Healthcare Bankruptcies:
What Happens When It Is The Healthcare Provider Who Is Sick?

Elizabeth J. Futrell
Jones Walker
New Orleans

Cherie D. Nobles
Heller, Draper, Patrick, Horn and Manthey
New Orleans

TABLE OF CONTENTS

PAGE

1. BANKRUPTCY FILING TRENDS FOR HEALTH CARE BUSINESS 1

2. WHAT IS A HEALTH CARE BUSINESS, AND OTHER BANKRUPTCY FILING CONSIDERATIONS 3

   (a) What is a "Health Care Business?" 3

   (b) Where Should a Health Care Business File Bankruptcy? 4

   (c) Not for Profit Heal Care Businesses Cannot be the Subject of an Involuntary Bankruptcy 6

3. IMMEDIATE ISSUES UNIQUE TO HEALTH CARE BUSINESS DEBTORS 7

   (a) Medicare, Medicare and the CMS 8

   (b) Provider Agreements 10

   (c) The Patient Protection and Affordable Care Act (ACA) and the False Claims Act (FCA) 12

   (d) The Automatic Stay 13

   (e) Recoupment and Setoff 18

   (f) Accounts Receivable and Deposit Issues 20

   (g) Limits on Bankruptcy Court Jurisdiction Over Medicare Disputes 23

   (h) Limits on Bankruptcy Court Jurisdiction Over Medicaid Disputes 24

   (i) Appointing a Patient Care Ombudsman 25

(j) Physicians as “Critical Vendors” 29

4. HEALTH CARE BUSINESS CLOSURES WITHOUT GOING CONCERN SALES 32

(a) WARN Act Issues 32

(b) When Business Closure is Commenced after the Chapter 11 Case is Filed 40

(c) Transferring Patients When the Business is Closing 40

(c) Disposal of Patient Records 41

5. GOING-CONCERN SALES, WITH OR WITHOUT A CONFIRMED PLAN 44

(a) The Federal Anti-Assignment Act 44

(b) Provisions that Limit or Condition Use 45

HEALTH CARE BANKRUPTCIES: WHAT HAPPENS WHEN IT IS THE HEALTH CARE PROVIDER WHO IS SICK?

1. BANKRUPTCY FILING TRENDS FOR HEALTH CARE BUSINESSES

(a) Healthcare bankruptcies are on the rise. According to *Bloomberg*, in 2017, healthcare bankruptcies tripled and accounted for 7.25% of all bankruptcies, up from 5.25% since 1997. Furthermore, the southeast United States represented approximately 82% of the total index filings in the third quarter of 2018.

(b) The hardest hit areas are private, rural areas. According to the National Rural Health Association, 90 rural hospitals have closed since 2010.

(c) While each healthcare facility has its own unique set of circumstances leading to its bankruptcy filing, the following general factors have contributed and/or will continue to contribute to the high number of healthcare bankruptcy filings.

(i) Reductions in Disproportionate Share Hospital Medicare payments implemented under the Affordable Care Act. Under federal law, state Medicaid programs are required to make DSH payments to qualified hospital that serve a large number of Medicaid and uninsured individuals. The purpose of these payments is to compensate these hospitals for the high operating costs incurred in treating low-income patients. Hospitals are hit the hardest with these reductions since they treat a significant number of Medicaid and uninsured patients.

(ii) Increase in high-deductible and co-pay health plans making it more difficult for patients to pay their bills resulting in skyrocketing uncollectible accounts. A significant portion of this bad debt is then being written off.

(iii) Implementation of the value-based payment model versus fee-for-service model – The ACA implemented a bundled payment system under which the payer reimburses the healthcare facility based on a fixed amount for all expected services for a particular condition (ex. a hip replacement)

rather than paying for each service. Additionally, private payers are adopting similar models. While this new model can be rewarding, it can also be very risky as the healthcare facility assumes a financial risk in the event the cost of the services exceeds the reimbursement received.

(iv) New LTAC patient criteria and reimbursement rate changes. This factor led to the bankruptcy filing of Acadiana Management Group, LLC and its affiliates which owned several LTAC hospitals throughout the United States. AMG summarized the changes in its disclosure statement [Dkt. No. 650, p. 14, Case No. 17-50799, USBC, WDLA] stating:

"…[F]or patients to qualify for the LTAC reimbursement rate of approximately $41,000 for a twenty-five (25) day patient stay, the patient must now spend at least three (3) days in a hospital's intensive care unit or a coronary care unit immediately prior to being admitted to an LTAC, or the patient must require at least 96 hours on a ventilator and have had an acute hospital stay immediately prior to being admitted to an LTAC. For non-qualifying patients, the twenty-five (25) day reimbursement rate dropped to approximately $11,000. Accordingly, with respect to many patients, these changes yielded a reduction in reimbursement by approximately 75% per patient."

(v) Delays/disputes related to reimbursements and recoupment/setoff of overpayments

(vi) Advances in technology and the costs that are associated with implementing those technological updates

(vii) Tort Liability

(viii) Under- and Over-expansion. This factor partially led to the filing of the Louisiana Medical Center and Heart Hospital located in Lacombe, Louisiana. After Katrina, St. Tammany had an influx of residents, and to address the increase, LHH significantly expanded the hospital and transitioned into a full-service hospital at a cost of $40 million. Unfortunately, the hospital expansion did not generate sufficient revenue to

cover its operating costs, resulting in over $20 million in losses for the three years prior to filing for bankruptcy relief. *See*, Disclosure Statement, p. 10-11 and 13, Case No. 17-10353, USBC, EDLA].

(ix) Costs of infrastructure investments, regulatory compliance and employee wages

(x) Increase in urgent care facilities and competition.

2. WHAT IS A HEALTH CARE BUSINESS AND OTHER BANKRUPTCY FILING CONSIDERATIONS?

(a) What is a "Health Care Business"?

(i) The official forms for both an involuntary and voluntary petition ask whether the debtor is a "health care business," as defined in the Bankruptcy Code.

(ii) Bankruptcy Rule 1021 provides that, unless the court orders otherwise, if the petition states that the debtor is a health care business on the petition, the case "shall proceed" as the bankruptcy of a health care business. It also provides that if there is a dispute over whether the debtor is a health care business, "the United States trustee or any party in interest may file a motion" to determine whether, in fact, the debtor is a health care business.

(iii) "Health care business" is defined in Bankruptcy Code section 101(27A) as "any public or private entity … that is primarily engaged in offering to the general public facilities and services" for "the diagnosis or treatment" of medical conditions, including psychiatric and drug treatment care. Expressly included are hospitals, hospices, home health agencies, skilled nursing facilities, assisted living facilities, homes for the aged, and domiciliary care facilities.

(iv) "Health care business" also includes "any health care institution that is related to" one of the enumerated examples "if that institution is primarily engaged in offering room, board, laundry, or personal assistance with activities

of daily living and incidentals to activities of daily living." 11 U.S.C. § 101(27A).

(v) In *In re Medical Associates of Pinellas, LLC,* 360 B.R. 356, 359 (Bankr. M.D. Fla. 2007), the bankruptcy court set forth the following factors to determine whether a debtor is a health care business: (a) the debtor must be a private or public entity; (b) the debtor must be primarily engaged in offering to the general public facilities and services; (c) the facilities and services must be offered to the public for the diagnosis or treatment of injury, deformity or disease; and (d) the facilities and services must be offered to the public for surgical care, drug treatment, psychiatric care or obstetric care. Applying this test, the court determined that the debtor "was established to provide administrative support" and "laboratory support" to a group of doctors did not qualify as a "health care business." *Id*. at 361.

(vi) The *Pinellas* test appears to have been adopted by a number of courts, including the bankruptcy court in the Northern District of Texas. *In re Smiley Dental Arlington, PLCC,* 503 B.R. 680, 686 (Bankr. N.D. Tex. 2013).

(vii) In *In re Starmark Clinics, LP,* 388 B.R. 729 (Bankr. S.D. Tex. 2008), the court determined that a private entity that offered outpatient cosmetic surgery to the general public qualified as a health care business. *Id.* at 734 ("Debtor is a private entity which offers to the general public facilities and services for the diagnosis and treatment of physical injury, deformity, or disease, by *inter alia*, the injection of foreign substances into the body.").

(b) Where Should a Health Care Business File Bankruptcy?

(i) Venue for a health care business is the same for other debtors. Pursuant to 28 U.S.C. § 1408, venue is proper in the district in which the domicile, residence, principal place of business in the United States, or principal assets in the United States, of the person or entity that is the subject of the case have been located for the one hundred eighty days immediately preceding such commencement, or for a longer

portion of such one-hundred-and-eighty-day period than in any other district.

