it is not required to exhaust its administrative remedies in order to obtain judicial review. In *Mathews v. Eldridge*, 424 U.S. 319, 330–32, 96 S.Ct. 893, 47 L.Ed.2d 18 (1976), the Supreme Court held that the Secretary's denial of an individual's request for benefits constituted a final decision for the purpose of § 405(g) jurisdiction, even though he had not exhausted fully the Secretary's administrative procedures, because the individual's claim that a predeprivation hearing is constitutionally required is "entirely collateral" to his sub-

stantial review. *See* 42 U.S.C. § 1395ff. In light of this amendment, we have concluded that claims under Part A and Part B now must be treated in an identical manner and that we no longer apply an amount versus methodology analysis to determine whether federal jurisdiction is appropriate in Part B cases. *See Farkas v. Blue Cross & Blue Shield of Michigan*, 24 F.3d 853, 860 (6th Cir.1994). Thus, now even challenges to the methodology of a Part B amount determination must be made through the administrative process before judicial review is possible. *See id.*

stantive claim of entitlement and because he made a colorable claim that full relief would not be possible if he was awarded retroactive benefits through a post-deprivation hearing. The Supreme Court recently explained that the *Eldridge* opinion did not create an exception to the application of § 405(g) and (h), but rather required the Secretary to excuse some of its procedural requirements so that its decision would be considered a “final decision” and judicial review could follow under § 405(g). See *Illinois Council*, 529 U.S. at —, 120 S.Ct. at 1094.

This “entirely collateral” exception to the exhaustion of administrative remedies requirement is not applicable to the claims in Beechknoll’s complaint because they directly challenge the Secretary’s substantive determinations in imposing remedies against it rather than making any “entirely collateral” challenges to the Secretary’s substantive determinations. Beechknoll, however, also contends that the district court had jurisdiction to rule on its motion for a temporary restraining order. Because this motion requests that the district court prevent the Secretary from imposing its remedies pending the outcome of its administrative hearing, Beechknoll asserts that it does not seek substantive review of the Secretary’s determination but rather presents an “entirely collateral” claim.⁴ We note that Beechknoll requests an injunction pending the outcome of its administrative hearing rather than the 10-day period generally allowed under a temporary restraining order, and therefore it appears that Beechknoll actually seeks a preliminary injunction from the district court. See Fed.R.Civ.P. 65(a) & (b). Beechknoll cites to several district court cases which seem to grant federal jurisdic-

tion in this particular situation. In *Libbie Rehabilitation Center, Inc. v. Shalala*, 26 F.Supp.2d 128, 130–31 (D.D.C.1998), the district court concluded that it had jurisdiction to issue a preliminary injunction where “a claim challenging the Secretary’s authority for failure to adhere to the specific requirements of the Medicare Act in ordering a ‘termination’ of benefits payments is ‘entirely collateral’ to a claim for benefits and, therefore, falls outside the jurisdiction restrictions of §§ 405(g) and 405(h).” See also *Vencor Nursing Ctrs., L.P. v. Shalala*, 63 F.Supp.2d 1, 5 (D.D.C. 1999). Similarly, other district courts have concluded that where a party asserts a legal challenge to the Secretary’s scope of authority to terminate a provider agreement, which involves general questions of statutory construction rather than the particular facts involved in the Secretary’s termination decision, and the party could be irreparably harmed if required to exhaust administrative remedies before seeking review from the courts, then that party is excused from the exhaustion requirement for a “final decision” under *Eldridge* and the court has jurisdiction to issue a preliminary injunction. See *Lake County Rehabilitation Ctr., Inc. v. Shalala*, 854 F.Supp. 1329, 1336 (N.D.Ind.1994); see also *Mediplex of Massachusetts, Inc. v. Shalala*, 39 F.Supp.2d 88, 93 (D.Mass. 1999) (adopting reasoning of *Lake County*); *Northern Health Facilities, Inc. v. United States*, 39 F.Supp.2d 563, 570 (D.Md.1998) (same).

It appears that no circuit court of appeals has been presented with the opportunity to review these district court opinions allowing jurisdiction under the “entirely collateral” exception.⁵ After careful analy-

4. This case is distinguishable from *Illinois Council*, in which the plaintiff challenged an agency decision by filing a lawsuit rather than seeking administrative review. See 529 U.S. at —, 120 S.Ct. at 1094. Beechknoll requested injunctive relief to prevent the termination of its Medicare and Medicaid provider agreements while it sought the appropriate administrative review.

5. Beechknoll claims that one circuit court has followed the district courts’ holdings, but does not provide a citation. Although it seems that Beechknoll may be referring to *Illinois Council on Long Term Care, Inc. v. Shalala*, 143 F.3d 1072 (7th Cir.1998), *rev’d*, 529 U.S. 1, 120 S.Ct. 1084, 146 L.Ed.2d 1 (2000), the Seventh Circuit did not in fact resolve any

CATHEDRAL ROCK OF NORTH COLLEGE HILL v. SHALALA 363

Cite as 223 F.3d 354 (6th Cir. 2000)

sis of the *Eldridge* opinion, we conclude that the district courts cited above conducted an improper analysis in determining whether a claim is collateral to a substantive challenge under the Medicare Act. In *Eldridge*, an individual brought suit in federal court claiming that under the Due Process Clause of the Constitution he was entitled to a hearing before his benefits were terminated, which the Supreme Court concluded was an entirely separate claim from his substantive challenge to the termination of his benefits. See 424 U.S. at 330–31, 96 S.Ct. 893. The individual’s constitutional claim regarding his procedural rights involved an analysis of the Supreme Court’s jurisprudence on the Due Process Clause, which involved completely separate issues than his challenge to the Secretary’s decision to terminate benefits.

[6] The district court opinions allowing jurisdiction under the “entirely collateral” exception reason that where a party’s challenge to the Secretary’s authority to terminate a provider agreement presents a legal question involving general statutory analysis, it is collateral to a claim challenging the Secretary’s decision to terminate the agreement based on the particular facts of the case. A party’s characterization of its challenge to the Secretary’s termination of a provider agreement as a purely legal or statutory question, however, is not sufficient by itself to constitute an “entirely collateral” claim. See *Michigan Ass’n of Homes & Servs.*, 127 F.3d at 500–01 (concluding that there is no “broad exception for facial constitutional and statutory challenges to agency administration as opposed to individual challenges that are intertwined with claims for benefits”). For example, we have concluded that where an ambulance provider makes the legal argument that the Secretary violated the Medicare regulations and the Due Process Clause in determining that certain vehicles do not qualify as ambulances for the purpose of Medicare reimbursement, this challenge is “inextricably intertwined” with

the party’s claim that it is entitled to benefits for its ambulance service. *Manatee Prof’l Med. Transfer Serv., Inc. v. Shalala*, 71 F.3d 574, 579 (6th Cir.1995) (quoting *Ringer*, 466 U.S. at 614, 104 S.Ct. 2013). Such a claim is “inextricably intertwined” because if the ambulance provider were successful in reversing the Secretary’s determination, then it would be entitled to increased benefits for its vehicles. See *id.* To conclude otherwise would allow any party to avoid the Medicare Act’s administrative procedures for reviewing the Secretary’s determinations simply by making purely legal constitutional or statutory arguments. Rather, a court must examine whether the allegedly collateral claim involves completely separate issues from the party’s claim that it is entitled to benefits or continued participation in the Medicare program or whether it is inextricably intertwined with its substantive claim to benefits or participation.

In the present case, Beechnoll’s motion for injunctive relief challenges the Secretary’s termination of its provider agreement on two grounds: (1) the absence of a finding of immediate jeopardy and (2) the denial of a pre-termination hearing. Beechnoll characterizes these claims as “question[s] of law regarding the scope of the Secretary’s power” that are collateral to its substantive challenges to the Secretary’s determination. See Appellant’s Final Brief at 16. We conclude, however, that Beechnoll’s claim that the Secretary erred in terminating its participation in the Medicare program absent a finding of immediate jeopardy is “inextricably intertwined” with Beechnoll’s substantive challenge to the Secretary’s termination decision because a favorable resolution of this claim would result in the reinstatement of its Medicare provider agreement. Therefore, it cannot be considered an “entirely collateral” claim. See *Manatee Prof’l Med. Transfer Serv.*, 71 F.3d at 579.

question regarding the “entirely collateral” exception.

Like *Eldridge*, Beechknoll's second argument, that it is entitled to a pre-termination hearing under the Due Process Clause, involves Beechknoll's procedural constitutional rights and is "entirely collateral" from its substantive challenge to the Secretary's termination decision. *See* 424 U.S. at 330–32, 96 S.Ct. 893. Because this particular challenge is "entirely collateral," we must determine whether Beechknoll has made a colorable claim that full relief would not be possible if it was awarded retroactive relief through a post-deprivation hearing. *See id.* The district court made the following findings on this issue:

The Plaintiff is a corporation who is a wholly owned subsidiary of a larger corporation that handles multi or administers a number of nursing homes. There is no evidence that this Court can glean from this record that the corporation would, in any way, be irreparably harmed in this matter other than that their payments that they might be legitimately entitled to, would not be reimbursable to them after the conclusion of the administrative process.... [Plaintiff's] injuries, if any, could be remedied by retroactive payment after exhaustion. Plaintiff apparently [is] financially sound. The number of beds involved compared to the total number in the facility and the other facilities that the Plaintiff's mother corporation holds, comparing the fifty beds of Medicare and Medicaid patients here is minimal.

