

**UNDER THE KNIFE:
DISSECTING HEALTHCARE BANKRUPTCIES**

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In considering the complexities present in today's healthcare system in the United States, it shouldn't come as a surprise that healthcare bankruptcies present their own unique difficulties and complications. This paper broadly addresses some of the issues parties may encounter in both healthcare liquidations and reorganizations and also provides a more narrow analysis of the implications of a bankruptcy proceeding with respect to Medicare provider agreements.

Healthcare Liquidations

When a hospital or other healthcare facility closes suddenly or without warning, the results can be especially catastrophic. From the emergency transfer of patients, mass layoffs, partially-eaten food left rotting in patient rooms, vacant pharmacies full of unmonitored controlled substances, hundreds of thousands of patient files containing HIPPA-protected information, and expensive medical equipment requiring constant maintenance and attention, a trustee over a shutdown facility will need to act quickly to protect the estate's value and ensure that the facility and assets are secure and protected.

License Issues

A hospital license is not something easily, cheaply, or quickly obtained, and it can therefore hold significant value in a healthcare bankruptcy. Section 241.023 of the Texas Health and Safety Code governs the issuance of hospital licenses and allows a license to be transferred or assigned with the written permission of the Department of State Health Services.²

Even where a hospital has ceased operations, the State may have an interest in the ultimate survival of the facility as a hospital, and under certain circumstances, the State may even allow the license to remain in active, "non-operational" status, notwithstanding that the hospital itself is closed. However, even in "non-operational status," maintaining the license does not come without cost, and the State may require the hospital to continue to employ a (minimal) transition staff, including a chief nursing officer, a radiologist, a pharmacist, an IT-systems manager, a facilities manager, a medical-equipment manager, and a hospital CEO to prevent the license from being suspended.

Keeping the license active is especially important to maximize value in a sale. While a local system located within thirty miles of the facility with an active license may be able to use its existing license to reopen and operate a closed hospital with no license,³ an out-of-area system will not have that same luxury and must instead obtain a new license. Considering the significant amount of time, money, and effort necessary to obtain a new license, and knowing that there is no guarantee that a new license will be issued at all, many out-of-area systems may choose not to pursue an acquisition if the hospital license has been revoked. Maintaining the license, even in non-operational status, could vastly increase the number of potentially interested buyers and therefore have a significant impact on the ultimate sale price.

² TEX. HEALTH & SAFETY § 241.023(f).

³ *See, e.g.*, TEX. HEALTH & SAFETY § 241.023(c-1).

WARN Act Issues

While not unique to healthcare bankruptcies, when a hospital or other healthcare facility closes its doors suddenly and without advance notice, there may be certain implications under the federal Worker Adjustment and Retraining Notification Act of 1988 (the “WARN Act”).⁴ The WARN Act generally requires employers with more than 100 full-time employees to provide employees with 60-day advanced notice of a mass layoff, which is defined as a layoff affecting 50 or more employees that comprise more than 1/3 of the employer’s workforce or more than 500 employees.⁵ If an employer covered by the WARN Act fails to provide its employees with this required advanced notice, the claims asserted against the debtor could be multiplied due to the WARN Act’s significant penalties and damage provisions.

Section 2104 of the WARN Act provides former employees with damages equal to up to 60 days’ pay and benefits, civil penalties, and attorneys’ fees.⁶ And, because of fee-shifting provisions of the WARN Act, WARN Act class-action lawsuits are not uncommon. Indeed, some law firms actively seek putative-class plaintiffs to pursue such class actions immediately upon learning of a mass layoff. Healthcare bankruptcies are no exception, and in at least one local instance, class counsel located and solicited former hospital employees to act as class plaintiffs by using targeted Facebook ads.

Section 2102 of the WARN Act does allow certain exceptions to liability, specifically where: (i) an employer is actively seeking capital that would have enabled the employer to avoid the mass layoff; (ii) the layoff was caused by “business circumstances that were not reasonably foreseeable as of the time that notice would have been required;” or (iii) the layoff was caused by natural disaster.⁷

While WARN Act damages are generally not accorded priority status,⁸ depending on the number of employees, WARN Act claims may become a significant unanticipated addition to a healthcare facility’s total debt that may seriously alter the available recovery for unsecured creditors.