(ii) Under 28 U.S.C. §§ 1404, 1408 and 1412, and under Bankruptcy Rule 1014, a bankruptcy court may transfer venue of a bankruptcy case in "the interest of justice or for the convenience of the parties." 28 U.S.C. §§ 1404, 1408 and 1412; Bankruptcy Rule 1014. In determining whether a venue transfer would serve the convenience of the parties, courts generally examine the following six factors:

(1) the proximity of creditors of every kind to the court;

(2) the proximity of the debtor to the court;

(3) the proximity of the witnesses necessary to the administration of the estate;

(4) the location of the assets;

(5) the economic administration of the estate; and

(6) the necessity for ancillary administration if liquidation should result.

Commonwealth of Puerto Rico v. Commonwealth Oil Refining Co. (In re Commonwealth Oil Refining Co.), 596 F.2d 1239, 1247 (5th Cir. 1979).

(iii) A number of courts have included as an additional consideration or factor, "**a state's interest in having local controversies decided within its borders**." *In re Standard Tank Cleaning Corp.*, 133 B.R. 562, 567 (emphasis added); *In re Toxic Control Technologies, Inc.*, 84 B.R. 140, 143 (Bankr. N.D. Ind. 1988).

(iv) Clearly, the State of Louisiana and its regulatory agencies have a large role in the chapter 11 cases of health care businesses that operate in Louisiana. The Louisiana Department of Health has a strong public and regulatory interest to ensure patient health, safety and welfare while the debtor operates its health care business in Louisiana, as well

as to ensure that any closure complies with Louisiana statutes and regulations.

(v) In Delaware, the venue of bankruptcy cases for health care businesses with no operations in Delaware have been transferred to other courts in *In re LMCHH PLLC* (transferred to Louisiana), *In re Hawaii Medical Center (HMC), In re CHA Hawaii, LLC, In re Highlands of Arkansas, In re New England Dental Centers, Inc***.**, and *In re Ernst Home Ctr., Inc*.

(vi) Venue change is not always requested. For example, Curae Health filed chapter 11 in the Middle District of Tennessee, together with its four subsidiaries that operated rural hospitals in Mississippi. A change of venue was not requested.

(vii) Frequently, health care businesses are subsidiaries of holding companies, with operations in more than one state. For example, in cases filed in the Western District, the holding company Acadiana Management filed chapter 11 along with a number of its health care business subsidiaries that operated in many various states. In that instance, one state's interests does not predominate over another state's interests.

(c) Not for Profit Health Care Businesses Cannot be the Subject of an Involuntary Bankruptcy.

(i) Bankruptcy Code section 303(a) provides that an involuntary bankruptcy proceeding may be commenced only under chapter 7 or 11 and "only against a person, except a farmer, family farmer or a corporation that is not a moneyed, business, or commercial corporation." The legislative history indicates that the intent was to protect "schools, churches, charitable organizations and foundations" from involuntary bankruptcy. See H.R. Rep. No. 95-595, 95th Cong., 1st Sess. 321 (1977); S. Rep. No. 95-595, 95th Cong., 2d Sess. 33 (1978).

(ii) Because the Bankruptcy Code does not define a "moneyed, business or commercial corporation," courts have developed

standards for determining whether a potential debtor was "moneyed" within the meaning of section 303(a).

(iii) The Fifth Circuit Court of Appeals held whether an entity is not for profit depends on the powers and characteristics imposed upon it by the law of the state of its incorporation. *Clemons v. Liberty Savings & Real Estate Corp*., 61 F.2d 448, 450 (5th Cir. 1932) (holding that status of corporation is fixed by its charter). *But see In re The Centre for Management and Technology,* Inc., 2007 Bankr. LEXIS 3734 (Bankr. D. Md. Oct. 26, 2007) (a corporation must show that it both "(i) is considered an eleemosynary organization under state law, and (ii) actually conducts itself as an eleemosynary organization").

(iv) Participation in commercial activity, by itself, does not make a non-profit corporation a "moneyed" under section 303(a). *In re MAEDC Mesa Ridge, LLC*, 334 B.R. 197, 198 (Bankr. N.D. Tex. 2005).

(v) The Bankruptcy Court for the Southern District of Mississippi held that a debtor was not "moneyed" where the debtor's registration with the Secretary of State's office characterizes the debtor as a nonprofit corporation, and the debtor was a tax-exempt organization under the Internal Revenue Code. *In re Hyperion Foundation, Inc*., 2009 Bankr. LEXIS 4647, at *9 (Bankr. S.D. Miss. Aug. 11, 2009).

3. IMMEDIATE ISSUES UNIQUE TO HEALTH CARE BUSINESS DEBTORS

Health care bankruptcies involve many bankruptcy principles implicated in the bankruptcy of non-health care businesses. Because the business of health care differs from other businesses, Congress has enacted special provisions of the Bankruptcy Code to address the preeminent issues of patient care, safety and privacy, as well as the government's role in safeguarding patient care, safety and privacy.

"From the U.S. Trustee's perspective, health care bankruptcies are approached differently from the case's opening days. . . . [H]ealth care bankruptcies are more than financial disputes: They impose life-and-

death consequences on the public at large, whose interests are frequently no otherwise represented before the bankruptcy court." B. Jones, THE GOVERNMENT'S PERSPECTIVE ON HEALTH CARE BANKRUPTCIES, December 22, 2018 ABI Journal.

(a) Medicare, Medicaid and the CMS.

(i) Medicare is a federal program that provides health coverage if you are 65 and older or have a severe disability, no matter your income. Medicaid, on the other hand, is a joint federal and state program that provides health coverage or nursing home coverage to low income residents who meet certain other criteria. Louisiana has expanded Medicaid to cover low income adults, while Mississippi, Texas and Alabama have not. To date, **37** states (including DC) have adopted the Medicaid expansion and 14 states have not adopted the expansion.

(ii) The CMS. The Centers for Medicare & Medicaid Services ("CMS") is responsible for implementing laws passed by Congress related to Medicaid and the Children's Health Insurance Program (commonly known as CHIP). To implement these programs, the CMS issues various forms of guidance to explain how laws will be implemented and what states and others need to do to comply, as well as sub-regulatory guidance to address policy issues, operational updates, and technical clarifications of existing guidance. www.hhs.gov/about/agencies/hhs-agencies-and-offices/index.html (last visited May 14, 2018); *see La Fuente Home Health Servs. v. Burwell (In re La Fuente Home Health Servs.),* 2018 Bankr. LEXIS 1668, at *4 n.3 (Bankr. S.D. Tex. June 6, 2018).

(iii) Post-payment reviews or audits. The CMS estimates that a significant amount of fee-for-service payments are misspent on improper payments every year. While Payment Contracts generally pay Medicare and Medicaid claims paid before any audit or review, the payments are subject to later, substantive review.

(1) The Social Security Act obligates the CMS to procure contractors to audit Medicaid claims and identify overpayments. Similarly, the CMS is obligated to audit payment made under the Medicare program.

(2) To fulfill its obligations, the CMS contracts with third parties (generally referred to as "Payment Contractors"), who are typically private insurance companies, including, but not limited to: Medicaid Recovery Act Contractors; Medicare Recovery Act Contractors (operate nationwide, and only review issues approved by the CMS); Zone Program Integrity Contractors (investigate potential Medicare Parts A and B fraud, waste, and abuse for recoupment or to other federal and state agencies); and Comprehensive Error Rate Testing (identifies and estimates the rate of improper Medicare payments and publishes an annual report describing national paid claims and provider compliance error rates).

(3) A health care business may be selected for audit through a number of ways, including data analysis by other CMS contractors, as well as through collaborative efforts between states and the CMS. Collaborative audits allow the CMS and states to work together to identify issues for audit.

(4) The level of assistance that CMS provides for a Medicare audit varies from conducting the entire audit to providing limited assistance such as nurses or other specialists to support state efforts.

(5) The reach back period for post-payment audits depends on the type of audit, but some can take place for **a period of 4 to 5 years** after a payments were made.

(6) While Medicare and Medicaid claims are usually paid before the audit or review, the payments are subject to the later, substantive audit or review. When the actual reimbursement amount is determined after the

applicable post-payment audit or review, the Payment Contractor issues a Notice of Amount of Medicare Program Reimbursement ("NPR"), which determines whether the health care business was overpaid or underpaid for that cost year. 42 C.F.R. §§ 413.60, 405.1803. The NPR determination is final unless it is revised by the Payment Contractor or appealed to the Provider Reimbursement Review Board. 42 C.F.R. § 405.1807. The details of the appeals process varies depending on the type of the post-payment audit.

(7) Penalties also vary depending on the type of audit. If the health care business does not respond to the post-payment review request, CMS can recover the funds, with penalty and interest, similar to the powers of the IRS.

(8) In the case of Medicaid overpayments to health care businesses, the Louisiana Department of Health (the "Louisiana DH") will file a proof of claim and take other action necessary to protect the Louisiana DH's position.

(9) The Louisiana DH also collects, on a quarterly basis, a "Hospital Stabilization Assessment" pursuant to state law.

(b) Medicare and Medicaid Provider Agreements.