J.A. at 696–97 (Hearing Tr.). In response, Beechknoll does not cite to any harm that it would suffer if forced to exhaust its administrative remedies before obtaining judicial review of the Secretary's determination. Instead, Beechknoll claims that as a result of losing its right to participate in the Medicare and Medicaid programs, it will have to discharge and transfer its patients receiving care under these programs, and these patients will suffer irreparable harm of "transfer trauma." In *O'Bannon v. Town Court Nursing Center*, 447 U.S. 773, 787–90, 100 S.Ct. 2467, 65 L.Ed.2d 506 (1980), the Supreme Court

determined that nursing home patients do not have standing to challenge the Secretary's decertification of their facility. Because the Beechknoll patients do not have standing to challenge the Secretary's determination, Beechknoll cannot rely solely on the irreparable harm to its patients in this analysis. *But see Mediplex*, 39 F.Supp.2d at 98–99 (concluding that "while the residents here do not formally have standing to appear before the court ... their interests are still relevant in evaluating irreparable harm for the equitable determination whether or not to grant a preliminary injunction").

[7,8] Moreover, we hold that Beechknoll has not made a colorable claim that it is entitled to a pre-termination hearing under the Due Process Clause. The Supreme Court has set forth the following factors for determining whether procedural due process requires a pre-termination hearing:

First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.

Eldridge, 424 U.S. at 335, 96 S.Ct. 893; *see Gilbert v. Homar*, 520 U.S. 924, 931–32, 117 S.Ct. 1807, 138 L.Ed.2d 120 (1997); *see also United States v. Brandon*, 158 F.3d 947, 953 (6th Cir.1998) (applying the *Eldridge* analysis to evaluate the procedural safeguards required under the Due Process Clause).

In *Northlake Community Hospital v. United States*, 654 F.2d 1234, 1241–43 (7th Cir.1981), the Seventh Circuit concluded that a Medicare provider is not entitled to hearing before the termination of its provider agreement under this analysis. First, the court noted that the private

CATHEDRAL ROCK OF NORTH COLLEGE HILL v. SHALALA 365

Cite as 223 F.3d 354 (6th Cir. 2000)

interest at stake is not particularly strong because the Medicare provider is not the intended beneficiary of the Medicare program. *See id.* at 1242 (citing *Town Court Nursing Ctr., Inc. v. Beal*, 586 F.2d 266, 277 (3d Cir.1978)). Although termination of its agreement may have a severe economic impact on the provider, “a provider’s financial need to be subsidized for the care of its Medicare patients is only incidental to the purpose and design of the [Medicare] program.” *Id.* (quotations omitted); *see also Green v. Cashman*, 605 F.2d 945, 946 (6th Cir.1979) (commenting that the Medicare and Medicaid statutes were not designed “to provide financial assistance to providers of care for their own benefit” but rather “to aid the patients and clients of such facilities”).⁶ A provider will still be able to receive payments from the care of private patients. Second, the court concluded that “[t]he risk of erroneous deprivation of provider status is also quite manageable.” *Northlake Community Hosp.*, 654 F.2d at 1242. A termination decision is well-documented and typically is based on survey reports from unbiased health professionals who apply well-defined criteria developed through the administrative process; the provider has the opportunity to submit written material in response to the survey findings so that a hearing likely is not necessary for the provider to present its position. *See id.* (relying on *Town Court*,

586 F.2d at 277). Finally, the court stated that the government has a strong interest in expeditious provider-termination procedures for two reasons: first, “[t]he Secretary’s responsibility for insuring the safety and care of elderly and disabled Medicare patients is of primary importance,” and second, “the government has a strong interest in minimizing the expenses of administering the Medicare program.” *Id.* Balancing the government’s strong interest in an expeditious procedure against the provider’s less significant interest and the relatively small risk of erroneous termination, the court held that a provider’s procedural due process rights are adequately protected by a post-termination hearing. *See id.*; *see also Varandani v. Bowen*, 824 F.2d 307, 310–11 (4th Cir.1987) (holding that a physician is not entitled to a formal hearing before being suspended from the Medicare program under *Eldridge*), *cert. dismissed*, 484 U.S. 1052, 108 S.Ct. 1000, 98 L.Ed.2d 968 (1988); *Ritter v. Cohen*, 797 F.2d 119, 123 (3d Cir.1986) (concluding that a physician faced with termination of participation in the Medicaid program is not entitled to a pre-termination hearing under *Eldridge*); *Geriatrics, Inc. v. Harris*, 640 F.2d 262, 265 (10th Cir.) (holding that a nursing home participating in the Medicaid program is not entitled to a pre-termination hearing), *cert. denied*, 454 U.S. 832, 102 S.Ct. 129, 70 L.Ed.2d 109 (1981).

6. We note that the Supreme Court recently reaffirmed that “the elderly and disabled rank as the primary beneficiaries of the Medicare program.” *Fischer v. United States*, — U.S. —, —, 120 S.Ct. 1780, 1786, 146 L.Ed.2d 707 (2000). The Court went on to conclude, however, that Medicare providers also receive “benefits” within the meaning of the federal bribery statute, 18 U.S.C. § 666(b), which prohibits defrauding an organization which “receives, in any one year period, benefits in excess of \$10,000 under a Federal program involving a grant, contract, subsidy, loan, guarantee, insurance, or other form of Federal assistance.” The structure and operation of the Medicare program show that Congress intended to provide a certain quality of care for patients and to maintain provider stability in order to ensure that providers are able to

continue giving such care. The funds a provider receives for participating in the Medicare program thus are intended in part to keep providers financially stable and constitute “benefits” to providers under § 666(b). *See id.* at —, 120 S.Ct. at 1788. This holding does not change our analysis in this case because the Court acknowledged that the patients are the primary beneficiaries of the Medicare program and that any benefits to providers are intended to help them maintain a certain quality of care for their patients. Beechnoll allegedly has failed to meet the Medicare program’s quality of care standards to the detriment of its patients, and therefore its interests in receiving continued Medicare payments cannot outweigh the interests of its patients in receiving quality care.

We find the Seventh Circuit's analysis persuasive and conclude that Beechnoll is not entitled to a pre-termination hearing under the Due Process Clause for the reasons set forth in the Seventh Circuit's opinion. *See Northlake Community Hosp.*, 654 F.2d at 1241–43. Because Beechnoll has not made a colorable claim that full relief would not be possible through a post-termination hearing and that it is entitled to a pre-termination hearing, we conclude that the Supreme Court's "entirely collateral" exception to the exhaustion of administrative remedies set forth in *Eldridge* is not applicable to this claim.

In sum, we conclude that the district court did not have jurisdiction to consider the claims presented in Beechnoll's complaint or in its motion for preliminary injunctive relief because Beechnoll failed to exhaust its administrative remedies and neither the *Michigan Academy* nor the "entirely collateral" exception, which both allow federal jurisdiction despite the failure to exhaust all administrative remedies, is applicable in this case.

C. Jurisdiction under the Medicaid Act

In the alternative, Beechnoll argues that its claims also arise under the Medicaid Act because the Secretary terminated its Medicaid provider agreement, and therefore that it is not required to exhaust its administrative remedies through the Medicare procedures before seeking judicial review. The Medicaid Act does not have a provision, such as § 1395ii in the Medicare Act, incorporating § 405(h) and its exclusive jurisdiction limitation to channel legal challenges through the administrative procedures set forth in § 405(g).

[9–11] The Medicare and Medicaid Acts impose common certification and quality of care requirements on nursing facilities. *See* 42 U.S.C. § 1395i–3(a)(3), (b)–(d) (Medicare); 42 U.S.C. § 1396r(a)(3), (b)–(d) (Medicaid); 42 C.F.R. § 483.1 (facilities must comply with the same requirements in order to participate

in the Medicare and Medicaid programs). Where the Secretary finds that a dually certified nursing facility is not in compliance with these requirements, it has authority to impose remedies on the facility, including termination, under both the Medicare and Medicaid Acts. *See* 42 U.S.C. § 1395i–3(h)(2)–(4) (Medicare); 42 U.S.C. § 1396r(h)(3)–(5) (Medicaid). The regulations provide that the appeals procedures set forth for reviewing the Secretary's determinations affecting participation in the Medicare program also apply to the Secretary's determination to terminate a nursing facility's Medicaid provider agreement. *See* 42 C.F.R. § 498.3(a)(2)(i); *see also* 42 C.F.R. § 498.4 (stating that a Medicaid nursing facility is treated as a Medicare provider subject to the Medicare administrative appeals procedures when it has agreed to participate in both Medicaid and Medicare and is the subject of a compliance action following review of a state's survey findings). The Medicare and Medicaid statutory and regulatory provisions thus provide that when a dually certified facility challenges a determination that it is not in substantial compliance with the common Medicaid and Medicare regulations and a termination of its participation in both programs, the facility must seek review of this determination through the Medicare administrative appeals procedure.

[12] In the present case, the ODH performed several surveys of Beechnoll and found that it was not in substantial compliance with the common Medicare and Medicaid certification and quality of care requirements. The Secretary then adopted the ODH's recommendation to deny payment for new Medicare admissions, to impose a civil penalty, and to terminate Beechnoll's provider agreements for the Medicare and Medicaid programs. Beechnoll now challenges the Secretary's imposition of remedies and the termination of its participation in both the Medicare and Medicaid programs. Under the Medicare and Medicaid statutory and regulato-

CATHEDRAL ROCK OF NORTH COLLEGE HILL v. SHALALA 367

Cite as 223 F.3d 354 (6th Cir. 2000)

ry provisions discussed above, Beechnoll must obtain review of the Secretary's decision through the Medicare administrative appeals procedure.