Valuation Issues

A hospital is a unique business that is operated with various types of real-estate interests; therefore, common valuation methods may not be appropriate when valuing the underlying real estate. It may be difficult to find comparable sales of other hospital facilities for use in an appraisal, and the use of other real-estate sales like shopping centers and office buildings may not accurately reflect the true value of a hospital. In determining the value of a hospital, some suggest it may be a better practice to assign value based on the number of operating rooms, which are the primary generator of the income of the hospital, and others look at patient beds as

⁴ 29 U.S.C. §§ 2101 *et seq*

⁵ 29 U.S.C. § 2101(a)(3).

⁶ 29 U.S.C. § 2104.

⁷ 29 U.S.C. § 2102.

⁸ See [REDACTED]

a valuation tool in the healthcare space. Both are different than an office building or other kind of commercial real estate where value is typically based on rental income.

Hart-Scott-Rodino Act

Healthcare facilities, especially larger hospitals, can be extremely valuable and expensive acquisitions. Where a trustee is attempting to sell the facility, both the purchaser and the seller may need to make a disclosure to the Federal Trade Commission and the Department of Justice under the Hart-Scott-Rodino Antitrust Improvements Act of 1976 (the “HSR Act”) before the parties close the transaction, if the transaction price is large enough.⁹ As its full name implies, the HSR Act provides the government with additional tools to investigate and prevent anti-competitive acquisitions before they occur.

The HSR Act requires both the seller and proposed buyer to submit a detailed “Notification and Report Form for Certain Mergers and Acquisitions” to provide the federal government with detailed information about the respective parties’ businesses. Once the form is submitted, the transaction cannot close until the mandatory waiting period has expired. With respect to bankruptcy sales, the usual 30-day waiting period is reduced to 15 days, and once the waiting period expires without further action by the government, the parties may consummate the transaction. However, if the government requests additional information (a second request), the review-and-waiting period will be extended for an additional period while the government continues to investigate, and possibly takes action to prevent consummation of the transaction, because of anti-competition concerns. In 2018, the HSR Act’s pre-notification process applies to transactions totaling more than \$84.4 million, and the filing fee ranges from \$45,000 to \$280,000, depending on the acquisition price.

United States Trustee Fees

28 U.S.C. § 1930 governs the amount of quarterly fees payable by a debtor while in a Chapter 11 bankruptcy. The statute was recently amended to significantly increase the fees payable by debtors with more than \$1 million in quarterly distributions.

Prior to the amendment, the amount of quarterly fees payable by a debtor was calculated on a sliding scale based on the amount of the debtor’s quarterly distributions, and the maximum fee assessable was \$30,000. Under the new amendments, the sliding scale no longer applies to debtors with quarterly disbursements of \$1 million or more, and such debtors now pay the lesser of 1% of the quarterly disbursements and \$250,000. Specifically, 28 U.S.C. § 1930(a)(6)(B) now provides:

During each of fiscal years 2018 through 2022, if the balance in the United States Trustee System Fund as of September 30 of the most recent full fiscal year is less than \$200,000,000, the quarterly fee payable for a quarter in which disbursements equal or exceed

⁹ 15 U.S.C.A § 18a.

\$1,000,000 shall be the lesser of 1 percent of such disbursements or \$250,000.¹⁰

This new fee may cripple a reorganization and push a reorganized debtor to a “chapter 22,” especially in the middle-market space. To put this change into context, a Chapter 11 debtor with \$4 million in quarterly disbursements used to pay \$10,400 a quarter in UST fees. Now that same Chapter 11 debtor will pay \$40,000 a quarter in UST Fees – an almost 400% increase. Likewise, a Chapter 11 debtor with \$30 million in quarterly disbursements used to pay \$30,000 a quarter in UST fees, and now that debtor will pay \$250,000 a quarter in UST fees.

Without a doubt, these amendments will have a significant impact on the cost and viability of mid-sized and large chapter 11 reorganizations and will certainly have an effect on some healthcare restructurings.