(i) "Cure" issues. Medicare and Medicaid provider agreements provide a license that permits participation in the Medicare and Medicaid reimbursement programs. If a provider agreement is an executory contract, it cannot be assumed or assumed and assigned absent cure of defaults, including any alleged overpayments. "[T]he majority of courts have concluded that Medicare provider agreements are executory contracts." *In re Bayou Shores SNF*, LLC, 525 B.R. 160, 168 (Bankr. M.D. Fla. 2014); *accord 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*

Vitalsigns 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); *United States v. Consumer Health Servs.*, 171 B.R. 917 (Bankr. D.C. 1994), *rev'd on other grounds,* 108 F.3d 390, 394 (D.C. Cir. 1997); *In re Slater Health Center, Inc.,* 294 B.R. 423, 432 (Bankr. D.R.I. 2003); *In re St. Johns Home Health Agency, Inc.,* 173 B.R. 238, 242 n.1 *(Bantu. S.D. Fla. 1994); Matter of Visiting Nurse Ass'n, Inc.,* 121 B.R. 114, 119 (Bankr. M.D. Fla. 1990); *In re Tidewater Mem'l Hosp.,* 106 B.R. 876, 883 (Bankr. E.D. Va. 1989).

(1) Of course, if the provider agreement was terminated before the petition date, it cannot be assumed or assumed and assigned. *Bayou Shores*, 525 B.R. at 19-20 (termination not complete until conclusion of the appeals process).

(2) According to the CMS, to avoid successor liability, the seller's provider agreement must not be assigned to the purchaser. In fact, absent rejection of an assignment, "the buyer is subject to all applicable statues and relations and to the terms and conditions under which the assigned agreement was originally issued," including, but not limited to overpayments. CMS bulletin, dated September 5, 2013. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-60.pdf ("rejecting assignment precludes the buyer from having successor liability for Medicare overpayments or underpayments")

(3) When the provider agreement is not assigned to the purchaser.

a. If the provider agreement is not assigned to the purchaser, there is a voluntary termination of the existing provider agreement, effective when the as of the acquisition completion date. *Id.* An exception to this rule is a continuation,

up to 30 days, of payments for hospital or crucial access hospital inpatients, home health agency or hospice patients, or skilled nursing facility residents who were admitted before termination. *Id.*

b. To participate in the program, the new owner of the facility is considered an initial applicant to the Medicare program. See *U.S. v. Vernon Home Health, Inc.*, 21 F.3d 693, 695 (5th Cir. 1994), *cert. denied,* 513 U.S. 1015 (1994) (corporation that purchased the assets of predecessor corporation, and accepted by assignment the predecessor corporation's Medicare provider number, held liable for predecessor's overpayment liabilities).

i. To obtain the new provider agreement, generally the purchaser must comply with all applicable provider accreditation requirements.

ii. It is possible for the owner of an existing participating hospital to acquire another participating hospital and make the new acquired hospital a remote location or second campus of the original hospital. 42 C.F.R. 413.65.

(c) The Patient Protection and Affordable Care Act (ACA) and the False Claims Act (FCA).

(i) The ACA enacted new rules governing overpayments made by Medicare and Medicaid. Under the ACA, a person has "60 days after the date on which the overpayment was identified" to report and return such overpayment. 42 U.S.C. § 18001.

(ii) Under the ACA, any overpayment retained after the 60-day deadline is an "obligation" subject to liability under the FCA. The FCA provides, in relevant part, that "any person

who . . . knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government . . . is liable to the United States Government for a civil penalty . . . plus 3 times the amount of damages which the Government sustains because of the act of that person." 31 U.S.C. § 3729 (a)(1)(G) (emphasis added); *see also* 31 U.S.C. § 3279(b)(3) (the term "obligation" means an "established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment").

(d) The Automatic Stay.

(i) Section 362(b)(24) Exception to Automatic Stay. Section 362(b)(28) provides that the filing of a petition does not operate as a stay for "the exclusion by the Secretary of Health and Human Services of the debtor from participation in the Medicare program or any other Federal health care program (as defined in section 1128B(f) of the Social Security Act pursuant to title XI or XVIII of such Act)."

(ii) Bankruptcy Code section 362(b)(28) contains an exception to the automatic stay, so that Health and Human Services ("HHS") can exclude a provider from participating in the Medicare and Medicaid programs (by terminating the provider agreement). However, this is less commonly used than section 362(b)(4).

(iii) In fact the only reference in case law is a footnote in *Parkview Adventist Medical Center v. United States on behalf of Department of Health and Human Services*, 842 F.3d 757, 763, n. 13 (1st Cir. 2016), wherein the government asserted the subsection (b)(28) exception, but the court found adequate justification under subsection (b)(4) and never addressed that argument.

(iv) Part of the reason for this explicit exception may be to reinforce the fact that a bankruptcy court lacks jurisdiction over any challenges to a decision by the HHS, which would

include a revocation of a provider's license to participate in Medicare and Medicaid.

(v) 42 U.S.C. § 405(h) within the Medicare Act states:

> 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.

(vi) Although 28 U.S.C. 1334 is not specifically mentioned in the statute, it has been held to apply to a district court's bankruptcy jurisdiction as well. *See In re Bayou Shores SNF, LLC*, 828 F.3d 1297 (11th Cir. 2016). While never directly referencing subsection (b)(28), the court in *Bayou Shores* compared determinations made by the commissioner of social security and/or HHS to those made by another administrative agency: the Federal Reserve System. The *Bayou Shores* court relied on *Bd. of Governors of Fed. Reserve Sys. v. MCorp. Fin., Inc.*, 502 U.S. 32 (1991) and held that decisions made by the Fed fell within the exception of section 362(b)(4) or the governmental police and regulatory powers. *Bayou Shores*, 828 F.3d at 1323.

(vii) Hence, once the HHS or applicable state agency determines that the provider is no longer in compliance with the requirements to participate in Medicare or Medicaid, that is a determination based on the agency's assessment of the public welfare and cannot be enjoined by the bankruptcy court and the automatic stay.

(viii) <u>Section 362(b)(4) Exception to the Automatic Stay</u>. The most commonly used exception to the automatic stay is section

362(b)(4), which allows a governmental unit to exercise its police and regulatory power.

(ix) HHS commonly uses the governmental regulatory exception under section 362(b)(4) in connection with its authority to terminate provider agreements granted to it under 42 U.S.C. §§ 1320a-7 and 1320a-7a

(1) §1320a-7 provides for "mandatory exclusion" under subsection (a) and "permissive exclusion" under subsection (b).

a. Mandatory exclusions arise when the person/entity has been convicted of a criminal offense related to the delivery of healthcare.

b. Permissive exclusions are allowed in cases involving, inter alia:

i. convictions of misdemeanors related to the delivery of healthcare

ii. revocation and suspension of a license to provide healthcare "for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity."

iii. exclusion or suspension under a Federal or State health care program "for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity."

iv. filing of claims for unnecessary services

v. failure to disclose required information

vi. failure to take corrective action

(2) §1320a-7a similarly allows HHS to exclude a provider from Medicare and/or Medicaid for improperly filed claims and allows civil penalties for such misleading or improper claims, but this requires notice and a hearing and is reserved for intentional violations.

(3) The overriding question in whether exclusion from the Medicare and Medicaid programs falls within the section 362(b)(4) exception is whether the exclusion falls within HHS's regulatory power or whether it is pecuniary in nature and/or meant to enforce the contractual rights within the provider agreements.

(4) If HHS is exercising its regulatory power to protect the public interest, that falls within the exception. However, if the action is meant to enforce the contractual provisions within the provider agreements such action falls outside the regulatory exception.

a. "CMS has a strong public policy interest in seeing that Medicare-program dollars are not spent on institutions that fail to meet qualification standards. . . . Reimbursing [the provider] pursuant to the Provider Agreement after it had taken actions to disqualify itself from the Medicare program, rendering it unable to provide services required by that program, would have been a waste of public monies. And unlike a dispute over a contractual agreement between the government and a single private party, . . . applying the stay against CMS here would threaten CMS's ability to enforce generally the Medicare statute's carefully articulated regulatory structure." *Parkview Adventist Med. Ctr. v. United States on behalf of Dep't of Health & Human Servs.*, 842 F.3d 757, 764 (1st Cir. 2016).

b. In *Parkview Adventist*, the regulatory agency (Center for Medicare and Medicaid Services

"CMS") determined that the provider no longer met the definition of "hospital" and, thus, could be excluded from participation in the Medicare and Medicaid programs. Because this action furthered the public interest, the court found it fell within the police and regulatory function exception to the automatic stay.

(x) Limitations by Bankruptcy Code section 525(a)

(1) 11 U.S.C. §525(a) provides in 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 . . . 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 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."

(2) "Courts must find the balance between giving deference to a governmental unit's unsupported explanation that its actions serve public safety, health, and welfare and to demanding proof to avoid self-serving declarations. [T]he balance against deference shifts in favor of demanding proof of public safety purpose when it is obvious the plain purpose is to serve a pecuniary interest." *In re North*, 128 B.R. 592, 602 (Bankr. D. Vt. 1991).

