Session Date: Friday, May 19, 2023

Session Time: 3:15pm – 4:15pm

Session Name: Shuffling the Deck: Managing Business Operations and Complex Chapter 11 Issues in Healthcare and Hospital Bankruptcies

Total Minutes: 60

Total Credit Hours: 1

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PARTNERS

Healthcare Industry Overview

Healthcare Industry Overview

Healthcare organizations face mounting headwinds from economic and regulatory forces resulting in compressed operating margins and financial distress.

- Cost of labor, goods, services, and technology continue to rise
- Persistent clinical workforce shortages continue to drive increased labor expense
- Increasing interest rates are negatively impacting operating margins however, investments into healthcare technology continues.
- Continued shift of care from the IP setting to OP care impacting operating margins
- Loss of Medicaid expansion coverage and resulting increase in uninsured patients
- Continued margin declines

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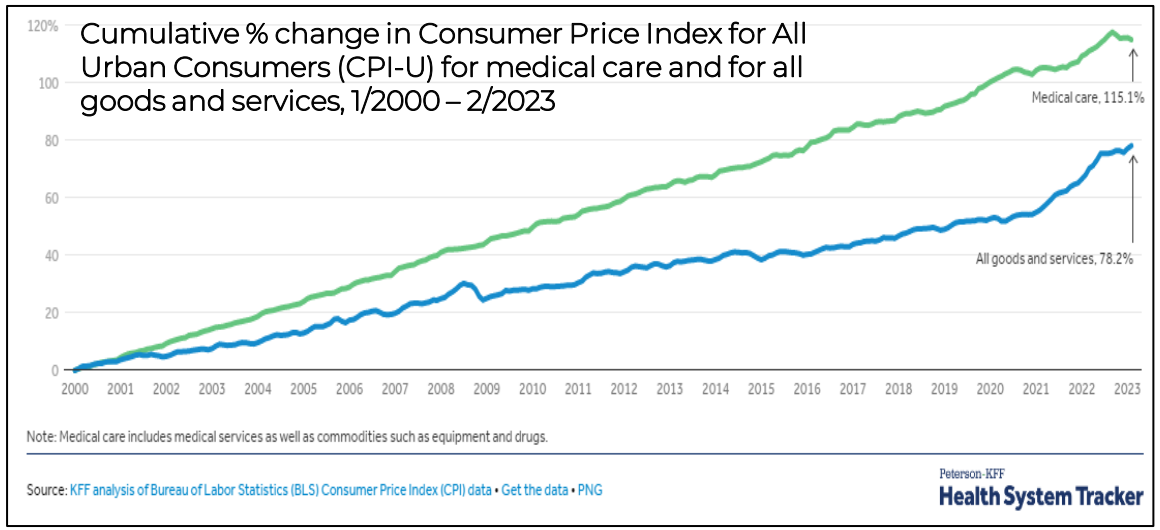
Cost of labor, goods, services, and technology continue to rise

- The cost of healthcare labor and goods has grown faster than the overall cost of consumer goods and services.
- Increasing operating expenses, staffing shortages, rising interest rates and investment losses are expected to continue.
- Analysts estimate that the annual US national health expenditure is likely to be $370 billion higher by 2027 due to the impact of inflation compared with pre pandemic projections.



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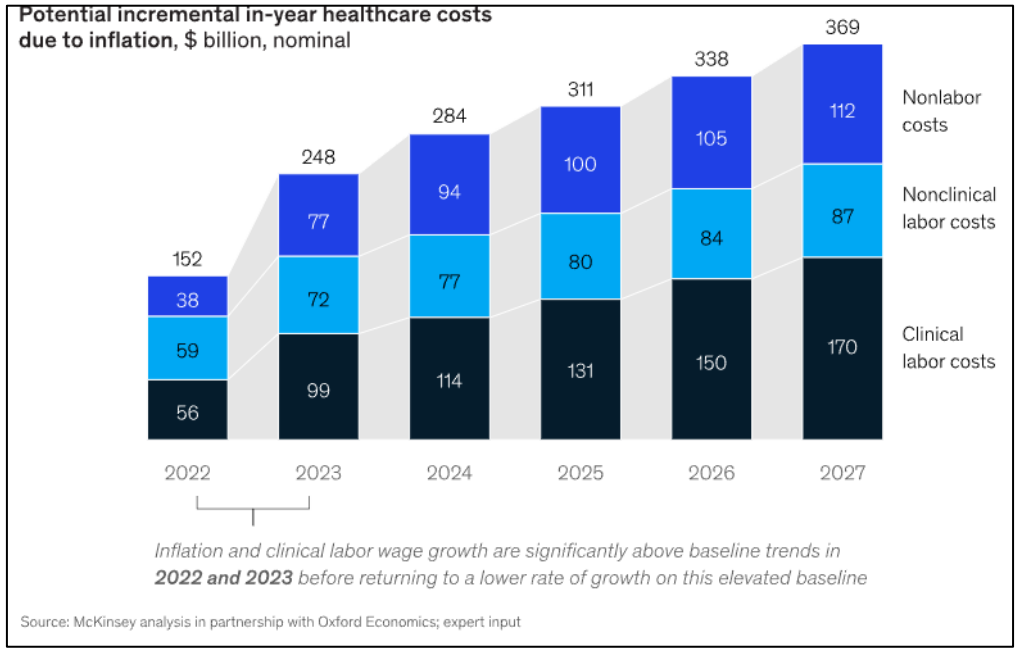
Cost of labor, goods, services, and technology continue to rise

- By 2027, non-labor costs are expected to increase by 195% and clinical labor costs are expected to increase by 204% over 2022 levels.