Medicare Provider Agreements

A significant number of medical providers provide services to patients who are insured under Medicare. Medicare is a federally-subsidized health-insurance program for elderly and disabled people. Medicare is administered by the Centers for Medicare and Medicaid Services (“CMS”), a division of the U.S. Department of Health and Human Services (“HHS”). The Medicare provider agreement (the “Provider Agreement”)¹¹ executed between the medical provider and the governmental entity details the arrangement for the payment of Medicare funds to the medical provider for services provided.

By executing a Provider Agreement, the medical provider becomes eligible to receive reimbursements in accordance with the terms of Medicare statutes for services rendered to Medicare patients. In exchange, the medical provider agrees to comply with the provisions of Medicare and to charge the reasonable costs for the services rendered to the patients only as allowed by the relevant statutes. Payments under the Provider Agreement are made through private government contractors (“MACs”) pursuant to pre-determined rates.¹² On a yearly basis, the Zone Program Integrity Contracts (“ZPICs”) audits the actual expenditures of the medical facility to determine if any overpayment or underpayment true-up is needed.

A finding of overpayment will likely have a significant financial impact on medical-service providers, particularly those who predominantly see Medicare patients. To recover overpayments, the MAC will recoup the (old) overpayments from new payments due to the medical-service provider. In an industry with decreasing margins, this recoupment reduces (expected) revenue, which significantly and adversely impacts a medical-service provider’s operations and cash flows – potentially leading to bankruptcy. This section of the article analyzes certain issues related to Provider Agreements, False Claims Act (“FCA”) claims, and

¹⁰ 28 U.S.C. § 1930(a)(6)(B)

¹¹ The terms “Provider Agreement” and “Provider Number” are used interchangeably. The Provider Number confers enrolled status on a medical provider. The Provider Agreement is a uniform document not subject to negotiation or alteration.

¹² See 42 U.S.C. § 1395kk-1; 42 C.F.R. §§ 405.904(a)(2), 405.920-405.928.

the Medicare administrative-appeals process in connection with a medical-service provider's bankruptcy.

1. Is a Provider Agreement an Executory Contract?

An initial matter is whether bankruptcy courts treat Provider Agreements as executory contracts. As the costs of assuming a Provider Agreement may be significant, particularly if the debtor has received overpayments, the ability to sell Provider Agreements free and clear of liabilities under § 363(f) of the Bankruptcy Code could be beneficial for buyers. Whether the court determines the Provider Agreement to be an executory contract or not could have a significant impact on a buyer's on successor-liability risks and, ultimately, the sales price.

In the bankruptcy context, the government will assert that Provider Agreements are executory contracts, requiring buyers who want the benefit of the Provider Agreements to cure all defaults, including prior Medicare overpayments, prior to assignment. Further, if the Provider Agreement is an executory contract, and the new owner takes assignment of that contract, then the new owner will be subject to all government claims, because the Medicare statutes and regulations impose these obligations on the new owner. However, if the Provider Agreement is not considered an executory agreement, then the debtor could sell the Provider Agreement to the buyer free and clear of all liens, claims, encumbrances, and interests.

Courts are split on whether Provider Agreements are executory contracts, with limited precedent directly addressing this question. The majority of courts that have reviewed this issue find that Provider Agreements are executory contracts that cannot be assumed and assigned to buyers without the associated liabilities.¹³ The minority of courts find that the Provider Agreements are statutory entitlements that can be sold free and clear of claims and interests.¹⁴ The minority courts reason that the Provider Agreements are statutory entitlements because: (a) the rights and duties of healthcare providers are set forth in statutes and regulations and not in the Provider Agreements, and (b) a provider must initiate administrative proceedings, not a lawsuit for breach of contract, to contest the government's reimbursement decisions.¹⁵ Therefore, while the government may still assert pre-transfer claims against the debtor, it may not burden the new owner with the debtor's pre-sale liabilities and the government's attempts to recoupment and FCA claims.