(3) In other words, section 525 ensures that the exclusion of a provider from Medicare or Medicaid is truly

meant to further a public interest and is not merely pecuniary.

(e) Recoupment and Setoff

(i) For Medicare overpayments, the Center for Medicare and Medicaid Services ("CMS") will file a proof of claim, and will allege that the claim is secured by its rights of recoupment and setoff pursuant to 42 C.F.R. § 405.371.

(1) "Medicare payments to providers and suppliers, as authorized under this subchapter (excluding payments to beneficiaries), may be . . . [o]ffset or recouped, in whole or in part, by a Medicare contractor if the Medicare contractor or CMS has determined that the provider or supplier to whom payments are to be made has been overpaid." 42 C.F.R. § 405.371.

(ii) For Medicaid overpayments, the applicable state agency will file a proof of claim, and will allege that the claim is effectively secured due to setoff (*Lee v. Schweiker*, 739 F.2d 870, 875 (3d Cir.1984)) or subject to the equitable doctrine of recoupment.

(iii) Often the government will assert its rights of recoupment by merely withholding funds otherwise due to the debtor. This has been done both with and without requesting relief from the automatic stay. *Compare U.S. v. Consumer Health Services of America, Inc.*, 108 F.3d 390 (D.C. Cir. 1997) *with In re University Medical Center*, 973 F.2d 1065 (3d Cir. 1992).

(iv) Section 553 of the Bankruptcy Code prohibits a creditor from offsetting a pre-petition claim against a post-petition debt it owes to the debtor. However, if both debts arise pre-petition, setoff is permitted. In such cases, the government will withhold pre-petition payments and when the debtor or trustee seeks payment from the government for Medicare or Medicaid reimbursement, the government will assert the defense of setoff. Again, this is only permitted in cases where both debts arose pre-petition.

(v) Recoupment, on the other hand, arises out of the same transaction and is therefore not subject to the same chronological limitations of the automatic stay as setoff. It can assert recoupment regardless of when the debt arose. *University Medical Center*, 973 F.2d at 1079–80. In recoupment, the government will often simply withhold payments either pre- or post-petition and force the debtor to take action against it.

(vi) Whether Medicare payments may be withheld by recoupment depends on whether the payments arose from the same transaction. Courts have developed a "logical relationship" test and an "integrated transaction" test to make such a determination.

(1) Under the logical relationship test, the court merely asks whether there is a logical relationship between the two transactions.

(2) Under the integrated transaction test, the transactions must be integrated into a single transaction such that it would be inequitable to hold a party accountable to one transaction, but not the other.

(vii) The 5th Circuit has not spoken on this issue in the context of a healthcare bankruptcy involving Medicare payments, however, it appears to use the "integrated transaction" test in the context of other bankruptcies. *In re Gasmark, Ltd.*, 193 F.3d 371, 374–75 (5th Cir. 1999) ("The obligations must arise out of a single integrated transaction so that it would be inequitable for the debtor to enjoy the benefits of the transaction without also meeting its obligations."); *In re Northstar Offshore Group, LLC*, 2018 WL 4445082 (Bankr. S.D. Tex. Sep. 14, 2018); *In re Mirant Corp.*, 310 B.R. 548 (Bankr. N.D. Tex. 2004).

(viii) The Medicare regulations (42 C.F.R. §§ 413.20(b), 413.24(f)) call for separate cost reports for each fiscal year, which suggests that reimbursement payments made for one year are distinct from reimbursement payments for subsequent years. *See In re Univ. Med. Ctr.*, 973 F.2d at 1080.

(ix) SO… In order to recover Medicare or Medicaid overpayments, the debts against which CMS is offsetting or recouping against must either both be pre-petition debts in the case of offsetting, or arise within the same year as each other in the case of recoupment.

(f) Accounts Receivable and Deposit Issues.

(i) Sources of Receivables. The three primary sources of payments to health care business are (a) Medicare and Medicaid, (b) private health care insurers, and (c) third-party payors, such as patients. "Medicare and Medicaid accounts receivable are the lifeblood of many struggling health care institutions." A. Sherman and B. Mankoveskiy, "INTENSIVE CARE, NAVIGATING THE CHOPPY WATERS OF HEALTH CARE INSOLVENCY CASE," 29-8 ABI Journal 14 (August 2018).

(ii) Value of Accounts Receivables. Because of the setoff and recoupment issues discussed above, particularly with CMS, it is more difficult in health care businesses to accurately determine the value of receivables.

(iii) Deposits. CMS regulations require that all proceeds of Medicare and Medicaid receivables must be paid into a deposit account with respect to which only a medical provider can give instructions. See Medicare Claims Processing Manual, Chapter 1, § 30.2.5, available at https://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/Downloads/clm104c01.pdf (the "Medicare Processing Manual"). Financial institutions must provide waive their rights of offset with respect to such accounts. *Id.*

(iv) Assignments of and Security Interests in Medicare and Medicaid Receivables. Before the bankruptcy petition date, federal laws generally prohibit Medicare and Medicaid payments from being made to anyone other than health care business. 7 COLLIER BANKRUPTCY PRACTICE GUIDE P 130.09 (2018). CMS regulations provide that "[i]rrespective of the language in any agreement a provider/supplier has with a third party that is providing financing, that third party

cannot purchase the provider/supplier's Medicare receivables." Medicare Processing Manual, § 30.2.5. *See also* 42 U.S.C. § 1395g(c).

(1) While these anti-assignment statutes do not prevent a provider from granting a *security interest* in Medicare and Medicaid receivables, they limit a lender's ability to obtain direct payment of those receivables in the event of default, absent a court order. In addition, the federal statutes prevent a secured party from perfecting a security interest in a provider's deposit account through a deposit account control agreement or otherwise.

(2) For these reasons, lenders who take a security interest in Medicare and Medicaid receivables often require the use of a lockbox arrangement, whereby Medicare and Medicaid receivables are first deposited in the borrower's segregated accounts, and the lender sweeps the accounts daily. Under these arrangements, the lender faces the risk that receivables are diverted, commingled, and/or otherwise become unidentifiable.

(3) After the bankruptcy petition date, assignments of Medicare and Medicaid receivables are permissible if the assignment is pursuant to a court order. CMS regulations provide that, if a court of competent jurisdiction orders the assignment of Medicare payments, Medicare will follow that order if, as stated in 42 C.F.R. §424.73(b)(2) and 42 C.F.R. §424.90, a certified copy of the court order and of the executed assignment or reassignment (if it was necessary to execute one) is filed with the payment contractor responsible for processing the claim.

(v) Reimbursement rights of health care insurers and third-party payors, such as patients.

(1) In the ordinary course of business, health care businesses are obligated to make refunds to health

care insurers and other third-party payors for overpayments.

(2) As with Medicare and Medicaid, a significant time period can lapse between the date of the overpayment and the date when the overpayment is identified.

(3) Where overpayments are identified, private insurers will assert setoff or recoupment rights in the bankruptcy case.

(vi) Motions to Honor Overpayment Refund Obligations. A health care businesses may file a motion to honor its refund obligations to private parties and the government, reciting that failure to honor the refund obligations could result in penalties and damages under the ACA and the FCA, as well as the negative impact on the business's reputation. See *In re 4 West Holdings Inc*. (Orianna Health Systems) (Bankruptcy Court for the Northern District of Texas) (unopposed refund motion granted).

(vii) Resident Trust Accounts. Many health care businesses, such as nursing homes, have one or more resident trust or escrow accounts where residents maintain money, including social security payments or other payments from third parties. The health care business is obligated to hold, safeguard and manage these resident trust accounts. Where probably segregated, trust accounts are not property of the business's bankruptcy estate, but are the resident's property.

(viii) Resident Trust Petty Cash Accounts. Likewise, many health care businesses have a petty cash trust account, from which residents may withdraw small amounts of cash for personal use, such as entertainment, travel, and personal care. When probably maintained, like the resident trust accounts, the funds in the petty cash accounts are not property of the debtor's estate, but are the resident's property.

(g) Limits on Bankruptcy Court Jurisdiction over Medicare Disputes.

(i) If a health care business disputes an overpayment assessment from the government, it must avail itself of the administrative appeals process. See 42 C.F.R. § 405(h) and (i); 42 U.S.C. § 1395ff. The process has several steps. First, the business may seek a redetermination through the appeals department of the applicable Payment Contractor. 42 C.F.R. § 405.940. If the business is dissatisfied with the redetermination decision, it may then request a reconsideration decision, which is issued by a different Payment Contract, known as a QIC. 42 C.F.R. § 405.960. If satisfaction is still not achieved, the third step is to request a hearing before an Administrative Law Judge. 42 C.F.R. § 405.1000. The fourth step is to request a review by the Medicare Appeals Council ("Appeals Council"). 42 C.F.R. § 405.1100. The Appeals Council's decision is final and binding on all parties. 42 C.F.R. § 405.1130. A business has not exhausted its administrative remedies until after completing all four levels of review. It may then file complaint and seek judicial review. 42 C.F.R. §§ 405.1130, 405.1136; see 42 U.S.C. §§ 405(g), 405(h), 1395ff(b)(1)(A), 1395ii. *Bello v. Azar (In re Josephine C. Bello, M.D., PLC)*, 2018 Bankr. LEXIS 4013, at *8-9 (Bankr. E.D. Mich. Dec. 20, 2018).