[13] Moreover, we have held that where a provider is dually certified and brings a claim that challenges determinations made under both the Medicare and Medicaid Acts, the provider cannot avoid the jurisdictional bar and administrative channeling of the Medicare Act simply by characterizing the claim as arising under the Medicaid Act. In *Michigan Association of Homes & Services*, an association of nursing facilities certified to participate in both the Medicare and Medicaid programs argued that its claims, which challenged the Secretary's Medicare and Medicaid regulations, policies, and practices regarding nursing home examinations, certification, administration, enforcement, and appeal, arose under the Medicaid Act rather than the Medicare Act. See 127 F.3d at 502. We concluded, however, that "[e]ven if we were to interpret the Association's claim as arising under the Medicaid Act, the Association would still be required to exhaust its administrative remedies." *Id.* We reasoned that a contrary conclusion would "'allow [the Medicaid Act] to become the back door into the [Medicare Act], which has barred this case from entrance, would result in an automatic circumvention of the [Medicare programs] administrative machinery when its cost limitations have been adopted by the [Medicaid Act] and the provider, as will usually be the case, furnishes services under both Titles.'" *Id.* at 503 (quoting *Rhode Island Hosp. v. Califano*, 585 F.2d 1153, 1162 (1st Cir.1978)). Accordingly, Beechnoll cannot avoid the Medicare Act's administrative channeling requirement simply because as a dual Medicare and Medicaid provider, its claims also fall under Medicaid Act.⁷

Therefore, we hold that the district court did not have jurisdiction to consider Beechnoll's claims under the Medicaid Act.

III. CONCLUSION

Based on the foregoing reasons, we **AF-FIRM** the district court's dismissal of Beechnoll's claim for lack of subject matter jurisdiction.

BATCHELDER, Circuit Judge,
concurring in the judgment.

I concur in the majority's disposition of this case. I do not concur, however, in the majority's discussion of the "entirely collateral" exception. To the extent that this exception survives the Supreme Court's recent pronouncements in *Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 120 S.Ct. 1084, 146 L.Ed.2d 1 (2000), it is clear that it would apply only when a litigant satisfies a "nonwaivable and nonexcusable requirement" of initial presentation of its claim to the appropriate agency. Beechnoll did not satisfy this requirement in this case. That is the end of the matter.

In *Illinois Council*, the Supreme Court stated that two of its earlier cases, *Weinberger v. Salfi*, 422 U.S. 749, 95 S.Ct. 2457, 45 L.Ed.2d 522 (1975), and *Heckler v. Ringer*, 466 U.S. 602, 104 S.Ct. 2013, 80 L.Ed.2d 622 (1984), "foreclose distinctions based upon . . . the 'collateral' versus 'non-collateral' nature of the issues. . . ." *Illinois Council*, 529 U.S. at —, 120 S.Ct. at 1094. When the plaintiff in *Illinois Council* attempted to distinguish those cases on the basis of *Mathews v. Eldridge*, 424 U.S. 319, 96 S.Ct. 893, 47 L.Ed.2d 18 (1976), the Court remarked:

Eldridge, however, is a case in which the Court found that the respondent had followed the special review procedures set forth in § 405(g), thereby complying

See *Rhode Island Hosp.*, 585 F.2d at 1161–62.

7. We need not decide the jurisdictional basis of a case that presents only Medicaid claims.

with, rather than disregarding, the strictures of § 405(h). The Court characterized the constitutional issue the respondent raised as “collateral” to his claim for benefits, but it did so as a basis for requiring the agency to excuse, where the agency would not do so on its own, some (but not all) of the procedural steps set forth in § 405(g). The Court nonetheless held that § 405(g) contains the nonwaivable and nonexcusable requirement that an individual present a claim to the agency before raising it in court. The Council has not done so here, and thus cannot establish jurisdiction under § 405(g).

Illinois Council, 529 U.S. at —, 120 S.Ct. at 1094 (citations omitted).

Here, Beechnoll did not request a hearing before HHS until July 20, 1999, *see* J.A. 356, that is, after it had already filed its motion for a temporary restraining order in the district court, *see* J.A. 23. Thus, Beechnoll failed to satisfy “the nonwaivable and nonexcusable requirement that an individual present a claim to the agency before raising it in court.” *Illinois Council*, 529 U.S. at —, 120 S.Ct. at 1094. This failure deprived the district court of subject matter jurisdiction.

The majority nevertheless asserts that, “Like *Eldridge*, Beechnoll’s second argument, that it is entitled to a pre-termination hearing under the Due Process Clause, involves Beechnoll’s procedural constitutional rights and is ‘entirely collateral’ from its substantive challenge to the Secretary’s termination decision.” *Ante* at 364. The majority makes this assertion without considering—as the *Eldridge* Court did—whether the plaintiff satisfied the nonwaivable jurisdictional element under § 405(g). In so doing, the majority apparently means to suggest that the “nonwaivable and nonexcusable” requirement that an individual present a claim to the agency before raising it in court is in fact both waivable and excusable in cases in which the individual seeks preliminary injunctive relief.

Nothing in the Supreme Court’s cases supports this rather counterintuitive formulation. Indeed, *Illinois Council* makes clear that the jurisdictional bar is both uncomplicated and encompassing. “... Congress may well have concluded that a universal obligation to present a legal claim first to HHS, though postponing review in some cases, would produce speedier, as well as better review overall. And this Court crossed the relevant bridge long ago when it held that Congress, in both the Social Security Act and the Medicare Act, insisted upon an initial presentation of the matter to the agency.” *Illinois Council*, 529 U.S. at —, 120 S.Ct. at 1097. In view of this language, I cannot join in the majority’s stealthy attempt to carve off a class of cases in which initial presentation of a claim to the agency is not required.



UNITED STATES of America,
Plaintiff–Appellee,

v.

Roslyn BUTLER, Defendant–Appellant.

No. 99–1149.

United States Court of Appeals,
Sixth Circuit.

Argued: May 3, 2000

Decided and Filed: July 28, 2000

Defendant was convicted in the United States District Court for the Eastern District of Michigan, George C. Steeh, J., of conspiracy to distribute cocaine and possession with intent to distribute controlled substance. She appealed. The Court of Appeals, Clay, Circuit Judge, held that defendant was illegally seized when she was

HEALTH EQUITY RESOURCES, URBANA, INC. v. SULLIVAN Page: 16 of 24 963
Cite as 927 F.2d 963 (7th Cir. 1991)

It does appear, however, that Mr. Schroeder was not without an adequate remedy under state law in the form of mandamus. That remedy afforded Mr. Schroeder an adequate remedy against the random and unauthorized acts of the individual defendants. See *Zinerman v. Burch*, 494 U.S. 113, 110 S.Ct. 975, 108 L.Ed.2d 100 (1990); *Easter House v. Felder*, 910 F.2d 1387 (7th Cir.1990) (en banc). Accordingly, he cannot maintain an action for the deprivation of his right to due process of law under the federal constitution. On this basis, I join the judgment of the court.



HEALTH EQUITY RESOURCES, URBANA, INCORPORATED, doing business as Royal Fontana Nursing Center,
Plaintiff-Appellant,

v.

Louis W. SULLIVAN, Secretary of Health and Human Services,
Defendant-Appellee.

No. 90-1215.

United States Court of Appeals,
Seventh Circuit.

Argued Jan. 18, 1991.

Decided March 13, 1991.

Nursing home's Medicaid contract was canceled. Nursing home owner requested hearing before administrative law judge. Nursing home was sold. Buyer filed suit seeking to enjoin termination of contract while administrative proceeding was pending. The United States District Court for the Central District of Illinois, Danville Division, Harold Albert Baker, Chief Judge, dismissed suit for want of jurisdiction. Buyer appealed. Administrative law judge upheld termination of contract. The Court of Appeals, Posner, Circuit Judge, held that: (1) buyer was required to exhaust

administrative remedies before seeking judicial review, and (2) buyer received due process before Medicaid contract was terminated.

Affirmed.

Ripple, Circuit Judge, concurred in part, dissented in part, and filed opinion.

1. Administrative Law and Procedure

⇐229

Social Security and Public Welfare

⇐241.115

Medicaid statute provides for judicial review only of "final" decisions of Secretary of Health and Human Services; until seeker of judicial review has exhausted all administrative remedies, there is no final decision. Social Security Act, §§ 1 et seq., 205(g), as amended, 42 U.S.C.A. §§ 301 et seq., 405(g); § 1910(c)(2), as amended, 42 U.S.C.(1982 Ed.) § 1396i(c)(2).

2. Administrative Law and Procedure

⇐229

Ordinarily, exhaustion of administrative remedies is not required to obtain judicial review if exhaustion would be "futile," that is, if there is no reasonable prospect that applicant could obtain relief by pursuing all available administrative remedies.

See publication Words and Phrases for other judicial constructions and definitions.