In sum, because of the divergent views, there is still uncertainty on whether Provider Agreements are executory contracts. This uncertainty often results in negotiated settlements with the governmental entities. Through these settlements, the debtor and buyer will obtain the

¹³ See *In re Santiago*, 563 B.R. 457 (Bankr. D. P.R. 2017); *In re Bayou Shores SNF, LLC*, 525 B.R. 160 (Bankr. M.D. Fla. 2014); *In re Vitalsigns Homecare, Inc.*, 396 B.R. 232 (Bankr. D. Mass. 2008); *In re University Medical Center*, 973 F.2d 1065, 1075 and n. 13 (3rd Cir. 1992); *In re Advanced Professional Home Health Care, Inc.*, 94 B.R. 95 (E.D. Mich. 1988).

¹⁴ See *In re B.D.K. Health Management, Inc.*, 1998 WL 34188241, at *6 (Bankr. M.D. Fla. Nov. 16, 1998).

¹⁵ *Id.*

government's approval of the sale of the Provider Agreement and provide for a set cure amount inclusive of all outstanding obligations.

2. *Qui Tam and FCA Claims Impact on a Restructuring or Sale.*

Among other things, the FCA is utilized to reduce and prevent Medicare financial fraud.¹⁶ The FCA prohibits medical providers from submitting false or fraudulent claims to the government for payment.¹⁷ A medical provider may be found liable under the FCA for, among other things, billing for services not performed, billing for substandard services, or billing for a higher level of service than that actually provided. Under the FCA, the medical provider does not need to intentionally defraud the government to be liable. Instead, the "knowledge" standard includes a reckless disregard and deliberate ignorance of fraudulent activity.¹⁸ Therefore, a medical provider may encounter FCA liability if the medical provider's compliance functions and internal controls are sufficiently deficient to infer a reckless disregard and/or deliberate ignorance. *Qui Tam* claims are claims of the whistleblowers who notify the government of the medical provider's alleged fraudulent activities.¹⁹ These whistleblowers are entitled to a portion of the government's recovery.²⁰

FCA claims may have a significant impact on the medical provider's ability to transfer the Provider Agreement in bankruptcy. If the Provider Agreement is determined to be an executory contract, then the cure amount required to be paid in connection with the assignment and assumption of the Provider Agreement may include *Qui Tam* and FCA damages. This may make assumption and assignment of such agreements too expensive for the buyer. In addition to arguing that the FCA damages are connected to the Provider Agreement that was assumed and assigned, the government has argued that a purchaser of a provider agreement was a successor under common law standards and, therefore, liable for FCA liabilities.²¹ This too makes a transfer of a provider agreement cost prohibitive.

An argument against FCA successor liability is that the FCA liabilities did not result from a default or breach of the Provider Agreement; instead, such liability was the result of alleged violations of the FCA. The rationale to support that argument is that there is a distinct difference between liabilities arising under the Provider Agreement and liabilities arising under the FCA. A buyer may also be able to assert ordinary defenses against common-law successor-liability allegations.

¹⁶ 31 U.S.C. §§ 3729 *et seq.*

¹⁷ *Id.* at § 3729(a)(1).

¹⁸ *Id.* at § 3729(b)(1).

¹⁹ *Id.* at § 3730(b).

²⁰ *See Id.* at § 3730(d).

²¹ *See In re Our Lady of Mercy Med. Ctr.*, Case No. 07-10609 (REG) (Bankr. S.D.N.Y.) [D.I. 679] (the case settled prior to a ruling from the bankruptcy court).

Another risk for healthcare debtors is that the government may seek relief from the automatic stay to continue litigating FCA claims in a different forum. Section 362(b)(4) of the Bankruptcy Code excepts from the automatic stay any action by a governmental unit to enforce its police or regulatory powers.²² Because FCA actions are designed to deter fraud against the government and punish wrongdoers, courts have found that governmental units are entitled to relief from stay to prosecute the FCA actions under the (b)(4) exception.²³ Relief from the automatic stay to continue FCA actions may have a significant impact on a healthcare debtor that is already cash strapped, because it causes the debtor to continue litigating the FCA action in a different forum while also managing its bankruptcy case.