(ii) The majority view is that actions involving Medicare must be dismissed unless the debtor has exhausted its administrative remedies, as required by 42 U.S.C. § 405(h). *Bello v. Azar (In re Josephine C. Bello, M.D., PLC)*, 2018 Bankr. LEXIS 4013, at *10 (Bankr. E.D. Mich. Dec. 20, 2018); *Bodimetric Health Servs., Inc. v. Aetna Life & Cas.*, 903 F.2d 480, 488-90 (7th Cir. 1990); *Midland Psychiatric Assocs., Inc. v. United States*, 145 F.3d 1000, 1004 (8th Cir. 1998); *Nichole Med. Equip. & Supply, Inc. v. Tricenturion, Inc.*, 694 F.3d 340, 346-47 (3d Cir. 2012).

(iii) 42 U.S.C. § 405 provides that "[t]he findings and decisions 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, United States Code [28 USCS § 1331 or 1346], to recover on any claim arising under this title." 42 U.S.C. § 405.

(h) Limits on Bankruptcy Court Jurisdiction over Medicaid Disputes.

(i) Opinions vary on whether, and to what extent, the Medicare jurisdiction provisions in 42 C.F.R. § 405(y) apply to Medicaid disputes.

(ii) Some courts have held that the statutory bar on federal jurisdiction over unexhausted Medicare disputes does not apply to bankruptcy court jurisdiction under 28 U.S.C. § 1334, reasoning the plain language of § 405(h) only bars Medicare dispute actions with § 1331 and § 1346. *See, e.g., Nurses' Registry & Home Health Corp. v. Burwell (In re Nurses' Registry & Home Health Corp.*), 533 B.R. 590 (Bankr. E.D. Kent. 2015); *Sullivan v. Town & Country Home Nursing Servs., Inc. (In re Town & Country Home Nursing Servs., Inc.*), 963 F.2d 1146 (9th Cir. 1992).

(iii) In *Maine Dept. of Health and Human Services v. The Getchell Agency*, civil no. 1:17-cv-00252, a small health care business with Medicaid provider agreements with the Maine Department of Health and Human Services (the "Maine DHS") filed chapter 11 after receiving a Notice of Violation from the Maine DHS that sought, among other things, to terminate the provider agreements for failure to pay overpayments. Thereafter, the Maine DHS moved the bankruptcy court to declare that the automatic stay did not apply to its efforts to terminate the debtor's provider agreements, relying on 42 C.F.R. § 405(h). The bankruptcy court denied the motion. Thereafter, the district court denied the Maine DHS's motion for leave to appeal the bankruptcy court's interlocutory denial order, concluding that the bankruptcy court "was likely correct" when it determined that there was bankruptcy jurisdiction, because

42 C.F.R. 405(h) is inapplicable to the Medicaid statute. The district court pointed out that some courts have interpreted the Medicare jurisdiction-stripping provision in 42 C.F.R. § 405(h) to cover decisions revoking a Medicaid provider agreement in some specific situations, such as when the provider operates under both Medicare and Medicaid provider agreements, or when the decision to revoke Medicaid approval automatically revokes Medicare approval. Those cases were distinguishable because the health care business did not have a Medicare provider agreement. Additionally, "[t]here have been legislative attempts to add a similar provision to the Medicaid statute, but those attempts have been unsuccessful." *Maine Dept. of Health and Human Services* at pages 7-8 (citations omitted).

(i) Appointing a Patient Care Ombudsman (PCO).

(i) Patient Care Ombudsmen (referred to commonly as a PCO) are only appointed if the debtor is a "health care business," as defined in Bankruptcy Code section 101(27A).

(ii) In a health care business bankruptcy, Bankruptcy Code section 333 provides for the appointment of a patient care "ombudsman" within 30 days after a health care business files bankruptcy, as follows:

> (a) (1) If the debtor in a case under chapter 7, 9, or 11 is a health care business, the court shall order, not later than 30 days after the commencement of the case, the appointment of an ombudsman to monitor the quality of patient care and to represent the interests of the patients of the health care business unless the court finds that the appointment of such ombudsman is not necessary for the protection of patients under the specific facts of the case.
>
> (2) (A) If the court orders the appointment of an ombudsman under paragraph (1), the United States trustee shall appoint 1 disinterested person (other than the United States trustee) to serve as such ombudsman.

(B) If the debtor is a health care business that provides long-term care, then the United States trustee may appoint the State Long-Term Care Ombudsman appointed under the Older Americans Act of 1965 for the State in which the case is pending to serve as the ombudsman required by paragraph (1).

(C) If the United States trustee does not appoint a State Long-Term Care Ombudsman under subparagraph (B), the court shall notify the State Long-Term Care Ombudsman appointed under the Older Americans Act of 1965 for the State in which the case is pending, of the name and address of the person who is appointed under subparagraph (A).

(b) An ombudsman appointed under subsection (a) shall—

(1) monitor the quality of patient care provided to patients of the debtor, to the extent necessary under the circumstances, including interviewing patients and physicians;

(2) not later than 60 days after the date of appointment, and not less frequently than at 60-day intervals thereafter, report to the court after notice to the parties in interest, at a hearing or in writing, regarding the quality of patient care provided to patients of the debtor; and

(3) if such ombudsman determines that the quality of patient care provided to patients of the debtor is declining significantly or is otherwise being materially compromised, file with the court a motion or a written report, with notice to the parties in interest immediately upon making such determination.

(c) (1) An ombudsman appointed under subsection (a) shall maintain any information obtained by such

ombudsman under this section that relates to patients (including information relating to patient records) as confidential information. Such ombudsman may not review confidential patient records unless the court approves such review in advance and imposes restrictions on such ombudsman to protect the confidentiality of such records.

(2) An ombudsman appointed under subsection (a)(2)(B) shall have access to patient records consistent with authority of such ombudsman under the Older Americans Act of 1965 and under non-Federal laws governing the State Long-Term Care Ombudsman program.

(3) if such ombudsman determines that the quality of patient care provided to patients of the debtor is declining significantly or is otherwise being materially compromised, file with the court a motion or a written report, with notice to the parties in interest immediately upon making such determination. 11 U.S.C. § 333.

(iii) Bankruptcy Rule 2007 provides that the bankruptcy court "shall order the appointment" of the PCO unless a party in interest, including the United States trustee, files a motion within 21 days of the commencement of the bankruptcy case (unless the court sets another deadline).

(iv) In *In re Acadiana Management Group, LLC*, the Bankruptcy Court for the Western District of Louisiana scheduled a hearing, *sua sponte*, to determine whether to appoint a PCO. After the hearing, the court ordered the United States trustee to appoint a PCO.

(v) Generally, the party opposing appointment of a PCO bears the burden of overcoming mandatory appointment. *In re Smiley Dental Arlington, PLCC*, 503 B.R. 680 (Bankr. N. D. Texas 2013).

(vi) In *In re Alternate Family Care*, 377 B.R. 754, 758 (Bankr. S.D. Fla. 2007), the court adopted the following "salient" and non-exclusive factors to determine whether to appoint an PCO under section 331(a)(1): (a) the cause of the bankruptcy; (b) the presence and role of licensing or supervising entities; (c) debtor's past history of patient care; (c) the ability of patients to protect their rights; (d) the level of dependency of the patients on the facility; (e) the likelihood of tension between the interests of the patients and the debtor; (f) the potential injury to the patients if the debtor drastically reduced its level of patient care; (g) the presence and sufficiency of internal safeguards to ensure an appropriate level of care; and (h) the impact of the cost of an ombudsman on the likelihood of a successful reorganization.

(vii) These factors have been adopted by a number of courts, including in a cases pending before the Bankruptcy Court for the Southern and Northern Districts of Texas. *See In re Starmark Clinics, LP*, 388 B.R. 729, 734 (Bankr. S.D. Tex. 2008); *Smiley Dental*, 503 B.R. 680 (Bankr. N.D. Tex. 2013) (considering additional factors, and dispensing with appointment of the PCO where all licenses and insurance coverage were in place, and there was no evidence of past patient care issues).

(viii) In *In re Genesis Hospice Care LLC*, 2009 Bankr. LEXIS 418 (Bankr. N.D. Miss, Feb. 23, 2009), considering a timely motion by the debtor, the court dispensed with the appointment of a PCO. The court found that the appointment was not necessary for the protection of the patients, where the debtor provided only outpatient care, already had an internal ombudsman program to handle patient complaints, and was in compliance with all regulatory agency requirements. If, however, "the Debtor experience any negative trend which indicates the need for the appointment" of an ombudsman, the court would consider a motion to appoint filed at a later date. *Id.* *4.