3. Administrative Law and Procedure

⇐229

Social Security and Public Welfare

⇐241.115

Although futility alone is not an adequate excuse for failure to exhaust administrative remedies before seeking judicial review under Social Security Act, futility of administrative proceeding plus hardship may permit party to bypass administrative process by mounting collateral attack in circumstances demonstrating compelling need for immediate judicial review. Social Security Act, §§ 1 et seq., 205(g), as amended, 42 U.S.C.A. §§ 301 et seq., 405(g).

4. Administrative Law and Procedure
 ⌘229

Social Security and Public Welfare
 ⌘241.115

Nursing home buyer could not obtain judicial review of termination of Medicaid contract without first exhausting administrative remedies since buyer's challenge to regulation prohibiting it from preventing termination by showing that deficiency had been cured was not futile, even though administrative appeal would probably fail, and since Medicaid termination did not impose hardship, even though it would cause financial blow to nursing home, where Medicaid contract remained in force until administrative law judge upheld order of termination and where state had made loan to make up for lost Medicaid payments. Social Security Act, §§ 1 et seq., 205(g), as amended, 42 U.S.C.A. § 405(g).

5. Administrative Law and Procedure
 ⌘469

Adjudicative tribunal has inherent power to manage its calendar, in absence of statute or regulation prescribing order in which tribunal must consider cases tendered to it.

6. Constitutional Law ⌘277(1)

Social Security and Public Welfare
 ⌘241.100

Nursing home buyer's alleged loss of reputation because of termination of its Medicaid contract is not property and, thus, termination of Medicaid contract without prior judicial review did not violate buyer's due process rights. U.S.C.A. Const. Amends. 5, 14.

7. Constitutional Law ⌘278.7(3)

Social Security and Public Welfare
 ⌘241.100

Even if termination of nursing home Medicaid contract deprived buyer of liberty or property, buyer was not denied due process since it received full hearing before administrative law judge before contract was terminated. U.S.C.A. Const. Amends. 5, 14.

Ronald S. Mangum, Terrence J. Ben-shoof, Mangum, Smietanka & Johnson, Chicago, Ill., for plaintiff-appellant.

Frances C. Hulin, Asst. U.S. Atty., Dan-ville, Ill., Alvin N. Jaffe, Dept. of Health and Human Services, Region V, Office of the General Counsel, Chicago, Ill., for defendant-appellee.

Before BAUER, Chief Judge, and POSNER and RIPPLE, Circuit Judges.

POSNER, Circuit Judge.

In February of 1988, following an inspection, the Health Care Financing Administration, which is part of the Department of Health and Human Services, notified Royal Fontana Nursing Center, a 99-bed nursing home in Urbana, Illinois, that it was canceling Royal Fontana's Medicaid contract because of deficiencies in nursing care, rehabilitative services, social services, physical maintenance, and control of infection. 42 U.S.C. § 1396i(c). (The statute has since been amended to narrow the scope of its application, but the amended version does not govern this case.) The notification fixed April as the date of termination. But before the termination could become effective, Royal Fontana's owner was entitled to a hearing before an administrative law judge of the Health Care Financing Administration. § 1396i(c)(2). It requested such a hearing. In August 1988, Health Equity Resources, the plaintiff in this case, a buyer and operator of nursing homes some of which are "troubled," bought Royal Fontana Nursing Center. Health Equity knew about the termination proceeding. Pursuant to a regulation of the Administration, 42 C.F.R. § 442.14, Royal Fontana's Medicaid contract was automatically assigned to Health Equity, together with all the conditions in the contract, one of which was that the contract would terminate if and when the administrative law judge upheld the termination order. Since Royal Fontana's contract was now Health Equity's contract, Health Equity was substituted for Royal Fontana in the proceeding before the administrative law judge.

In January of last year, with that proceeding still pending before the administra-

tive law judge, Health Equity filed this lawsuit, seeking to enjoin the termination of Royal Fontana's Medicaid contract. The district judge dismissed the suit for want of jurisdiction. While the appeal from that dismissal was pending in this court, the administrative law judge, in July of last year, upheld the termination of Royal Fontana's—which is to say Health Equity's—Medicaid contract. With his decision, that termination finally became effective, pursuant to section 1396i(c)(2) as interpreted in *Wayside Farm, Inc. v. U.S. Dept. of Health & Human Services*, 863 F.2d 447 (6th Cir.1988); and we do not understand Health Equity to be challenging that interpretation. However, the State of Illinois, which administers the Medicaid program in Illinois with financial assistance from the federal government no longer available for services provided at the Royal Fontana nursing home, has made a loan to Health Equity to enable the nursing home to keep its Medicaid patients. The state can do this because the Health Care Financing Administration is not forcing Health Equity to close down the Royal Fontana or to discharge its Medicaid patients; the Administration just won't provide federal funds for reimbursing Health Equity under the Medicaid program. The state, through the loan, has assumed the financial burden because it bears the ultimate responsibility for these patients and has, for the time being anyway, nowhere else to put them.

Health Equity had a right to appeal the administrative law judge's decision to the Appeals Council of the Health Care Financing Administration. It exercised that right, and the case is now before the Appeals Council, awaiting decision. At any time after the administrative law judge confirmed the termination of its Medicaid contract—even before the Appeals Council decided the appeal—Health Equity could have sought reinstatement of its (formerly Royal Fontana's) Medicaid contract by showing “that the reason for termination has been removed and there is reasonable assurance that it will not recur.” 42 U.S.C. § 1396i(c)(1). Although Health Equity claims to have cured the deficiencies in the operation of the Royal Fontana that led to

the termination, it has not applied for reinstatement, fearing—it tells us—that such a move would be construed as a waiver of its right to maintain its challenges (in the Appeals Council and in the federal courts) to the termination order.

[1] The Medicaid statute provides for judicial review in accordance with the review provision of the Social Security Act. 42 U.S.C. § 1396i(c)(2). That provision, 42 U.S.C. § 405(g), provides for review only of *final* decisions of the *Secretary* of Health and Human Services, meaning that the seeker of judicial review must have exhausted all his administrative remedies, including, in this case, appeal to the Appeals Council of the Health Care Financing Administration. *Bowen v. City of New York*, 476 U.S. 467, 472, 482, 106 S.Ct. 2022, 2026, 2031, 90 L.Ed.2d 462 (1986). Until then, there is no final decision. Health Equity filed this suit not only before the Appeals Council had decided its appeal but before the appeal had even been filed—in fact before the administrative law judge had rendered his decision. That was grossly premature.

[2] It is true that, ordinarily, exhaustion of administrative remedies is not required if it would be futile, that is, if there is no reasonable prospect that the applicant could obtain any relief by pursuing them. *Randolph-Sheppard Vendors of America v. Weinberger*, 795 F.2d 90, 105–07 (D.C. Cir.1986). And although *Weinberger v. Salfi*, 422 U.S. 749, 766, 95 S.Ct. 2457, 2467, 45 L.Ed.2d 522 (1975), holds that futility is not an excuse under section 405(g), futility comes in by the back door, through the judge-made rule that allows a party to an administrative proceeding to bypass the administrative process by mounting “a collateral attack rather than one on the merits” in circumstances demonstrating a compelling need for immediate judicial review. *Johnson v. Sullivan*, 922 F.2d 346, 353 (7th Cir.1990) (en banc); see also *Bowen v. City of New York*, *supra*, 476 U.S. at 483, 106 S.Ct. at 2031. If, therefore, the party wants to challenge a regulation that is preventing him from making his case on the merits and he cannot feasibly defer the

challenge to the conclusion of the administrative proceeding, he can bring his judicial action forthwith.

[3] So futility is not an excuse for failure to exhaust administrative remedies, but futility plus hardship is. In the *City of New York* case, for example, a class of applicants for social security disability benefits who had been denied benefits on the basis of an unpublished, indeed secret, regulation were allowed to challenge the regulation without first exhausting their administrative remedies. Some of the applicants had not discovered the regulation until the administrative decisions denying them benefits had become final by conventional criteria of finality and the time for judicial review of those “final” decisions had expired. The applicants could not be faulted for failing to challenge a regulation that they didn’t know about—this was the futility of exhaustion—and the hardship came from the fact that their time to challenge it had now passed. Other applicants still had time to exhaust their administrative remedies—they were like Health Equity in this regard—but were excused anyway, on the basis of a finding by the district court that the ordeal of having to go through the administrative appeals process might trigger a severe medical setback. 476 U.S. at 483, 106 S.Ct. at 2031. See also *Mathews v. Eldridge*, 424 U.S. 319, 330–31, 96 S.Ct. 893, 900–01, 47 L.Ed.2d 18 (1976).

[4] The principle embodied in these decisions, fiercely criticized though it has been by Professor Davis, 4 Davis, *Administrative Law Treatise* § 26:8 (2d ed. 1983), is at least comprehensible when understood as reading section 405(g) by the light of the concept of practical finality that has sometimes been used to mitigate the severity of the final judgment rule of 28 U.S.C. § 1291. 15 Wright, Miller & Cooper, *Federal Practice and Procedure* § 3913 (1976). But neither requirement for applying the “futility plus hardship” doctrine is satisfied in this case. The first may seem to be, because Health Equity’s attack is not on the ruling that the operation of the Royal Fontana had violated the terms of the Medicaid contract—the ruling on the merits—but on the

agency’s refusal to allow Health Equity to ward off termination by showing that it has cured the deficiencies in the Royal Fontana’s operation. The regulation that Health Equity wants to challenge prevents it from introducing evidence that would demonstrate the injustice of the agency’s action. But there is nothing—so far as we are informed, at any rate—to prevent Health Equity from challenging the regulation before the Appeals Council. *Pittston Coal Group v. Sebben*, 488 U.S. 105, 123, 109 S.Ct. 414, 424, 102 L.Ed.2d 408 (1988); *Johnson v. Sullivan*, *supra*, 922 F.2d at 355. The challenge may, probably will, fail, but that does not make it futile; most appeals fail.