Further, the Bankruptcy Code may not permit the discharge of *Qui Tam* or FCA claims. Section 1141(d)(6)(A) of the Bankruptcy Code exempts two kinds of debts from bankruptcy discharge. These are debts owed to a domestic governmental unit arising out of fraud and debts owed to a person bringing suit under the FCA or similar state statute.²⁴ A court has held that *Qui Tam* and FCA claims fall under these exceptions and are not dischargeable.²⁵

Given the complexity of *Qui Tam* and FCA claims and how these claims could impact a medical provider's reorganization, it is important for the healthcare debtors to assess these claims immediately. Further, to successfully effectuate a plan of reorganization, the healthcare debtor may need to settle these *Qui Tam* and FCA claims to discharge them under the plan of reorganization.

3. Bankruptcy Court Jurisdiction Over Provider Agreements and Related Claims.

Bankruptcy courts have broad jurisdiction to make determinations over many things that conceivably affect the bankruptcy estate. But courts are split on whether bankruptcy courts have jurisdiction over Medicare claims and Provider Agreements. The majority of courts hold, and as recently affirmed in the Eleventh Circuit, that a bankruptcy court may not assert jurisdiction over Medicare claims and disputes when administrative remedies have not been exhausted.²⁶ The Eleventh Circuit further argued that bankruptcy courts have no jurisdiction to make determinations affecting the Provider Agreement, the ability to assume and assign the Provider

²² 11 U.S.C. § 362(b)(4).

²³ *U.S. v. Vanguard Healthcare, LLC*, 565 B.R. 627, 632 (M.D. Tenn. 2017); *see also In re McOuat*, 2016 WL 5947229, at *2 (Bankr. E.D.N.C. Oct. 13, 2016) (stating that actions brought under the FCA fall squarely within the § 362(b)(4) exception); *United States ex rel. Kolbeck v. Point Blank Solutions, Inc.*, 444 B.R. 336, 341-42 (E.D. Va. 2011) (same, and limiting the relief from stay to only those actions brought by the government and not by a private citizen as a *qui tam* action in which the government has chosen not to intervene); *In re Commonwealth Companies, Inc.*, 913 F.2d 518, 526 (8th Cir. 1990); *In re Universal Life Church, Inc.*, 128 F.3d 1294, 1298 (9th Cir. 1997).

²⁴ 11 U.S.C. § 1141(d)(6)(A). This generally requires that the creditor satisfy the common-law elements required to show fraud.

²⁵ *See In re Hawker Beechcraft, Inc.*, 515 B.R. 416 (S.D.N.Y. 2014).

²⁶ *In re Bayou Shores SNF, LLC*, 828 F.3d 1297 (11th Cir. 2016). This opinion joins the holdings of the Third, Seventh, and Eighth Circuits. *Nichole Medical Equipment & Supply v. TriCenturion*, 694 F.3d 340 (3rd Cir. 2012); *Bodimetric Health Services v. Aetna Life & Casualty*, 903 F.2d 480 (7th Cir. 1990); *Midland Psychiatric Associates, Inc. v. United States*, 145 F.3d 1000 (8th Cir. 1998).

Agreement, and claims arising under the Medicare Act, because the healthcare debtor had not exhausted the administrative appeals process.²⁷

The minority position is found in a bankruptcy court in the Ninth Circuit. In that case, the bankruptcy court found that it could assert jurisdiction over Medicare Act claims, even if the medical provider has not exhausted its administrative remedies.²⁸ The rationale is 42 U.S.C. § 405(h) does not limit the bankruptcy court's jurisdiction, because the specific language only bars actions under 28 U.S.C. §§ 1331 and 1346, but it does not bar actions under § 1334.²⁹ The majority's counter-argument is that, because the previous version of 42 U.S.C. § 405(h) expressly precluded bankruptcy court review of Medicare claims under section 1334, the revised 42 U.S.C. § 405(h) should as well.³⁰

Because there is a split in treatment among certain circuits, a bankruptcy court may have limited jurisdiction over Medicare claims and, potentially, the Provider Agreement when the medical provider has not exhausted the administrative appeals process discussed below. Given the complexities of the administrative appeals process for Medicare issues, understanding the potential venues for a bankruptcy filing is important for medical providers.