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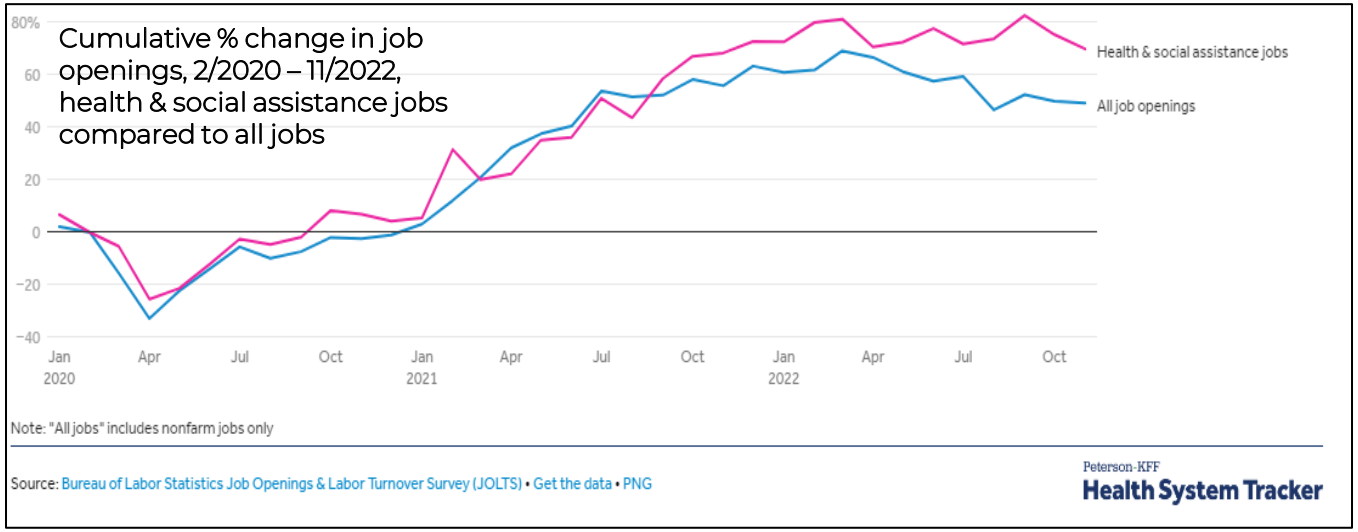
Source: https://www.mckinsey.com/industries/healthcare/our-insights/the-gathering-storm-the-transformative-impact-of-inflation-on-the-healthcare-sector

Persistent clinical workforce shortages continue to drive increased labor expense

- Job openings in the health sector are higher than all job sectors and higher than pre-pandemic levels, especially for clinical RN and ancillary specialty roles. By 2025, there is an expected gap of 200,000 to 450,000 (10-20%) registered nurses.
- A combination of increasing demand, increasing utilization, and decreasing supply will drive the shortage.
- Projected shortages will drive increased healthcare labor costs and outpace inflation.