And what is the hardship? The loss of a Medicaid contract could of course be a financial blow to a nursing home, even if not all of its patients were Medicaid patients. (We have not been told what fraction of the Royal Fontana’s patients were Medicaid patients—only that 75 percent of its revenues are derived from Medicaid and Medicare.) Yet until the administrative law judge handed down his decision, the Medicaid contract for the Royal Fontana remained in force; afterward, any direct pecuniary harm was staved off, for the time being anyway, by the loan from the State of Illinois. The state’s patience may not be inexhaustible, but neither will the proceeding in the Appeals Council last forever. Health Equity has given us no reason to believe that the loan will be called before the Appeals Council acts. It is true that the loan was not made until the administrative law judge upheld the termination of the Medicaid contract, which was after this suit had been filed and dismissed, so it was too late for the parties to make a record in the district court concerning the loan—its terms, duration, etc. But as soon as the administrative law judge acted, Health Equity asked the district court and then this court to stay his order (both courts refused)—not because the order had inflicted any direct pecuniary harm on Health Equity, but because the termination of its Medicaid contract has besmirched its good name in the nursing-home community. This is also the irreparable harm claimed in

Health Equity's brief in this court. We are baffled by the claim. Health Equity bought the Royal Fontana nursing home after the Health Care Financing Administration had issued its order of termination. It bought *knowing* that the regulations of the Administration would automatically substitute the purchaser for Royal Fontana as the Medicaid provider, so that if and when the administrative law judge upheld the order of termination it would be Health Equity's contract that was terminated. The price that Health Equity paid for the Royal Fontana—a figure that Health Equity's lawyer surprisingly but perhaps significantly was unable to tell us—no doubt was discounted to reflect the probability that the termination order would be upheld and that there might be some publicity fallout upon Health Equity.

[5] If there really were irreparable harm here, we imagine that Health Equity would have asked the Appeals Council to accelerate its consideration of the appeal—which Health Equity has not done—or would have filed for reinstatement, which it hasn't done either, believing without any basis we can find that filing for reinstatement would operate as a waiver of its procedural rights. Although the rules of the Appeals Council contain no provision for the acceleration of an appeal, it does not follow that the Council has no power to accelerate; on the contrary, an adjudicative tribunal has inherent power to manage its calendar, in the absence of statute or regulation prescribing the order in which the tribunal must consider the cases tendered to it. *Will v. Calvert Fire Ins. Co.*, 437 U.S. 655, 665, 98 S.Ct. 2552, 2558, 57 L.Ed.2d 504 (1978) (plurality opinion). So any irreparable harm here was triply self-inflicted: Health Equity bought the Royal Fontana knowing its contract had been (provisionally) terminated, failed to request reinstatement, and failed to ask the Appeals Council to speed up the decision of the appeal.

To state our conclusion on jurisdiction very mildly, Health Equity has not presented an adequate reason for bypassing the settled machinery for adjudicating chal-

lenges to administrative decisions in the health field. And while it is true that 42 U.S.C. § 405(h), which expressly makes section 405(g) the exclusive route for obtaining judicial review of decisions by the Social Security Administration, was not incorporated into the Medicaid statute (as it was into the Medicare statute, 42 U.S.C. § 1395ii), we do not interpret the omission as abrogating the doctrine of exhaustion of remedies in Medicaid cases. The incorporation of section 405(g) can only be understood as a determination to make section 405(g) the route for judicial review of Medicaid determinations, since if it were only a route every provider would avoid it, as Health Equity has tried to do by basing its suit not on section 405(g) but on 28 U.S.C. § 1331, the general federal-question jurisdictional statute. Even if this end run could succeed to the extent that section 1331 might (though we think not) be thought, in the absence of section 405(h), to provide an alternative basis to section 405(g) for federal court jurisdiction, it would not follow that the doctrine of exhaustion of administrative remedies was inapplicable. That doctrine is not tied to section 405(g). Granted, *Weinberger v. Salfi* interprets section 405(g) as incorporating a particularly severe version of the doctrine; but even the less severe versions would rebuke the gratuitous impatience displayed by Health Equity in this case.

[6] Lest Health Equity think that it can refile this suit if and when the Appeals Council affirms the administrative law judge, we add that the suit is as frivolous as it is premature, and on both counts fails to invoke the jurisdiction of the federal courts. *Crowley Cutlery Co. v. United States*, 849 F.2d 273, 276 (7th Cir.1988), and cases cited there. Health Equity argues that the loss of reputation that it fears as a result of the termination of its Medicaid contract, and that is also the basis of its futile appeal to the hardship half of the test for excusing a party from having to exhaust administrative remedies, will if it occurs be a deprivation of property within the meaning of the due process clause. But reputation is not property in that sense. *Paul v. Davis*, 424 U.S. 693, 96

S.Ct. 1155, 47 L.Ed.2d 405 (1976). It is true that a number of cases, illustrated by *Lawson v. Sheriff of Tippecanoe County*, 725 F.2d 1136 (7th Cir.1984), hold that firing a public employee in circumstances that publicly “stigmatize” him as dishonest or incompetent deprives him of his liberty of employment and therefore may not be done without due process, such liberty being a component of the “life, liberty, or property” to which the due process clause refers. These cases build from the gloss that *Paul v. Davis* had placed on *Wisconsin v. Constantineau*, 400 U.S. 433, 91 S.Ct. 507, 27 L.Ed.2d 515 (1971). In that case a town’s police chief had caused to be posted in all retail liquor outlets in the town a notice that they were forbidden to sell liquor to the plaintiff, and in holding that the chief could not do this without giving the plaintiff due process the Court noted that the posting was “a stigma, an official branding of a person. The label is a degrading one.” *Id.* at 437, 91 S.Ct. at 510. From this one might have inferred that defamation by a public official was actionable under the due process clause. But the Court in *Paul v. Davis* scotched this suggestion, emphasizing that “the government action taken in that case [*Constantineau*] deprived the individual of a right previously held under state law,” and therefore “significantly altered his status as a matter of state law.” There was more than defamation; there was, as in the employment cases, the infringement of a liberty—the liberty to purchase goods.

The extent to which the combination of an injury to reputation with “a change in legal status” might be actionable under the due process clause at the behest of an institution as distinct from an individual remains open. *Somerset House, Inc. v. Turnock*, 900 F.2d 1012, 1015 (7th Cir. 1990). We tend to think of liberty as the interest of an individual rather than of a business firm or other artificial person. Defamatory conduct by public officials that caused the revocation of a license or other property right of a business firm might meet the “altered legal status” test, but there is nothing of that sort here and *Goulding v. Feinglass*, 811 F.2d 1099, 1103

(7th Cir.1987), holds that there is no property right to carry on a business as such.

[7] We need not pursue these interesting questions further. Even if Health Equity was deprived of liberty or property, this can make no difference to the outcome because there was no denial of due process. Health Equity received a full hearing before an administrative law judge before it was terminated. Due process required no more, and probably less. *Northlake Community Hospital v. United States*, 654 F.2d 1234, 1243 (7th Cir.1981); *American Healthcare Corp. v. Schweiker*, 688 F.2d 1072, 1083–84 (7th Cir.1982); *Patchogue Nursing Center v. Bowen*, 797 F.2d 1137, 1144 (2d Cir.1986).

By arguing that the regulation which substituted it for Royal Fontana in the termination proceeding cut off its right to present evidence to the administrative law judge proving that it had corrected the deficiencies which led to the termination, Health Equity tries to give the case a due process flavor. But it is only a flavor. The evidence was irrelevant, given the statutory scheme; and the refusal to admit irrelevant evidence in a legal proceeding is an example of due process, not of its denial. The real challenge, then, is to the regulatory scheme itself, and it is a scheme that strikes us as eminently sensible and certainly not a violation of any constitutional or statutory provision. The termination proceeding is limited to the deficiencies uncovered in the inspection, and the correction of those deficiencies is adjudicated when and if the terminated nursing-home operator seeks reinstatement. Health Equity thinks the Constitution entitles it to ward off termination by showing that it has corrected its predecessor’s deficiencies, even if it is not prepared to provide reasonable assurance that they will not recur—for if it is so prepared, it can obtain reinstatement. It wants in other words a regime under which a Medicaid provider can violate his contract with impunity and when caught sell out to a purchaser of “troubled” homes, like Health Equity, without termination of the contract, provided only that the purchaser cures the deficien-

Case: 15-13731 Date Filed: 03/30/2016 Page: 24 of 24
 CHASTAIN v. FREEMAN UNITED COAL MIN. CO. 969
 Cite as 927 F.2d 969 (7th Cir. 1991)

cies before termination is to become effective and submits proof of such cure before the proceeding is over. Such a regime would not only stretch out the administrative process by requiring the administrative law judge to reopen the termination proceeding after the close of the record; it would also weaken the incentives of nursing-home operators to comply with Medicaid contracts, for there would be no penalty for what could be a protracted period of noncompliance.

AFFIRMED.

RIPPLE, Circuit Judge, concurring in part and dissenting in part.