4. The Complexities of the Medicare Administrative-Appeals Process.

Because the Medicare appeals process is lengthy, convoluted, and permits the government to recoup overpayments before the appeals process is completed, a healthcare debtor may need to consider filing for bankruptcy before exhausting the appeals process. As mentioned above, this can cause problems for a healthcare debtor because certain jurisdictions may limit a bankruptcy court from making determinations over Medicare claims and the Provider Agreements. Under applicable law governing Medicare, courts have routinely held that federal courts have jurisdiction over Medicare disputes only after the medical provider exhausts the applicable appeal processes within the Medicare system.³¹ Ordinarily, this means that a medical provider may come to the federal district court only after either (a) satisfying all four stages of administrative appeal or (b) the medical provider has escalated the claim and the Medicare Appeals Council ("Council") acts or fails to act within 180 days.³²

The Medicare administrative-appeals process is a four-step process that may take years to complete. Initially, when a ZPIC identifies an overpayment, it notifies the relevant MAC, which then issues a demand letter to the medical provider for the amount of overpayment. If the medical provider disputes the overpayment assessment, the medical provider must then go

²⁷ *Bayou Shores SNF, LLC*, 828 F.3d at 1331.

²⁸ *See Sullivan v. Town & Country Home Nursing Servs., Inc.*, 963 F.2d 1146 (9th Cir. 1991).

²⁹ *Id.* at 1155.

³⁰ *Bayou Shores SNF, LLC*, 828 F.3d at 1312 (stating that the exclusion of section 1334 from the statutory language is merely a reference error).

³¹ 42 U.S.C. §§ 405(g),(h) (Under 42 U.S.C. § 405(g) and (h), federal courts are vested with jurisdiction over only a "final decision" of HHS when dealing with claims arising under the Medicaid Act).

³² 42 U.S.C. §§ 405(g), (h); 42 C.F.R. § 405.1132.

through the four-level appeals process. First, the medical provider may submit to the MAC a claim for redetermination of the overpayment.³³ Second, the medical provider may ask for reconsideration from a Qualified Independent Contractor (“QIC”).³⁴ If the QIC affirms the MAC’s determination, the MAC may begin recouping the overpayment by garnishing future reimbursements due to the medical provider.³⁵

While the MAC is recouping against new amounts owed to the provider, the medical provider may request *de novo* review before an administrative law judge (“ALJ”) within the Office of Medicare Hearings and Appeals.³⁶ In this third stage, the medical provider is entitled to a live hearing in front of the ALJ.³⁷ The ALJ is required to render a decision within 90 days after a timely request from the medical provider.³⁸ Fourth, the medical provider may appeal to the ALJ decision to the Council.³⁹ The Council reviews the ALJ’s decision *de novo* and is required to issue a final decision within 90 days.⁴⁰ If the ALJ fails to issue a decision within 90 days, the medical provider may escalate the appeal to the Council, which will review the QIC’s reconsideration.⁴¹

The issue with this administrative appeals process is that a medical provider will likely not obtain an ALJ hearing within 90 days. Realistically, the medical provider is more likely to wait three to five years before it receives a hearing in front of an ALJ – all while the MAC is recouping alleged overpayments and garnishing against new reimbursements.⁴² This obviously presents a problem for medical providers that rely on Medicare reimbursements for a substantial amount of their revenues. Without a stay on the recoupment, the medical provider will almost certainly need to file for bankruptcy or shut down.

In a recent decision that may have a significant impact on medical providers in the administrative-appeals process, the Fifth Circuit held that federal courts may have jurisdiction to enjoin recoupment of alleged Medicare overpayments while the administrative appeals process is

³³ 42 U.S.C. § 1395ff(a)(3)(A).

³⁴ *Id.* § 1395ff(c), (g); 42 C.F.R. § 405.904(a)(2).

³⁵ 42 U.S.C. § 1395ddd(f)(2); 42 C.F.R. § 405.371(a)(2).

³⁶ 42 U.S.C. § 1395ff(d); 42 C.F.R. § 405.1000(d).

³⁷ 42 C.F.R. § 405.1036(c)-(d).

³⁸ 42 U.S.C. § 1395ff(d)(1)(A).

³⁹ 42 C.F.R. § 405.1100.