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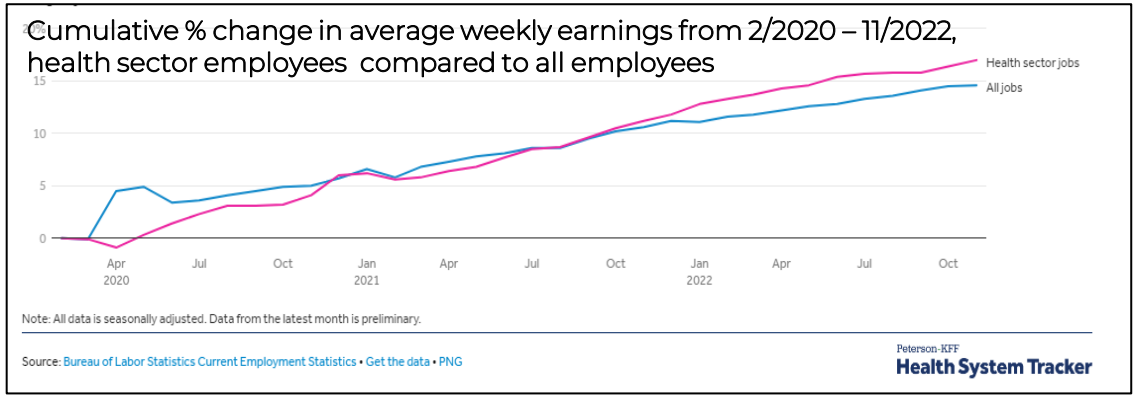
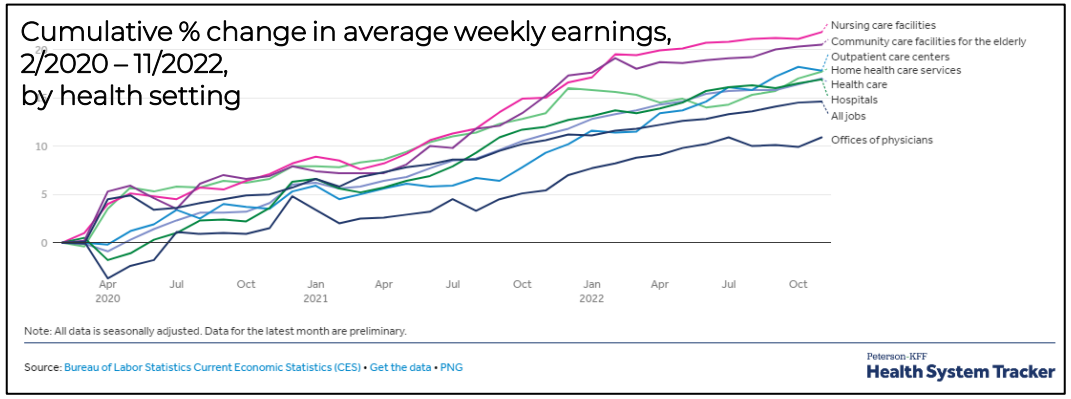
Persistent workforce shortages continue to drive increased labor expense

- Average earnings have increased higher for health sector employees than all job sectors.
- Average weekly wages for employees of private organizations increased by 14.6% compared to healthcare employee average wages increasing by 17.0%.
- The pandemic and the rapid changes of both supply and demand in the labor market will continue to have an impact on the employment of the health industry for years to come.





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Source: Kaiser Family Foundation. https://www.healthsystemtracker.org/chart-collection/what-impact-has-the-coronavirus-pandemic-had-on-healthcare-employment

Increasing interest rates are negatively impacting operating margins however, investments into healthcare technology continues.

- Rising interest rates and inflation are contributing to even greater difficulty in financial forecasting and sustainability planning.
- The expense of capital has increased, while the availability of capital has decreased. The February 2023 rate increase is the latest in a series of hikes beginning in early 2022. It boosted the target federal funds rate to a range of 4.50% to 4.75%, a 25-basis-point jump from the December 2022 range and a 450-basis-point increase from the beginning of 2022.
- As healthcare organizations continue to face rising costs, there is a greater demand to improve efficiencies through technology and automation. Organizations will shift investments to meet these demands.
- Technology adoption by providers and payers continues to accelerate, estimates reflect a 10 percent CAGR between 2021 and 2026, to $81 billion by 2026. [1]

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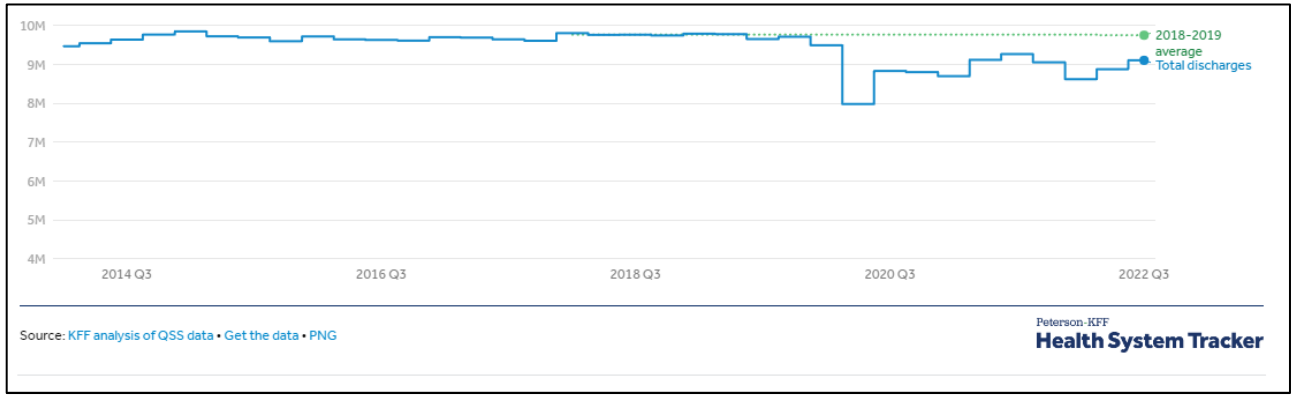
1. Source: https://www.mckinsey.com/industries/healthcare/our-insights/what-to-expect-in-us-healthcare-in-2023-and-beyond

Continued shift of care from the IP setting to OP care impacting operating margins

- Migration of inpatient care delivery to lower-acuity ambulatory settings is accelerating (urgent care and non-hospital outpatient departments).
- Alternative care settings are contributing to decreased hospital discharges.
- Although hospital discharges have increased recently, discharges remain below pre-pandemic levels.
  - Total discharges in the third quarter of 2022 were 9.1 million, about 700,000 discharges below the pre-pandemic quarterly average in 2018-2019.
  - Despite decreased discharges, there will still be a strain on hospital resources due to the increasing average length of stay.