(ix) If appointed, the PCO typically files reports every sixty days that comment on, among other things, compliance with state

and federal regulations, as well as any perceived patient care issues. 11 U.S.C. § 331(b)(2).

(x) Section 331(c)(3) also requires the filing of a report or motion if the PCO "determines that the quality of patient care provided to patients of the debtor is declining significantly or is otherwise being materially compromised."

(j) Physicians as "Critical Vendors."

(i) Health care businesses frequently retain the services of physicians and other medical professionals to provide services and treatment for patients. More often than not, this is done though employment agreements.

(ii) Bankruptcy Code section 507(a)(4) gives priority in distribution to claims of employees for prepetition wages, salaries, and commissions earned within one hundred eighty (180) days before the earlier of the date of the filing of the petition or the date the debtor ceased business. But there is a statutory cap to this type of priority claim.

(iii) If a physician is owed more than the statutory cap on the petition date, could the physician be treated as a "critical vendor?"

(1) A chapter 11 debtor generally may not make any payments or other distributions on account of prepetition claims except through a confirmed plan of reorganization or court-authorized liquidation. On occasion, a creditor that provides goods or services that are essential to the continued viability of a business declines to have any further dealings with the debtor unless its prepetition debt is paid in full or in part. *In re United Am., Inc.*, 327 B.R. 776, 781 (Bankr. E.D. Va. 2005). Under those circumstances, many courts have permitted a chapter 11 debtor to pay certain creditors their prepetition, unsecured claims before confirmation of a plan. *See, e.g., In re Ionosphere Clubs, Inc.*, 98 B.R. 174, 175-77 (Bankr. S.D.N.Y. 1989).

(2) In *In re Kmart Corp.*, 359 F.3d 866 (7th Cir. 2004), the Seventh Circuit criticized the commonplace practice in some courts of allowing critical vendor payments with little supporting evidence. Citing the doctrine of necessity and Bankruptcy Code section 105(a), the bankruptcy court designated more than half of Kmart's vendors as "critical" based solely on the testimony of its chief executive officer. On appeal, however, the Seventh Circuit concluded that Bankruptcy Code "Section 105(a) . . . does not create discretion to set aside the Code's rules about priority and distribution; the power conferred by § 105(a) is one to implement rather than override." 359 F.3d at 871. The Seventh Circuit also rejected the doctrine of necessity as justification for the critical vendor payments, calling it "just a fancy name for a power to depart from the Code." *Id.* Nonetheless, the Seventh Circuit suggested that section 363(b)(1) might operate as a possible bridge justifying the payment of prepetition claims under limited circumstances. 359 F.3d at 872. Those circumstances would exist if there was sufficient evidence that: (a) the payments are necessary for a successful reorganization, (b) the disfavored unsecured creditors will be as well off with reorganization as with liquidation, and (c) the critical vendors would cease doing business with the debtor if the payments are not made. *Id.* at 872-74.

(3) In *In re Mirant Corp.*, 296 B.R. 427, 429 (Bankr. N.D. Tex. 2003, the court articulated the following three-part test:

> First, it must be critical that the debtor deal with the claimant. Second, unless it deals with the claimant the debtor risk the probability of harm, or, alternatively, loss of economic advantage to the estate or the debtor's going concern value, which is disproportionate to the amount of the

claimant's prepetition claim. Third, there is no practical or legal alternative by which the debtor can deal with the claimant other than by payment of the claim. *Id.*

(iv) In determining whether a physician can be treated as a critical vendor, the Bankruptcy Court for the Northern District of Mississippi applied the three-part *K-Mart* test, and found that the evidence insufficient to satisfy the test. In *In re Pioneer Health Services, Incorporated,* 570 B.R. 228 (Bankr. S.D. Miss. 2017), the court found that the debtor did not show (a) that it was critical for the debtor to deal with the physicians (no evidence about the physician's education, skills, training or licensing, or that physicians could not be replaced), (b) that the physician intended to leave if he was not paid the pre-petition claim, and (c) that there was no legal alternative to payment (the physician had an employment agreement that could not be ignored by the physician without addressing the automatic stay). The *Pioneer Health* court was particularly concerned that (a) the debtor waited 10 months to file its critical vendor motion, and (b) the debtor was not asking, in return for payment, any commitment to continue providing services to the debtor and its patients.

(v) The holding in *Pioneer Health* should be compared to the entry of interim and final orders approving a critical vendor motion in *In re 4 West Holdings Inc.* (Orianna Health Systems), by the Bankruptcy Court for the Northern District of Texas. In that case, the court approved a "first day" critical vendor motion, and granted authority to pay certain categories of critical vendors (not physicians) provided those critical vendors agreed to customary trade terms).

4. **HEALTH CARE BUSINESS CLOSURES (WITHOUT GOING-CONCERN SALES)**

(a) Warn Act Issues.

(i) If a debtor closes its healthcare facility and terminates its employees, it may be subject to damages for violating 29 U.S.C.A. §2102, et seq., also known as the Worker Adjustment and Retraining Act (the "WARN Act").

(ii) Pursuant to the WARN Act, an employer is required to provide written notice to all affected employees of a mass layoff or a plant closing at least 60 days before the layoff or closing occurs. An employer who violates the WARN Act is liable for back pay, lost benefits, civil penalties and attorney's fees. 29 U.S.C. § 2104(a)(1); *see also Rowan v. Chicago Hous. Auth*., 149 F. Supp. 2d 390, 392 (N.D. Ill. 2001).

(iii) When a WARN Act "claim" arises in bankruptcy will determine whether the WARN Act claims are treated as pre-petition or post-petition claims. The bankruptcy court in *In re Circuit City Stores, Inc.*, 2010 WL 120014 (Bankr. E.D.Va. 2010), held the claims arise when the employer failed to give the notice rather than the date of the employee's termination.

(iv) Where the employment is terminated prior to the petition date and within the 180-day priority period, the WARN Act damages are entitled to priority status under §507(a)(4). *In re 710 Long Ridge Rd. Operating Co., II, LLC*, 505 B.R. 163, 180 (Bankr. D.N.J. 2014); citing *In re Hanlin Grp., Inc.*, 176 B.R. 329, 334 (Bankr. D.N.J. 1995). Where the termination occurs post-petition, some courts have held that such employees are entitled to an administrative claim under §503, which grants administrative priority status for certain claims and does not contain a damages limitation similar to priority wage claims. *See In re Truland Grp., Inc.*, 520 B.R. 197, 204 (Bankr. E.D. Va. 2014) (allowing administrative claim for WARN Act back pay wages to employees terminated post-petition); I*n re World Mktg. Chicago, LLC*, 564 B.R. 587, 596 (Bankr. N.D. Ill. 2017). (damages for violations of the WARN Act analogized

to severance in lieu of notice of termination and such claims are administrative claims).

(v) Proper Procedure: It is not uncommon when there are multiple employees affected by a WARN Act Notice violation to file a class action adversary proceeding. Some courts have held that the claims administration process is the proper avenue to handle WARN Act claims rather than as an adversary proceeding,. *See*, *In re Circuit City Stores, Inc.*, 2010 WL 120014 (Bankr. E.D.Va. 2010); *In re Ephedra Prods. Liab. Litig.,* 329 B.R. 1, 7 (S.D.N.Y. 2005) ("In bankruptcy, 'the only appropriate way to assert a claim against a debtor's estate is through the timely filing of a properly executed proof of claim' and not through an adversary proceeding."), while other courts have held that an adversary proceeding was appropriate in the interests of efficiency. *See*, eg. *Kettell v. Bill Heard Enters. (In re Bill Heard Enters.),* 400 B.R. 795, 801 (Bankr.N.D.Ala. 2009) (finding a class action adversary proceeding would be more efficient than the piecemeal claims process in handling WARN Act claims).

(vi) Statutory Exceptions:

(1) Section 2102(b) "contains three exceptions to the notice requirement: the 'faltering company' exception, the 'business circumstances' exception and the 'natural disaster' exception." *In re APA Transp. Corp. Consol. Litig.*, 541 F.3d 233, 240 (3d Cir. 2008). Under these exceptions, an employer giving less than 60 days' notice, or even no notice at all, may not be liable to former employees.

(2) Under the second defense - the "unforeseeable business circumstances" defense - an employer must show that the closing or layoff was "caused by business circumstances that were not reasonably foreseeable as of the time that notice would have been required." 29 U.S.C. § 2102 (b)(2)(A). *See Gross v. Hale-Halsell Co.*, 554 F.3d 870 (10th Cir. 2009). In determining foreseeability, one bankruptcy court, citing to 20 C.F.R. § 639(b) wrote:

> (1) An important indicator of a business circumstance that is not reasonably foreseeable is that the circumstance is caused by some sudden, dramatic and unexpected action or condition outside the employer's control. A principal client's sudden and unexpected termination of a major contract with the employer, a strike at a major supplier of the employer, and an unanticipated and dramatic major economic downturn might each be considered a business circumstance that is not reasonably foreseeable.
>
> (2) The test for determining when business circumstances are not reasonably foreseeable focuses on an employer's business judgment. The employer must exercise such commercially reasonable business judgment as would a similarly situated employer is predicting the demands of its particular market.