⁴⁰ *Id.*

⁴¹ *Id.*

⁴² Maria Castellucci, *HHS Says it Can’t Clear Medicare Appeals Backlog by 2021 Deadline*, MODERN HEALTHCARE (Mar. 8, 2017), available at <http://www.modernhealthcare.com/article/20170308/NEWS/170309902> (discussing a report by HHS made to the U.S. District Court for the District of Columbia). See also *Maxmed Healthcare, Inc. v. Price*, 860 F.3d 335, 344-45 (5th Cir. 2017) (noting the serious backlog of agency appeals, the lack of resources to deal with the problem, HHS’s admissions in federal court, and the “redundant, time-consuming, and costly procedures” that mire providers).

ongoing.⁴³ The Fifth Circuit recognized that the medical provider, Family Rehabilitation, Inc. (“Family Rehab”), would suffer irreparable injury if Family Rehab was required to exhaust the four-step administrative appeals process while its Medicare reimbursements were being recouped.⁴⁴

Using the “collateral-claim” exception,⁴⁵ the Fifth Circuit held that federal courts may hear procedural due-process and *ultra vires* claims – which are claims that are collateral to a ruling on the merits of a recoupment claim under the Medicare act.⁴⁶ Through this exception, the Fifth Circuit found that a federal court may enjoin recoupment of alleged Medicare overpayments while the administrative appeals process is ongoing.⁴⁷ The court recognized that Family Rehab had the risk of irreparable injury because Family Rehab would likely go out of business while awaiting the ALJ hearing because the ongoing recoupment which would disrupt care to Medicare patients.⁴⁸

Because recoupment often has disastrous effects on a medical provider’s cash flow, the *Family Rehab* decision may give a medical provider necessary breathing room to complete the administrative appeals process. During this time, the medical provider may work with legal professionals and CMS to settle the recoupment claims.

5. Acquisition and Termination of a Provider Agreement.

It is important for potential purchasers to balance the risks associated with acquiring a distressed medical provider’s assets, including the Provider Agreement, with the risks associated with acquiring the non-Provider Agreement assets. The process to apply for a new Provider Agreement is often lengthy and costly. Further, the medical provider will not be eligible for reimbursement during the period when it does not have an executed Provider Agreement. As such, it is often beneficial for an entity purchasing a healthcare facility to acquire or use the owner’s existing Provider Number.

Termination of the Provider Agreement also results in similar issues. Termination of a Provider Agreement occurs when the medical provider is no longer in compliance with the terms of the Provider Agreement and the underlying statutes.⁴⁹ Termination is effective immediately if CMS finds that the medical provider’s violations pose immediate jeopardy to the health or safety of individuals who present themselves for medical services.⁵⁰ If a Provider Agreement is

⁴³ *Family Rehabilitation, Inc. v. Azar*, Case No. 17-11337 (5th Cir. Mar. 27, 2018) {Document: 00514404477}.

⁴⁴ *Id.*

⁴⁵ The collateral-claim exception allows federal courts to exercise jurisdiction over “claims (a) that are ‘entirely collateral’ to a substantive agency decision and (b) for which ‘full relief cannot be obtained at a post-deprivation hearing,’” *Id. citing Mathews v. Eldridge*, 424 U.S. 319, 330-32.

⁴⁶ *Family Rehab.*

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ *See* 42 C.F.R. § 489.53.

⁵⁰ 42 C.F.R. § 489.53(d)(2).

terminated, the medical provider's first action is to rectify and provide reasonable assurance that it will satisfy all of its statutory and regulatory responsibilities. During this time, the Provider Agreement remains terminated and the medical provider is not entitled to reimbursement from Medicare or Medicaid.

For medical providers heavily reliant on Medicare and Medicaid patients, termination of the Provider Agreement eliminates reimbursement for the medical services performed. Without such reimbursement, the medical provider may run into liquidity issues and be forced to enter bankruptcy. Conversely, if an entity is considering acquiring the non-Provider Agreement assets from a medical provider, it must consider its cash flow situation before entering into a new Provider Agreement.

The above is not an exhaustive list of issues that a medical provider may encounter in bankruptcy. However, it provides a preliminary discussion of common issues in healthcare bankruptcies. Medical providers should team with their counsel to assess how these issues affect the business around which the reorganization is designed to evaluate the available chapter 11 exits before filing for chapter 11 bankruptcy.