IP Discharges Q1 -2014 through Q3 – 2022. Not seasonably adjusted.



Source: Kaiser Family Foundation.

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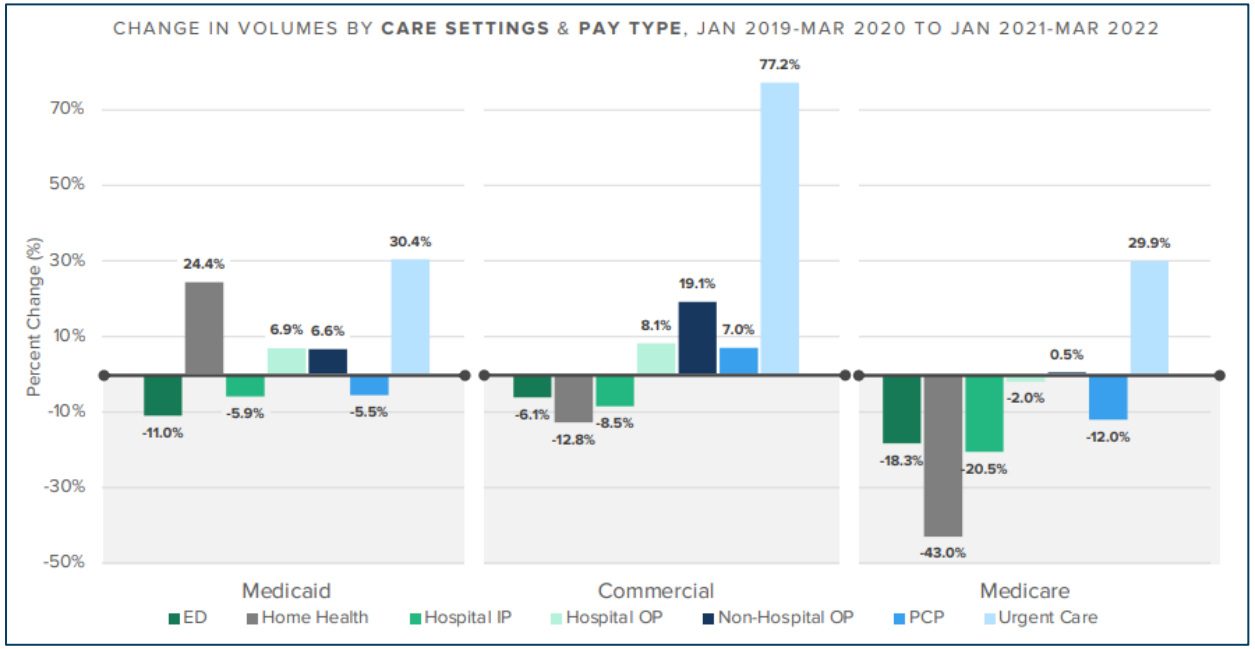
Continued shift of care from the IP setting to OP care impacting operating margins

- Consumer demands, a shift to value-based care, regulations, and advances in technology are shifting inpatient care to the outpatient setting.
  - Consumers are shifting to lower cost commodity healthcare.
  - Pressures to increase site neutral payment rates continue to mount and will impact hospital-based outpatient departments.
  - ASC's continue to grow, cases are lower acuity (almost 30% of surgeries are performed in an ASC).[1]
  - Tech enabled and retail based care providers continue to grow.

Ambulatory and non-hospital outpatient volume growth continues across all payor types [2]



1. Trilliant Health national all-payer claims database. 2022 Trends Shaping Health Economy.
2. Source: .https://www.trillianthealth.com/hubfs/U_TH_Annual%20Report_2022%20FINAL.pdf?hsCtaTracking=4d2e01e6-60a1-4161-892a-ca961794fa47%7C966d9f0e-dd96-44b5-ae61-7e89d6958cbe