I join the judgment of the court and the essential reasoning of the majority opinion. I must respectfully decline, however, from joining the dicta, *ante* at 9, suggesting unnecessarily restricted protection for corporate entities under the due process clauses of the fifth and fourteenth amendments. As the court quite correctly notes in the following paragraph, even if Health Equity was deprived of liberty or property, there was no denial of due process.



Helen CHASTAIN, Widow of Donald
 Chastain, Petitioner,

v.

FREEMAN UNITED COAL MINING
 COMPANY and Director, Office of
 Workers' Compensation Programs,
 United States Department of Labor, Re-
 spondents.

No. 88-3381.

United States Court of Appeals,
 Seventh Circuit.

March 14, 1991.

Coal miner filed claim for benefits under Black Lung Benefits Act. The adminis-

trative law judge (ALJ) found that miner was entitled to presumption that he was totally disabled due to pneumoconiosis arising out of coal mining employment but that employer rebutted presumption. The Benefits Review Board affirmed. Miner's widow appealed. The Court of Appeals, 919 F.2d 485, Cudahy, Circuit Judge, reversed and awarded benefits. Employer petitioned for rehearing. The Court of Appeals held that: (1) claim could not be denied solely on basis of negative x-ray evidence, and (2) remand was unnecessary since ALJ could not find rebuttal of presumptive existence of pneumoconiosis.

Petition for rehearing denied.

1. Labor Relations ⇌30

Claim for black lung benefits may not be denied solely on basis of negative x-ray evidence, even though x-rays demonstrating pneumoconiosis are reliable to prove existence of disease, since absence of such evidence in x-rays does not reliably indicate that miner does not suffer from pneumoconiosis. Federal Mine Safety and Health Act of 1977, § 413(b), 30 U.S.C.A. § 923(b).

2. Labor Relations ⇌31

Remand of claim for black lung benefits to administrative law judge (ALJ) for redetermination of entitlement to benefits, rather than simply deciding to award benefits, was unnecessary since ALJ could not find evidence rebutting presumption of existence of pneumoconiosis where record was devoid of evidence which could be combined with negative x-rays to support rebuttal of presumption. Federal Mine Safety and Health Act of 1977, § 413(b), 30 U.S.C.A. § 923(b).

3. Labor Relations ⇌30

Labeling of miner's alleged black lung disease as statutory, rather than clinical, pneumoconiosis does not affect availability of rebuttal of presumption of existence of disease through negative x-ray evidence. Federal Mine Safety and Health Act of 1977, § 413(b), 30 U.S.C.A. § 923(b).

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April 1, 2016

VIA ELECTRONIC FILING

Amy C. Nerenberg, Acting Clerk of Court
United States Court of Appeals for the Eleventh Circuit
56 Forsyth Street, N.W.
Atlanta, Georgia 30303

Re: *Agency for Health Care Adminis, et al. v. Bayou Shores SNF LLC*, Case No. 15-13731
Response to Federal Appellee's Citation of Supplemental Authority re: *Cathedral Rock of N. Coll. Hill, Inc. v. Shalala*, 223 F.3d 354 (6th Cir. 2000) ("*Cathedral*") and *Health Equity Res. Urbana. v. Sullivan*, 927 F.2d 963 (7th Cir. 1991)

Dear Ms. Nerenberg:

The federal government attempts to amend its concession at oral argument regarding the applicability of 405(h) to Medicaid, however, it fails to recognize a critical distinction in the facts and law at issue.

Cathedral did not arise from a bankruptcy case and, importantly, involved a situation where the federal government specifically "adopted the [state's] recommendations and imposed" penalties including the "termination of Beechnoll's participation in the Medicare and Medicaid programs." *Cathedral*, 223 F.3d at 357.

Here, however, the federal government did not specifically terminate the Medicare and Medicaid agreements. As a result, 42 U.S.C. § 1396r(h)(3)-(5) required that the state take action to terminate the Medicaid provider agreement. Furthermore, Florida law does not provide for an automatic termination of Medicaid agreements. Under section 409.913(14), Florida Statutes, the state must take action to terminate a Medicaid provider agreement, and section 409.907(2) requires reasonable notice. Here, the state gave no notice of termination until more than a year after Bayou filed the bankruptcy case.¹ As such, there is no question that the Medicaid agreement was still in effect on the date Bayou filed its bankruptcy case.

The Bankruptcy Court was required to evaluate, and properly evaluated, whether or not the Medicare and Medicaid agreements had terminated to determine the extent of Bayou's property interests; such is a "core" determination within its exclusive jurisdiction. See, e.g., *In re Gardner*, 913 F.2d 1515, 1518 (10th Cir. 1990) (the determination of whether property is part of the bankruptcy estate constitutes a core proceeding subject to the bankruptcy court's exclusive jurisdiction).

¹ The federal government's Medicare termination letter dated July 22, 2014, and the state's Medicaid termination letter dated August 18, 2015, appear multiple times in the court file. A composite exhibit including the two letters was previously filed with this Court and is again attached to this letter for the convenience of the reader.

GRAYROBINSON
PROFESSIONAL ASSOCIATION

Case: 15-13731 Date Filed: 04/01/2016 Page: 2 of 17

Amy C. Nerenberg, Acting Clerk of Court
April 1, 2016
Page 2

Moreover, 405(h) would have to be rewritten to ever apply to Medicaid,² and rewritten for it to apply to Medicare in connection with a bankruptcy case, which violates the Supreme Court's pronouncement that plain statutory language must be enforced "according to its terms," *King v. Burwell*, 135 S. Ct. 2480, 2489 (2015), absent "rare and exceptional circumstances." *Bull v. U.S.*, 479 F.3d 1365, 1377 (Fed. Cir. 2007). In this case, no rare or exceptional circumstance exists. The plain language of section 405(h) applies only to "actions brought under section 1331 or 1346 of Title 28," not section 1334.

Sincerely,

Jeffrey T. Kuntz

cc: All Counsel of Record via ECF

² *Matter of Townview Nursing Home*, 28 B.R. 431, 440 (Bankr. S.D.N.Y. 1983) ("No similar statute, however, makes Section 405(h) applicable to the Medicaid program.").

AMERICAN BANKRUPTCY INSTITUTE



Case: 15-13731 Date Filed: 09/01/2016 Page: 2 of 17

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

CERTIFIED MAIL NO.: 91 7199 9991 7033 6478 6466

August 18, 2015

Bayou Shores SNF LLC
d/b/a Rehabilitation Center of St. Pete
435 42nd Ave S
St. Petersburg, FL 33705-4504

Provider No.: 007205400

Provider License No.: 1364095

MPI Case ID: 2015-0004963

NPI No.: 1063766707

In Reply Refer to: Termination from Participation

Dear Provider:

In accordance with Sections 409.913(14) if a provider has been suspended or terminated from participation in the Medicaid program or the Medicare program by the Federal Government or any other state, the agency must immediately suspend or terminate, as appropriate, the provider's participation in the Florida Medicaid program for a period no less than that imposed by the Federal Government or any other state, and may not enroll such provider in the Florida Medicaid program while such foreign suspension or termination remains in effect. The Bureau of Medicaid Program Integrity learned that the Centers for Medicare and Medicaid Services (CMS) involuntarily terminated the Rehab Center of St. Pete from participation in the Medicare program. (See, generally, notice from CMS to provider dated July 22, 2014).

Our records indicate that orders were issued by the United States District Court, Middle District of Florida, Tampa Division which impacts the termination effective date. Pursuant to the July 20, 2015 Order of the United States District Court for the Middle District of Florida in *Agency for Health Care Administration, et al. v. Bayou Shores SNF LLC*, Case No: 8:14-cv-2816-T-30, payments under your Medicaid provider agreement will end on October 18, 2015. As such, the effective date of the provider termination from the Florida Medicaid program shall be October 19, 2015.

You have the right to request a formal or informal hearing pursuant to Section 120.569, F.S. If a request for a formal hearing is made, the petition must be made in compliance with Section 28-106.201, F.A.C., and mediation may be available.

If a request for an informal hearing is made, the petition must be made in compliance with rule Section 28-106.301, F.A.C. Additionally, you are hereby informed that if a request for a hearing is made, the petition must be **received by the Agency** within twenty-one (21) days of receipt of this letter. **For more information regarding your hearing and mediation rights, please see the attached Notice of Administrative Hearing and Mediation Rights.**

2727 Mahan Drive • Mail Stop #6
Tallahassee, FL 32308
AHCA.MyFlorida.com



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SlideShare.net/AHCAFlorida

2017 CARIBBEAN INSOLVENCY SYMPOSIUM

Case: 15-13731 Date Filed: 08/01/2016 Page: 3 of 17

Bayou Shores SNF LLC
d/b/a Rehabilitation Center of St. Pete
Provider No: 007205400
August 18, 2015
Page 2 of 4

Section 409.913(12), F.S. provides exemptions from the provisions of Section 119.07(1), F.S. All information obtained pursuant to this review is confidential and exempt from the provisions of Section 119.07(1), F.S., until the Agency takes final agency action with respect to the provider and requires repayment of any overpayment or imposes an administrative sanction by Final Order.