In re Organogenesis Inc., 316 B.R. 574, 587-588 (Bankr. D.Mass. 2004).

(3) The term "unforeseeable" is not defined. However, six circuits now hold that an employer must give employees notice under the federal WARN Act when a mass layoff or plant closing becomes *probable* – or where objective facts indicate the occurrence of the layoff is more likely than not, as opposed to *possible*, a lower threshold. *See In re AE Liquidation, Inc.*, 866 F.3d 515 (3d Cir. 2017); *United Steel Workers of Am. Local 2660 v. U.S. Steel Corp.*, 683 F.3d 882, 887 (8th Cir. 2012); *Gross v. Hale-Halsell Co.*, 554 F.3d 870, 876 (10th Cir. 2009); *Roquet v. Arthur Andersen LLP*, 398 F.3d 585, 589 (7th Cir. 2005); *Watson v. Mich. Indus. Holdings, Inc.*, 311 F.3d 760, 765 (6th Cir. 2002); *Halkias v. Gen. Dynamics Corp.,* 137 F.3d 333, 335 (5th Cir. 1998). The Fifth Circuit was the first to adopt this heightened standard in 1998. *Halkias v. Gen. Dynamics Corp.*, 137 F.3d 333, 335 (5th Cir. 1998). The most recent Court to adopt this heightened threshold is the Third Circuit where mass layoffs are most likely to

occur. *In re AE Liquidation, Inc*., 866 F.3d 515 (3d Cir. 2017).

(4) The reasoning behind the higher threshold is practicality. As the Third Circuit in *In re AE Liquidation, Inc*. stated:

> If reasonable foreseeability meant something less than a probability, nearly every company in bankruptcy, or even considering bankruptcy, would be well advised to send a WARN notice, in view of the potential for liquidation of any insolvent entity. And, as we explained in *Elsinore*, there are significant costs and consequences to requiring these struggling companies to send notice to their employees informing them of every possible "what if" scenario and raising the specter that one such scenario is a doomsday. 173 F.3d at 185 n.7. When the possibility of a layoff—while present—is not the more likely outcome, such premature warning has the potential to accelerate a company's demise and necessitate layoffs that otherwise may have been avoided.

Id. at 530.

(vii) Non-Statutory Exceptions

(1) The Liquidating Fiduciary Exception is not found in the WARN Act text itself, but is instead a judicially created exception to WARN Act liability based on the Department of Labor's regulations relating to the WARN Act. *See* 20 CFR 639. The general idea behind this exception is that the WARN Act only applies to a business entity, and therefore, the liquidating company falls outside the purview of an "employer" required to give WARN Act notice.

(2) The leading case on this issue is *In re United Healthcare Systems, Inc.*, 200 F.3d 170 (3rd Cir. 1999). The Third Circuit in *United* held that a debtor-hospital was not an "employer" subject to WARN Act notice

requirements. *Id*. at 177. The Court cited to the Department of Labor's commentary to the WARN Act which provides that "The term 'employer' includes public and quasi-public entities which engage in business (i.e., take part in a commercial or industrial enterprise, supply a service or good on a mercantile basis, or provide independent management of public assets, raising revenue and making desired investments) …" *Id*. citing 20 C.F.R. § 639.3(a)(1)(ii), 54 Fed.Reg. 16042, 16065 (1989). Thus, the *United* court considered whether the "entity was engaged in business during the time prior to the plant closing or mass layoff." Id. The court noted that the commentary continues to state that "[a] fiduciary whose sole function in the bankruptcy process is to liquidate a failed business for the benefit of creditors does not succeed to the notice obligations of the former employer because the fiduciary is not operating a 'business enterprise' in the normal commercial sense." *Id*. citing 54 Fed.Reg. at 16045.

(3) Therefore, where the business is no longer continuing operations while in bankruptcy, the Third Circuit held that a debtor-in-possession does not remain an "employer" subject to the WARN notice requirements. *Id*. at 178. "The more closely the entity's activities resemble those of a business operating as a going concern, the more likely that the entity is an 'employer,' the more closely the activities resemble those of a business winding up its affairs, the more likely it is the entity is not subject to the WARN Act." *Id*. The hospital in *United*, although it had filed for Chapter 11, rather than chapter 7, clearly demonstrated its "intent to liquidate" from the time the petition was filed and throughout the proceedings thereafter. *Id*. The Court was sure to limit its opinion, however, by noting that a debtor whose "economic activities leading up to and during the bankruptcy proceedings reveals that the fiduciary has continued in an 'employer' capacity, operating the business as

an ongoing concern," would be subject to WARN Act obligations. *Id*.

(4) Recently, in *In re World Marketing Chicago, LLC*, 2017 WL 751150 (Bankr. N.D. Ill. Feb. 24, 2017), the bankruptcy court called into question the reasoning of its sister courts in following *In re United Healthcare*. The bankruptcy court pointed out that cases such as *United* fail to take into consideration the plain language of the Department of Labor in its commentary to the WARN Act (i.e. the very language relied on by the *United* court in its ruling), which states in relevant part:

> A fiduciary whose sole function in the bankruptcy process is to liquidate a failed business for the benefit of creditors does not succeed to the notice obligations of the former employer because the fiduciary is not operating a 'business enterprise' in the normal commercial sense.

In other situations, where the fiduciary may continue to operate the business for the benefit of the creditors, the fiduciary would succeed to the WARN obligations of the employer precisely because the fiduciary continues the business in operation. 54 Fed.Reg. at 16045. While there is no debate that a debtor in possession is a fiduciary, the *World Market* court noted the difficulty in rationalizing this language within a Chapter 11. Citing *United*, the bankruptcy court noted that the *United* court "clearly focused on the debtor's 'intent to liquidate'" rather than what authority the debtor had, i.e. to continue to operate the business. *Id*. citing *In re United*, 200 F.3d at 178. "Recall for the moment the plain words of the Department of Labor commentary, that the fiduciary's sole function in the bankruptcy process must be to liquidate a failed business and that where the fiduciary may continue to operate the business for the benefit of creditors, the

exception does not apply." *Id*. (emphasis added in opinion). The *World Market* court thus held that the commentary excludes debtors-in-possession and Chapter 11 trustees from the liquidating fiduciary exception, unless the court has entered an order constraining the right to continue to operate the business. *Id*. Therefore, even though the fiduciary may choose to only act on its authority to liquidate, under the *World Market* opinion, if it is within the purview of their powers to continue to operate the business, the liquidating fiduciary exception is not available to them. *Id*. at 10.

(viii) Trustee Exception

(1) While there are no Chapter 11 cases that specifically refer to a "trustee exemption" from the WARN Act notice requirement, there are some Chapter 7 cases that do.

(2) For instance, in *In re Century City Doctors Hospital, L.L.C.*, 417 B.R. 801 (Bankr. C.D. Cal. 2009), a chapter 7 trustee obtained authority to operate Century City Doctors Hospital for a limited period of time for the purpose of transferring patients, shutting down operations and complying with government regulations relating to the disposal of medical waste and hazardous materials. When WARN Act claims were made against the estate because the Chapter 7 Trustee did not give 60-day notice prior to closing the hospital, the court determined that the trustee was a "fiduciary whose sole function in the bankruptcy process [was] to liquidate a failed business for the benefit of the creditors", *Id*. at 805 (citations omitted), and was not an employer under the WARN Act. Thus, the Chapter 7 trustee was not subject to the notice requirements of the WARN Act.

(ix) Settlement of WARN Act Claims in Plan. One issue recently addressed is whether a debtor can settle employee wage claims, including WARN Act claims, in a plan rather than

have the claims decided through a class action. In *In re LMCHH PCP, LLC, et al*, Case No. 17-10353, the Louisiana Heart Hospital located in Lacombe, Louisiana filed for chapter 11 bankruptcy. Within the month after the petition date, the hospital closed and stopped admitting patients and providing patient services. Prior to the bankruptcy and after, the debtors provided notice to the hospital's employees of the shut-down. Class action adversary proceedings were filed on behalf of all terminated employees seeking recovery of wage claims and WARN Act claims.

(x) The bankruptcy court for the Eastern District of Louisiana, confirmed a plan which proposed a settlement of each employee's wage claims and WARN Act claims. The plan allowed the employees to accept or opt out of the settlement. Those that rejected would remain a party to the pending class action. Class action counsel objected to the plan arguing, among other things, that (a) the employees did not receive adequate information to permit an informed judgment on whether to accept or opt out of the plan, (b) it was likely the employees would receive a more lucrative settlement under the class action litigation, (c) no serious defenses existed to the WARN Act claims, and (d) the plan did not provide proper protocol required under Federal Rule 23 for approval of class settlements. The bankruptcy court overruled these objections, finding among other things, that (a) the employees had more than adequate notice to make an informed decision on whether to accept the settlement or opt out, particularly where they were given the exact amount they would each receive under the settlement, and (b) neither due process nor Rule 23 dictate the procedures that must be followed to approve the employee settlement in the context of a plan containing individual settlements.