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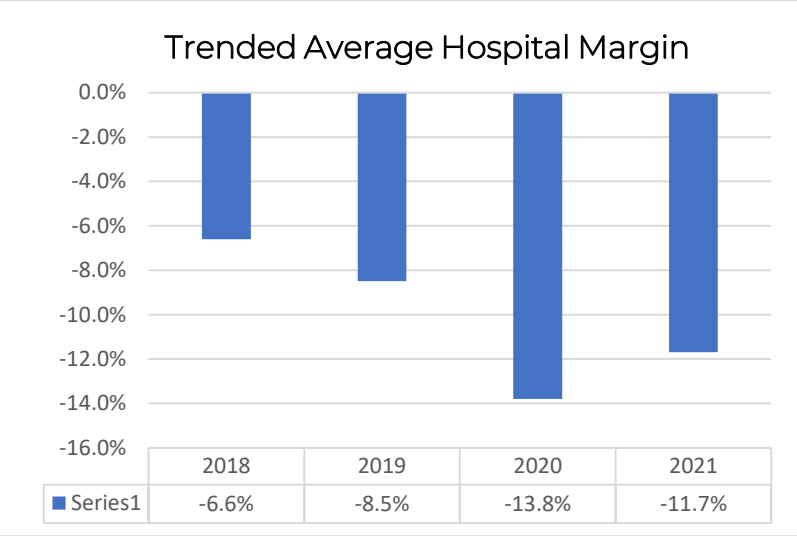
Loss of Medicaid expansion coverage and resulting increase in uninsured patients

- Estimates indicate about **15-18 million people may lose Medicaid coverage** over the coming year due to the expiration of the Pubic Health Emergency (PHE) on 5/11/2023. (Estimates range widely across reporting states from about **7% to 33% of total enrollees** will be disenrolled).
- Healthcare providers will experience both regulatory and financial implications.
- Certain Medicare and Medicaid waivers and broad flexibilities for healthcare providers are no longer necessary and will end with the expiration of the PHE.
- States are moving from planning for the end of the continuous enrollment provision to implementation of their unwinding plans, but the impact of the unwinding will vary by state.
- It is likely that the **uninsured rate will increase** resulting from the Medicaid disenrollments. (Research indicates that 65% of people disenrolled from Medicaid experience a period of uninsurance in the year following disenrollment).
  - Roughly four in ten (41%) people who disenroll from Medicaid/CHIP will eventually go on to re-enroll in Medicaid/CHIP within a year.

Source: Kaiser Family Foundation. https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-and-renewal-policies-as-states-prepare-for-the-unwinding-of-the-pandemic-era-continuous-enrollment-provision/; https://www.kff.org/medicaid/issue-brief/what-happens-after-people-lose-medicaid-coverage/

Continued margin declines

- Hospital operating margins have been impacted by increasing costs and decreasing net patient revenue.
- Hospital expenses increase about 5% each year, while hospital net revenues increase by about 3% each year, further increasing negative margins over future years.
- Many hospitals run a small loss each year and do not have high profit margins. In 2018, the average hospital operating margin was negative 6.6%, further decreasing to negative 11.7% in 2021. [1]



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Source: https://www.definitivehc.com/resources/healthcare-insights/hospital-operating-margins-united-states.
1. Data source: October 2022 Medicare Cost Report.

Conclusions

- Changes in payment models; revenue, risk and expense management; and staffing remain top areas of concern for the healthcare industry.[1]
- Rising expenses, supply chain and workforce shortages will continue.
- Future Federal and State support is uncertain.
- Greater than 50% of hospitals have negative margins and the trend is expected to continue.
- Operational and financial difficulties continue to put many organizations at risk of breaching debt covenants.
- Access to affordable capital will become more difficult to obtain.

FORCE 10 PARTNERS

1. HFMA Outlook Survey, Fourth Quarter, 2022

HEALTHCARE AND HOSPITAL PANEL OUTLINE – FRIDAY, 5/19/2023

1. Operational Issues & Drivers of Healthcare Bankruptcy Cases

a. Labor and employment issues, staffing costs, and unions.

b. Liquidity Issues (Volume, Delayed Capital Investments, Increased Costs, Reimbursement Rates, etc).

c. Operational team and leadership and organizational issues.

d. COVID Hangover

i. COVID-related relief exhausted

ii. January 3, 2023 deadline to pay payroll taxes deferred under CARES Act

iii. National Nursing Shortage

iv. Supply chain and sourcing challenges

v. Inflation and rising interest rates

e. Reduced ability to pass on out-of-network and emergency costs

i. Mismatch between rising costs and provider reimbursement levels

ii. No Surprises Act (effective 1/3/2023)

f. Provider agreements are essential asset posing unique challenges

i. Revenue heavily dependent on timely reimbursements from Medicare and/or Medicaid

ii. Government suspensions of reimbursements due to allegations of fraud or wrongdoing

iii. Federal and state regulators require assignees to assume liabilities, including unknown claims for overpayments

iv. Seeking new agreement can cause months of delay

g. How can the above issues force the debtor into bankruptcy?