Any questions you may have about this matter should be directed to: Tim Helms, AHCA Administrator, **Agency for Health Care Administration, Medicaid Program Integrity, 2727 Mahan Drive, Mail Stop #6, Tallahassee, Florida 32308-5403, telephone (850) 412-4600, facsimile (850) 410-1972.**

Sincerely,



Tim Helms, MHSc, LDO
AHCA Administrator
Office of the Inspector General
Medicaid Program Integrity

th/lcj

cc: Shena Grantham, FFS, Medicaid Chief Counsel
Division of Health Quality Assurance (HQA)
Tracy Jeter-Cummings, Health Systems Development (via email only)

Bayou Shores SNF LLC
d/b/a Rehabilitation Center of St. Pete
368 New Hempstead Road, Suite 309
New City, NY 10956-1900
(U.S. mail)

AMERICAN BANKRUPTCY INSTITUTE

Case: 15-13731 Date Filed: 09/01/2016 Page: 3 of 17

Bayou Shores SNF LLC
d/b/a Rehabilitation Center of St. Pete
Provider No: 007205400
August 18, 2015
Page 3 of 4

NOTICE OF ADMINISTRATIVE HEARING AND MEDIATION RIGHTS

You have the right to request an administrative hearing pursuant to Sections 120.569 and 120.57, Florida Statutes. If you disagree with the facts stated in the foregoing Final Audit Report (hereinafter FAR), you may request a formal administrative hearing pursuant to Section 120.57(1), Florida Statutes. If you do not dispute the facts stated in the FAR, but believe there are additional reasons to grant the relief you seek, you may request an informal administrative hearing pursuant to Section 120.57(2), Florida Statutes. Additionally, pursuant to Section 120.573, Florida Statutes, mediation may be available if you have chosen a formal administrative hearing, as discussed more fully below.

The written request for an administrative hearing must conform to the requirements of either Rule 28-106.201(2) or Rule 28-106.301(2), Florida Administrative Code, and must be received by the Agency for Health Care Administration by 5:00 P.M. no later than 21 days after you received the FAR. The address for filing the written request for an administrative hearing is:

Richard J. Shoop, Esquire
Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop # 3
Tallahassee, Florida 32308
Fax: (850) 921-0158
Phone: (850) 412-3630
E-File Website: <http://apps.ahca.myflorida.com/Efile>

Petitions for hearing filed pursuant to the administrative process of Chapter 120, Florida Statutes may be filed with the Agency by U.S. mail or courier sent to the Agency Clerk at the address listed above, by hand delivery at the address listed above, by facsimile transmission to (850) 921-0158, or by electronic filing through the Agency's website at <http://apps.ahca.myflorida.com/Efile>.

The request must be legible, on 8 ½ by 11-inch white paper, and contain:

1. Your name, address, telephone number, any Agency identifying number on the FAR, if known, and name, address, and telephone number of your representative, if any;
2. An explanation of how your substantial interests will be affected by the action described in the FAR;
3. A statement of when and how you received the FAR;
4. For a request for formal hearing, a statement of all disputed issues of material fact;
5. For a request for formal hearing, a concise statement of the ultimate facts alleged, as well as the rules and statutes which entitle you to relief;
6. For a request for formal hearing, whether you request mediation, if it is available;
7. For a request for informal hearing, what bases support an adjustment to the amount owed to the Agency; and,
8. A demand for relief.

A formal hearing will be held if there are disputed issues of material fact. Additionally, mediation may be available in conjunction with a formal hearing. Mediation is a way to use a neutral third party to assist the parties in a legal or administrative proceeding to reach a settlement of their case. If you and the Agency agree to mediation, it does not mean that you give up the right to a hearing. Rather, you and the Agency will try to settle your case first with mediation.

Bayou Shores SNF LLC
d/b/a Rehabilitation Center of St. Pete
Provider No: 007205400
August 18, 2015
Page 4 of 4

If you request mediation, and the Agency agrees to it, you will be contacted by the Agency to set up a time for the mediation and to enter into a mediation agreement. If a mediation agreement is not reached within 10 days following the request for mediation, the matter will proceed without mediation. The mediation must be concluded within 60 days of having entered into the agreement, unless you and the Agency agree to a different time period. The mediation agreement between you and the Agency will include provisions for selecting the mediator, the allocation of costs and fees associated with the mediation, and the confidentiality of discussions and documents involved in the mediation. Mediators charge hourly fees that must be shared equally by you and the Agency.

If a written request for an administrative hearing is not timely received you will have waived your right to have the intended action reviewed pursuant to Chapter 120, Florida Statutes, and the action set forth in the FAR shall be conclusive and final.

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909



Refer to: 10-5772.Invol.Term.07.22.14.docx

IMPORTANT NOTICE – PLEASE READ CAREFULLY

NOTICE OF INVOLUNTARY TERMINATION

(Receipt of this Notice is Presumed to be July 22, 2014 - Date Notice E-mailed)

Via Federal Express, Regular Mail & E-mail

July 22, 2014

Ms. Tracy Johnson, Administrator
Rehabilitation Center of Saint Petersburg
435 42nd Avenue South
Saint Petersburg, Florida 33705

Re: Involuntary Termination Notice
CMS Certification Number (CCN #): 10-5772

Dear Ms. Johnson,

A facility must meet the pertinent provisions of Sections 1819 and 1919 of the Social Security Act, and be in substantial compliance with each of the requirements for long term care facilities, established by the Secretary of Health and Human Services in 42 C.F.R. section 483.1 *et seq.*, in order to qualify to participate as a skilled nursing facility (SNF) in the Medicare program, and as a nursing facility (NF) in the Medicaid program.

On July 11, 2014, a recertification and complaint investigation survey was completed at Rehabilitation Center of Saint Petersburg, Inc. by the Florida Agency for Healthcare Administration to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid program. **This survey found that your facility was not in substantial compliance with the participation requirements, and that conditions in your facility also constituted immediate jeopardy to residents' health and safety and substandard quality of care that was determined to exist on June 21, 2014, and is considered ongoing.** A statement of the deficiencies (CMS-2567) will be furnished to you by the Florida State Survey Agency.

All regulatory requirements referenced in this letter are found in Title 42, Code of Federal Regulations.

Remedies imposed Based on the July 11, 2014 Recertification and Complaint Survey

Based on the July 11, 2014 survey findings, CMS is imposing the following remedies:

Involuntary Termination

Your Medicare provider agreement will be terminated at 11:59 pm on August 3, 2014, in accordance with 42 C.F.R. 488.456(b) (i) and 42 C.F.R. 489.53. We are required to provide the general public with a notice of impending termination and we published a notice in your local newspaper, *The Tampa Bay Times*, prior to the effective date of the termination. Medicare and Medicaid payments for services rendered to those residents admitted to Rehabilitation Center of Saint Petersburg, before August 3, 2014, will continue to be made up to a 30-day period in order to facilitate the orderly transfer/relocation of residents. The 30-day time interval for payment is from August 3, 2014 through September 2, 2014.

Discretionary Denial of Payment for New Admissions (DPNA)

Denial of Payment for new admissions is effective as of July 24, 2014.

Please note that any filing of Medicare or Medicaid claims for new admissions after the denial of payment for new admissions (DPNA) is in effect could result in such claims being considered "false" claims under applicable federal statutes and thus potentially subjecting the filing entity to a referral to the appropriate authorities and possibly to the penalties prescribed under such statutes. An exception possibly applies where a timely appeal of the controlling certification/finding of non-compliance is filed (and remains pending) under 42 C.F.R. Part 498, and where your facility has made arrangements acceptable to your Medicare and Medicaid fiscal intermediaries to submit the claim (or claims) with prominent flagging clearly indicating that the claim(s) is/are being filed not for current payment, but "under protest" and for the sole purpose of preserving a timely filing should the facility prevail on its administrative appeal under 42 C.F.R. Part 498.

Civil Money Penalty (CMP)

As a result of your facility's noncompliance as evidenced by the findings of the July 11, 2014 survey, and in accordance with sections 1819 (h) and 1919 (h) of the Social Security Act and the enforcement regulations specified at 42 C.F.R. Part 488, **we are imposing a Federal Civil Money Penalty in the amount of \$3050.00 per day effective June 21, 2014.** We considered factors identified at 42 C.F.R. 488.438 (f) in setting the amount of the CMP being imposed for each day of noncompliance.

NOTICE OF INTENT TO HOLD YOUR FACILITY'S CMP IN ESCROW

In accordance with federal law at 42 C.F.R. 488.431 and based on the scope/severity of noncompliance identified during your facility's survey, we have decided to collect your facility's CMP and place it in an escrow account.

If you wish to dispute the findings of noncompliance upon which we have made this decision, you may request an Independent Informal Dispute Resolution (Independent IDR) proceeding in accordance with 42 C.F.R. sections 488.331 and 488.431. **If you would like to request an Independent IDR, you must do so in writing within ten (10) days of receiving this notice.**

Your written request should identify the specific findings of noncompliance you are disputing, as well as an explanation of why you are disputing them (and/or why you are disputing the scope/severity of noncompliance constituting immediate jeopardy or substandard quality of care). Your request for an Independent IDR should be sent to the following address:

Carol Higgins, IDR Coordinator
Agency for Health Care Administration, Field Operations
2727 Mahan Drive, Building 2, Third Floor
Tallahassee, Florida 32308
Email: IDRcoordinator@ahca.myflorida.com
Telephone: (850) 412-3942

Please note that an incomplete Independent IDR process will not delay the effective date of any enforcement remedy imposed on your facility, and it will not delay our collection of your facility's CMP for more than ninety (90) days. We are authorized by federal law at 42 CFR 488.431(b) to collect your CMP in 90 days and place it in escrow, or to do so when a decision is issued from an Independent IDR proceeding, whichever is earlier.