(b) When Business Closure is Commenced after the Chapter 11 Case is Filed.

(i) In some instances, an operating health care business will file bankruptcy and later determine that it needs to close its operations.

(ii) For example, in the Curae Health bankruptcy case in the Bankruptcy Court for the Middle District of Tennessee, "in the face of mounting operating losses and a lack of immediate sale prospects," the debtors moved the court for authority to shut down two of its rural hospitals and reject all executory contracts and unexpired leases related to those hospitals.

(iii) Subsequently, when it later appeared that a purchaser was identified for the hospitals, the local County agreed to provide financial assistance to the debtor hospitals to ensure continued operations pending a sale as a going concern.

(c) Transferring Patients When the Business is Closing.

(i) For health care businesses that are closing, Bankruptcy Code section 704(a)(12) imposes an affirmative duty on the trustee or debtor-in-possession to:

> use all reasonable and best efforts to transfer patients from a health care business that is in the process of being closed to an appropriate health care business that—
>
> (A) is in the vicinity of the health care business that is closing;
>
> (B) provides the patient with services that are substantially similar to those provided by the health care business that is in the process of being closed; and
>
> (C) maintains a reasonable quality of care.

(ii) Expenses incurred in connection with the transfer of patients are treated as administrative expense claims pursuant to Bankruptcy Code section 503(b)(8)(B).

(iii) Bankruptcy Rule 2015.2 requires that patient transfers must be preceded by at least 14 days' notice to the patient care ombudsman (PCO), if any, the patient and the patient's family member or other contact person. All such notices are subject to applicable nonbankruptcy patient privacy laws

(iv) Further, all patient transfers made in accordance with Bankruptcy Code section 704(a)(12), unless otherwise ordered by the court.

(d) Disposal of Patient Records

(i) A "patient" is defined as "any individual who obtains or receives services from a healthcare business." 11 U.S.C. §101(40A). "Patient records" are defined as "any record relating to a patient, including a written document or a record recorded in a magnetic, optical, or other form of electronic medium." 11 U.S.C. §101(40(B).

(ii) Healthcare providers are subject to patient records retention requirements under both federal and state laws, some of which require patient records be retained for lengthy periods of time. Once a healthcare provider closes, it does not want to be bound by these lengthy and costly retention requirements.

(iii) Section 351 of the Bankruptcy Code, which was added to the Bankruptcy Code in 2005, provides a procedure for a debtor to dispose of its patient records if the debtor does not have sufficient funds to pay for the storage of the patient records in the manner required under federal and state law.

(iv) Procedure for Destroying Patient Records.

(1) <u>Publication Notice and Direct Mail Notice</u>: Prior to destroying the patient records, the debtor shall provide the following notices:

a. Promptly publish notice, in one or more newspapers, that the patient records will be destroyed if patient records are not claimed by the patient or an insurance provider (if applicable law permits the insurance provider to make that claim) within 365 days after the notification date. *See*, 11 U.S.C. §351(1)(A). This notice shall not identify any patient name or other identifying information, but shall, (a) identify the (i) the health care facility, (ii) the name, address, telephone number, email and website, if any, from whom the patient records may be obtained, and (b) state (i) how to claim the records, and (ii) the date by which the records must be claimed and if they are not claimed by that date, they will be destroyed. *See* Fed.R.Bankr.P. 6011(a).

b. During the first 180 days of that 365-day period, promptly attempt to notify directly each patient and insurance carrier by mailing a notice regarding the right to claim the patient record and if the patient or insurance company fails to claim the records, the debtor's right to destroy the patient records. *See*, 11 U.S.C. §351(1)(B). Subject to applicable nonbankruptcy law relating to patient privacy, direct mail notices shall in addition to including the information required for publication notice, direct that a patient's family member or other representative who receives the notice inform the patient of the notice. *See* Fed.R.Bankr.P. 6011(b). Direct mail notices shall be mailed to the patient, any family member or other person whose name has been given to the debtor for the purpose of providing information regarding the patient's health, the Attorney General of the State where the healthcare facility is located, and any known insurance company. *Id.*

c. Unless otherwise ordered by the court to file proof of compliance with section 351(1)(B) under seal, the debtor shall not file, but shall maintain, proof of compliance for a reasonable time. *See*, Fed.R.Bankr.P. 6011(c).

(2) Federal Agency Request: If, after providing publication notice and direct mail notice, the patient records are not claimed during the 365-day period, the debtor shall mail, by certified mail, a written request to each appropriate federal agency, such as United States Department of Health and Human Services and CMS, requesting permission to deposit the patient records with the agency. No federal agency is required to accept the patient records.

(3) Destruction of Patient Records: If the patient records are not claimed or a federal agency has not agreed to deposit the records following the 365-day period and after providing (1) publication and direct notice to the patients and insurance companies and (2) written requests to federal agencies to deposit the patient records, the debtor shall destroy the records by (a) shredding or burning any written records, and (b) destroying magnetic, optical or other electronic records so that such records cannot be retrieved.

(4) Notice of Destruction. No later than 30 days after a debtor destroys the patient records, a debtor shall file a report certifying the unclaimed records have been destroyed and explaining how the records were destroyed. *See*, Fed.R.Bankr.P. 6011(d).

5. GOING-CONCERN SALES, WITH OR WITHOUT A CONFIRMED PLAN

Closing a hospital, especially in rural areas where access to medical care can be extremely limited, impacts the entire community. In some circumstances, this adds to an impetus to restructure or sell a debtor as a going concern. For example, in the *Curae Health* bankruptcy case in Tennessee, previously discussed, the local county government agreed to finance the operations of two rural hospitals in bankruptcy pending the sale process.

As discussed supra, when attempting to sell a hospital as a going-concern, debtors will need to deal with whether their provider agreements are executory contracts that must be assumed and therefore, all defaults, including overpayments, must be cured. In addition to the foregoing, debtors are faced with restrictive assignment provisions and regulatory compliance issues when looking to sell or restructure as a going concern.

(a) The Federal Anti-Assignment Act.

The CMS takes the position that Federal Anti-Assignment Act, 41 U.S.C. § 6305, prohibits a debtor from transferring, or assuming and assigning, Medicare provider agreements without the consent of the United States.

(i) The Federal Anti-Assignment Act provides:

> The party to whom the Federal Government gives a contract or order may not transfer the contract or order, or any interest in the contract or order, to another party. A purported transfer in violation of this subjection annuls that contract or order so far as the Federal Government is concerned, except that all rights of action for breach of contract are reserved to the Federal Government. 41 U.S.C. § 6305(a).

(ii) According to the CMS, the Anti-Assignment Act precludes a debtor from selling or assigning its Medicare provider agreement without the consent of the United States. See, e.g., In re Verity Health Systems of California, Inc., pending before the Bankruptcy Court for the Central District of

(iii) California, Limited Objection of the U.S. Department of Health and Human Services and the CMS to Motion to Sell Free and Clear of Liens and Encumbrances (citing *In the Matter of West Elecs., Inc.*, 852 F.2d 79, 83-84 (3d Cir. 1988) (no assignment of an executory contract with a federal agency under the Bankruptcy Code without consent of the United States)).

(b) Provisions that Limit or Condition Use.

(i) Because regulatory approval is required to open or transfer a health care business, the regulatory approval may be conditioned upon certain conditions, such as the hospital continued provision of certain types of services. The questions becomes whether those conditions are enforceable following entry of a sale order that is "free and clear" under Bankruptcy Code section 363(f).

(1) This issue was raised in the bankruptcy case *In Verity Health Care Systems of California*. The Daughters of Charity sold certain hospitals to another not for profit entity, Verity, in a transaction that was approved by the State of California. That approval, however, was subject to numerous conditions, including that the hospitals would maintain specified levels of emergency services, intensive care services, cardiac services, and various other services. The conditions purported to be binding upon "any and all current and future owners" of the hospitals.

(2) In bankruptcy, Verity argued that its hospitals could be sold free and clear of the conditions under Bankruptcy Code section 363(f) ("[c]ourts have held that interests in property include monetary obligations arising from the ownership of property, even when those obligations are imposed by statute" and are subject to the legal requirements of a sale under § 363" (*citing In re Gardens Reg'l Hosp. & Med. Ctr., Inc.*, 567 B.R. 820 (Bankr. C.D. Cal. 2017) (California Attorney General's authority to impose

charitable care conditions on a buyer can be stripped through a section 363(f) sale)).

(3) Santa Clara County was the only bidder for the two Verity-owned hospitals within its borders. In December 2018, in the sale order, the bankruptcy judge ruled that the County was not obligated to satisfy the conditions of the previous sale. The merits were not decided, however, because the bankruptcy court found that the California Attorney General's office waived the right to object to the "free and clear sale." At this time, the sale order is on appeal, without a stay pending appeal, although it appears that the state and the county may compromise by agreeing to waive or modify the conditions.