2. Addressing operational and legal issues in the bankruptcy case.

a. Non-profits versus for-profit and fiduciary obligations.

b. Extending the Runway to Maintain and Unlock Value

    i. Labor Improvement

    ii. Implementations of Efficiency & Cost Saving Measures

c. Local, state, and federal government agencies and regulators & Government Claims.

d. Avoiding suspensions of Medicare and Medicaid reimbursements

    i. Automatic stay as bar

    ii. Pre-petition vs. post-petition allegations of fraud or wrongdoing

    iii. Pre-petition overpayments

e. Patient Care Ombudsman – are they required, how can they help your case, and addressing quality of care.

f. Sale process and issues unique to healthcare and hospital bankruptcies.

    i. Continuity of Care.

    ii. Special Rules for Selling Non-Profit Assets.

    iii. Medi-Cal and Medicare Provider Agreements Executory Contracts vs. Licenses

    iv. Successor liability and recoupment of government provider overpayments

    v. Regulatory Approval

        1. Non-Profit Hospitals: Attorney General's approval.

        2. Federally Qualified Health Centers: Health Resources and Services Administration.

        3. Section 525(a) limits on non-renewal of provider agreements

    vi. Qualified Buyer

g. DIP Funding.

h. Retention of medical records – procedures and best practices.

3. Chapter 9 Scenarios

4. Recent Decisions of Interest and Potential Trends

Order Entered on
October 26, 2022
by Clerk U.S. Bankruptcy Court
Southern District of California

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF CALIFORNIA
325 West "F" Street, San Diego, California 92101-6991

In re: BORREGO COMMUNITY HEALTH FOUNDATION, A CALIFORNIA NONPROFIT PUBLIC BENEFIT CORPORATION Debtor.	BANKRUPTCY NO. 22-02384-LT11
BORREGO COMMUNITY HEALTH FOUNDATION, A CALIFORNIA NONPROFIT PUBLIC Plaintiff.	ADVERSARY NO. 22-90056-LT
v. CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, BY AND THROUGH ITS DIRECTOR, MICHELLE BAAS Defendant.	Date of Hearing: October 6, 2022 Time of Hearing: 2:00 p.m. Name of Judge: Laura S. Taylor

FINDINGS OF FACT AND CONCLUSIONS OF LAW RE: EMERGENCY MOTION TO (I) ENFORCE THE AUTOMATIC STAY OR (II) ALTERNATIVELY FOR TEMPORARY RESTRAINING ORDER

IT IS HEREBY ORDERED as set forth on the continuation page(s) attached, numbered two (2) through seven (7).

Related Motion/Order Docket Entry No. 3

DATED: October 26, 2022

Judge, United States Bankruptcy Court

Findings of Fact[1]

1. The Debtor filed its voluntary petition (the "Petition") under Chapter 11 of the Bankruptcy Code on September 12, 2022 (the "Petition Date"). The creditor matrix has approximately 6,000 creditors as of the Petition Date.

2. The Debtor has approximately 700 employees and is a nonprofit federally qualified health center ("FQHC") that provides health care services, including but not limited to primary care, urgent care, behavioral health, dental services, specialty care, transgender health, women's health, prenatal care, and veteran's health, to approximately 94,000 low income and rural patients (collectively, the "Patients") and approximately 386,000 patient visits in San Diego and Riverside Counties through a system of eighteen clinics, two pharmacies, and six mobile units. Bk. Dkt. No. 7 ¶ 9-10, 12, 14.

3. The Debtor specializes in providing care to underserved populations and aims to deliver high-quality, culturally- and linguistically-competent care, including care to specialized populations such as the LGBTQ and transgender communities. Bk. Dkt. No. 7 ¶ 13.

4. The California Department of Health Care Services ("DHCS") administers the California Medicaid Program, which is called "Medi-Cal." The Medi-Cal program is California's implementation of the federal Medicaid program, a joint federal and state program for rendering health care services to the needy and disabled under Title XIX of the Social Security Act. 42 U.S.C. §§ 1396, et seq.

5. On November 18, 2020, DHCS imposed a payment suspension as a result of an ongoing investigation of allegations of fraud in the Debtor's external contract dental services. Shortly thereafter, DHCS limited the suspension to dental claims only; this suspension remains in effect and the investigation into that fraud continues. The Debtor has ceased providing contract dental services in 2020, cooperated with civil and criminal investigations, replaced much of its leadership, and brought a lawsuit against former staff and contractors involved in the fraud. DHCS did not indicate any ongoing fraud as to any of Debtor's current services, only an ongoing investigation into the prior external dental services fraud.

[1] Neither party requested an evidentiary hearing; consequently, these factual findings are based on declaratory evidence from the adversary proceeding and main bankruptcy.

6. On January 27, 2021, the Debtor and DHCS entered into a settlement agreement (the "Agreement"), wherein, among other things, DHCS required the Debtor to retain Berkeley Research Group as an independent monitor that reported to DHCS.

7. In May of 2022, the Debtor requested that the Department limit the payment suspension to contract dental claims only and lift the requirement to maintain the independent monitor.

8. Prior to the Petition Date, on August 19, 2022, DHCS notified the Debtor that it intended to impose a full suspension of Medi-Cal program payments to the Debtor (the "Payment Suspension"), for both medical and dental services, effective September 29, 2022. In its letter to the Debtor, DHCS cited several factors to justify the full payment suspension: (i) concerns about quality of care, patient grievances, referrals, compliance, and billing; (ii) failure to "fully" comply with the Agreement; and (iii) the continuation of the investigation for fraud. Dkt. No. 31, Exh. E. The letter states, "A payment suspension may be lifted when a resolution of an investigation for fraud or abuse occurs." *Id*. DHCS's letter did not in any way limit Debtor's continued provision of Debtor's Medi-Cal medical or dental services.