Please note, furthermore, that an incomplete IDR or Independent IDR process will not delay any deadline listed below under "Appeal Rights" for requesting a hearing, or for requesting a waiver of hearing rights.

NOTICE OF RIGHT TO REQUEST HEARING OR WAIVE HEARING RIGHTS

As explained more fully below under "Appeal Rights," you have the right to request a hearing before the Departmental Appeals Board (DAB) if you wish to dispute the basis and amount of your facility's CMP. You may also decide to waive your right to a hearing, in accordance with regulations at 42 C.F.R. 488.436. **If you would like to waive your right to a hearing, you must do so in writing within sixty (60) days of receiving this notice.** If you waive your right to a hearing, the amount of your CMP will be reduced by thirty-five percent (35%); on the other hand, if you request a hearing or miss the deadline for requesting a waiver, your CMP will not be reduced by 35 percent.

2017 CARIBBEAN INSOLVENCY SYMPOSIUM

Case: 15-13731 Date Filed: 09/07/2015 Page: 10 of 117

You must submit your waiver request directly to our Atlanta Regional Office by **certified mail** or via Internet e-mail to the **CMP Waiver mail box**. **The Atlanta Regional Office does not accept CMP waivers via facsimile.** Please address correspondence via certified mail to:

Stephanie M. Davis, MS., RD
Chief, LTC Certification & Enforcement Branch
Centers for Medicare & Medicaid Services
Sam Nunn Atlanta Federal Center
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909

CMP waivers may also be submitted via Internet e-mail to the CMP Waiver mail box. The Internet e-mail address is:

CMPWaiversATL@cms.hhs.gov

Substandard Quality of Care (SQC)

Your facility's noncompliance with 483.13 cited at tags F224(J), F225(J), and F226(J), and 483.25 cited at tags F323(J), has been determined to constitute substandard quality of care (SQC) as defined at 42 C.F.R. 488.301.sections 1818(g)(5)(C) and 1919 (g)(5)(C) of the Social Security Act, as well as implementing regulations at 42 C.F.R. 488.325(h), require the State Survey Agency to send written notice of your facility's SQC to the attending physician of each resident, as well as the state board responsible for licensing the facility's administrator. In order to satisfy these notification requirements, you are required to provide the State Survey Agency with the name and address of the attending physician for each resident found to have received SQC. The State Survey Agency will advise you of the deadline for providing this information.

Please note that, in accordance federal law at 42 C.F.R. 488.325(g), your failure to provide this information in a timely fashion will result in the termination of your facility's Medicare provider agreement, or the imposition of alternative remedies.

Loss of Nurse Aide Training Program (NATCEP)

Please note that Federal law, as specified in the Social Security Act at sections 1819 (f)(2)(B) and 1919 (f)(2)(B), prohibit approval of nurse aide training and competency evaluation programs offered by or in your facility which within the previous two years has operated under a section 1819 (b)(4)(c)(ii)(II) or section 1919 (b)(4)(ii) waiver; has been subject to an extended or partial extended survey; or has been assessed a civil money penalty of not less than \$5,000; or, has been subject to denial of payment, the appointment of a temporary manager, termination or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities. As a result of the involuntary termination, this provision is applicable to your facility and you will receive further notification from the State.

Appeal Rights for July 11, 2014 Recertification and Complaint Investigation Survey

If you disagree with CMS determinations that are based on the July 11, 2014, recertification and complaint survey as reflected in this Notice, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in section 498.40, et seq. A written request for a hearing must be filed no later than sixty days of receipt from the date of this letter. Such a request should be directed to:

Stephanie M. Davis, MS. RD
Chief, LTC Certification & Enforcement Branch
Centers for Medicare & Medicaid Services
Sam Nunn Atlanta Federal Center
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909

And

Chief, Civil Remedies Division
Departmental Appeals Board, MS 6132
Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building, Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may be represented by counsel at a hearing at your own expense.

Application for Readmission Following Involuntary Termination:

Under the Medicare regulation at 42 C.F.R. § 489.57(a) when a provider agreement is terminated by CMS, a new agreement will not be accepted until it has been determined that the reason for the termination of the agreement has been removed and there is a reasonable assurance that it will not recur. Once terminated, therefore, you must demonstrate through a reasonable assurance period that you can maintain substantial compliance for at least 180 consecutive days. Substantial compliance with the applicable participation requirements at 42 C.F.R Part 483 will be verified by surveys conducted at the beginning and end of this period. Additionally, before readmission to the Medicare program, you must demonstrate your ability to comply with all pertinent requirements of Title XVIII of the Social Security Act (including your financial ability to provide services required for Medicare participation). You must also establish that you have fulfilled, or made satisfactory arrangements to fulfill, all of the statutory and regulatory responsibilities of your previous provider agreement (including resolution of all outstanding financial obligations due the Medicare program) 42 C.F.R. § 489.57(b).

2017 CARIBBEAN INSOLVENCY SYMPOSIUM

Case: 15-13731 Date Filed: 09/01/2016 Page: 12 of 17

Assuming substantial compliance with participation requirements is documented at the beginning and end of the reasonable assurance period, and assuming all other federal requirements are met, Medicare certification and reimbursement will begin following the conclusion of the reasonable assurance period in accordance with the terms of 42 C.F.R. § 489.13.

If you have any questions regarding this matter, please contact Stephanie M. Davis, LTC Enforcement Branch Manager at (404) 562-7471 or Phyllis King at (404) 562-7456.

Sincerely,

/s/

Sandra M. Pace
Associate Regional Administrator
Division of Survey & Certification

cc: State Survey Agency
State Medicaid Agency
Medicare Administrative Contractors
Jackie Glaze, DMCHO, ARA
Stephanie M. Davis, LTCCEB Manager

NOTE TO THE MEDICARE ADMINISTRATIVE CONTRACTORS:
This letter replaces the CMS-2007, Provider Tie-In Notice

No. 15-13731-FF
In The United States Court of Appeals
for the Eleventh Circuit

BAYOU SHORES, SNF, LLC,

Appellant

v.

FLORIDA AGENCY FOR HEALTH
CARE ADMINISTRATION and THE
UNITED STATES OF AMERICA, ON
BEHALF OF THE SECRETARY OF THE
UNITED STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES,

Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF FLORIDA, TAMPA DIVISION

Case No. 8:14-cv-02816-T-30 (Lead Case) as consolidated with
8:14-cv-02617-T-30; 8:15-cv-00103-T-30; 8:15-cv-00128-T-30

THE HONORABLE JAMES S. MOODY, JR.

APPELLANT BAYOU SHORES, SNF, LLC'S
CERTIFICATE OF INTERESTED PERSONS

Elizabeth A. Green
Tiffany D. Payne
Baker & Hostetler LLP
200 South Orange Avenue, Suite 2300
Orlando, Florida 32801
Telephone (407) 649-4000

Frank P. Terzo
Jeffrey T. Kuntz
Gray Robinson, P.A.
401 E. Las Olas Blvd. Suite 1000
Fort Lauderdale, Florida 33301
Telephone (954) 761-8111

Counsel for Appellant,
BAYOU SHORES, SNF, LLC

**CERTIFICATE OF INTERESTED PERSONS AND CORPORATE
DISCLOSURE STATEMENT BY COUNSEL FOR APPELLANT**

Appellant, Bayou Shores, SNF, LLC, (“Bayou Shores”), by and through its undersigned counsel and pursuant to Rule 26.1 of the Federal Rules of Appellate Procedure and Eleventh Circuit Rule 26.1, hereby re-files its certificate of interested persons and corporate disclosure statement and identifies the following persons and entities:

CORPORATE DISCLOSURE STATEMENT

Bayou Shores, in accordance with Fed. R. App. P. 28(a)(1), 26.1(a), and Eleventh Circuit Rule 26.1-2, files this statement disclosing that no parent corporation or any publicly held corporation owns or has ever owned any stock in Bayou Shores.

CERTIFICATE OF INTERESTED PERSONS

AKERMAN SENTERFITT

BAKER, DONELSON, BEARMAN, CALDWELL & BERKOWITZ, PC

BAKER & HOSTETLER LLP

BARNETT, DENISE

BANCROFT, ZACHARY JAMES

BAYOU SHORES, SNF, LLC

BOGOMILSKY, TZVI

CAHILL, MATHEW M.

DAVIS, KIRK S.

EMDEN, CHRISTOPHER JOHN

FALKNER, I, WILLIAM CARROLL

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

FLYNN, SEAN

GRAYROBINSON, P.A.

GREEN, ELIZABETH A.

KUNTZ, JEFFREY T.

LAYDEN, ANDREW V.

LUPINACCI, TIMOTHY M.

MATHEWS, MARGARET DIANE

MOODY, JR., HON. JAMES S.

MURPHY-DAVIS, COLLEEN

PARRISH, JIMMY D.

PAYNE, TIFFANY D.

PINELLAS COUNTY TAX COLLECTOR (NF)

SHEERAN, ANDREW T.

STREET, LESLIE G.

SYNOVUS BANK

TERZO, FRANK P.

THE UNITED STATES OF AMERICA, ON BEHALF OF THE SECRETARY
OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN
SERVICES

UNITED STATES TRUSTEE

VITALE, MICHAEL S.

WILLIAMSON, HON. MICHAEL G.