9. On or about August 19, 2022, DHCS notified the various managed care plans ("MCP") who had contracts with the Debtor for the Debtor to provide health care services to their members of its intention to suspend all Medi-Cal program payments to the Debtor effective September 29, 2022, and directed the MCP to provide plans for potential reassignment of their members. Dkt. No. 33, Exh. A. MCPs were not required to terminate their contracts with Debtor. Dkt. No. 33, Exhs. A, C. After the suspension date, health plans were explicitly permitted to adjudicate Debtor's claims for services provided to Medi-Cal members but were required to withhold payment.

10. Medi-Cal pays approximately 44% of the Debtor's revenue. Bk. Dkt. No. 7 ¶ 16. The Court reasonably concludes that the loss of such revenue would be catastrophic to Debtor's patient care and business operations. Much of Debtor's remaining revenue derives from federal grants.

11. Given the proposed Payment Suspension, the Debtor filed the Petition to obtain the protection of the automatic stay, to protect its patient population, and to explore all available restructuring options.

12. Post-petition, DHCS reiterated its intent to enforce the Payment Suspension effective September 29, 2022, despite notification from counsel for the Debtors of its position that the automatic stay applied to the suspension. DHCS had the authority to, but did not, suspend the Debtor from the Medi-Cal program for quality-of-care issues.

13. On September 16, 2022, the Office of the United States Trustee appointed, pursuant to 11 U.S.C. § 333, Dr. Nathan Rubin as the Patient Care Ombudsperson (the "PCO"). Pursuant to § 333(b), the PCO is required to monitor patient care and report his findings as applicable to the Court as an advocate for the patients. The PCO is an independent party from the Debtor and DHCS.

14. The PCO visited the Debtor's facilities on multiple days during the last week of September 2022. The PCO reported on his findings in several declarations,[2] and stated, among other things, that: (i) the Debtor is currently serving its patients when no one else can; (ii) the Debtor's patients are well cared for; (iii) the Debtor's health care providers are dedicated and compassionate; (iv) the Debtor's clinics are state of the art and spotless; and (v) the consequences of a shut down or material drawback of services would be devastating to the communities served by the Debtor. Dkt. No. 20 ¶ 12. The PCO stated that he "witnessed the potential for serious, life-threatening deficiencies" as a result of MCPs' transfer of patients, and further that:

> DHCS' total disregard for the patients and the providers is shocking. I cannot discern why DHCS, no matter what kind of financial facts it believes exist, has taken actions that are causing health plans to move patients from an organization that is providing healthcare consistent with the standard of care and with no reasonable alternatives for the patients.

Id. at ¶¶ 10, 11.

15. On September 26, 2022, the Debtor commenced this Adversary Proceeding. On the same day, the Debtor filed its Emergency Motion: (I) To Enforce The Automatic Stay Pursuant To 11 U.S.C. § 362; or, Alternatively (II) For Temporary Restraining Order (the "Emergency Motion"), and sought (i) a ruling that the Payment Suspension violated the automatic stay imposed pursuant to 11 U.S.C. § 362 of the Bankruptcy Code, or, alternatively, (ii) issuance of a temporary restraining order enjoining the Payment Suspension under Rule 7065 of the Federal Rules of Bankruptcy Procedure. In support of the Emergency Motion, the Debtors filed multiple declarations evidencing the irreparable harm to the Debtor, the Debtor's estate, and its patients.

16. The Emergency Motion demonstrated a critical "emergency" given the evidence provided by the PCO that, among other things, DHCS' proposed Payment Suspension has potential to cause serious, life-threatening harm to patients, including pregnant patients and HIV/AIDS patients who need immediate and/or constant care. Many of

[2] The Court denied DHCS's motions to strike the PCO's declarations. While performing his duties under § 333(b), Dr. Rubin personally visited Debtor's facilities and conducted an investigation. Dkt. No. 20.

Debtor's patients have no reasonable alternative for care, risking "debility, deterioration in quality of life, worsening of otherwise controlled comorbid conditions and death without access to the Debtor's services."

17. On October 3, 2022, DHCS filed its opposition to the Emergency Motion (the "Opposition"), which Opposition asserted that the Payment Suspension was based on: (i) patient-care deficiencies; (ii) improper billing practices; (iii) a breach of the Agreement, and (iv) the fraud investigation.

18. On October 4, 2022, the Debtor filed its reply to the Opposition and a declaration in support thereof, including specific evidence to counter the alleged patient care deficiencies.

Conclusions of Law

1. The Court has jurisdiction pursuant to 28 U.S.C. §§ 157(b)(2) and 1334(b).

2. The evidence in the record establishes that the circumstances required an emergency hearing on the Emergency Motion given that the Payment Suspension would have a detrimental impact and cause irreparable harm to the Debtor and its patients, employees, and creditors.

3. The Debtor was not required to exhaust administrative remedies before seeking the relief in the Emergency Motion before this Court.

4. The Payment Suspension relates to payments that are property of the estate, pursuant to 11 U.S.C. § 541, for post-petition services rendered.

5. Section 362(a)(1) applies to the intended Payment Suspension in that it is the continuation of a prepetition administrative action intended to recover a claim that arose prepetition.

6. Section 362(a)(3) applies to the intended Payment Suspension in that it is an act to exercise control over property of the Debtor's estate.

7. Section 362(a)(6) likely applies to the Payment Suspension in that it is an act to collect, assess, or recover a prepetition claim from the Debtor.

8. The Payment Suspension is not exempt from the automatic stay, pursuant to 11 U.S.C. § 362(b)(4), under the "pecuniary purpose" test because the Payment Suspension (i) is intended to protect DHCS's pecuniary interest and is not related to

matters of public safety or health, and (ii) would allow DHCS to obtain an advantage over other creditors.

9. The Payment Suspension is not exempt from the automatic stay, pursuant to 11 U.S.C. § 362(b)(4), under the "public purpose" test because (i) the Payment Suspension is intended to effectuate DHCS's private rights rather than effectuate public policy, and (ii) DHCS' pursuit of its alleged breach of contract claim under the Agreement does not serve a public purpose.

10. There is no evidence in the record that DHCS is supporting a public interest rather than its own financial interest. DHCS's conclusory claims otherwise are illusory and pretextual.

11. DHCS's Payment Suspension sought to implement cessation of payments but did not limit the Debtor's continued provision of services—rather, the Debtor must continue to provide services until terminated by a health plan. Meanwhile, MCPs cannot terminate their contracts with Debtor without relief from stay. Refusing to pay for properly performed post-petition work thus represents an attempt to control assets of the estate to the detriment of all creditors and stake-holders other than the Department.

12. On the other hand, the record extensively documents risks to the public if the DHCS's financial interest leaves patients without care. The statements of public support for Debtor's continued operation are voluminous and compelling.

13. The record establishes that the Debtor provides adequate patient care, at a minimum, and that its patient services in the Communities are important and irreplaceable.

14. DHCS failed to provide evidence that the Debtor's alleged care deficiencies rendered Debtor's care below a reasonable standard of care in the industry. DHCS provided statistics relating to Debtor's "Third Next Available Appointment" time, patient referrals, patient-ended phone calls, and patient grievances but failed to compare them to acceptable standards. Dkt. No. 31. DHCS provided no evidence of the content of the grievances.

15. Debtor, meanwhile, supplied evidence in response to DHCS's claims that its performance is reasonable. For example, Debtor provided evidence that the 584 patient grievances cited by DHCS arose from 213,000 patient encounters for a .27% grievance rate per encounter. Debtor also provided evidence that the vast majority of next available appointments are the same-day and second next available appointments are days later. Debtor also provided evidence that the referral wait times and closures

depend on external specialists and/or health plans, not on Debtor. Based on Debtor's evidence and DCHS's lack of evidence, the Court reasonably concludes these alleged standard of care concerns are pretextual.

16. Breaches of the Agreement do not permit application of § 362(b)(4). Moreover, the alleged Agreement breaches relate to a business plan, employee time entries, and provision of board meeting records—matters that do not indicate a public purpose.

17. DHCS provided no evidence of currently existing fraud, but rather cited the ongoing investigation into the prior fraud to justify the Payment Suspension. As described above, Debtor took affirmative steps to ensure the prior fraud did not continue, including eliminating the contract dental program and removing individuals involved.

18. Consequently, DHCS does not satisfy either the pecuniary interest or public purpose tests, and, thus, 11 U.S.C. § 362(b)(4) does not apply, and the stay bars DHCS's proposed Payment Suspension.

TENTATIVE RULING

ISSUED BY JUDGE LAURA S. TAYLOR

Adversary Case Name: BORREGO COMMUNITY HEALTH FOUNDATION, v. CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Adversary Number: 22-90056

Case Number: 22-02384-LT11

Hearing: 11:00 AM Friday, September 30, 2022

Motion: HEARING SET BY COURT RE: EX PARTE APPLICATION SUPPLEMENTING EMERGENCY MOTION: (I) TO ENFORCE THE AUTOMATIC STAY PURSUANT TO 11 U.S.C. 362; OR, IN THE ALTERNATIVELY (II) FOR TEMPORARY RESTRAINING ORDER FILED ON BEHALF OF BORREGO COMMUNITY HEALTH FOUNDATION

HEAR.

On September 27, 2022, the Court held an initial hearing on Debtor's emergency motion seeking in general terms: (1) a statement regarding the applicability of the automatic stay in relation to the actions of the California Department of Health Care Services (the "State") seeking to terminate certain payments/reimbursements and enforcing or failing to rescind a prepetition order requiring block patient transfers; or (2) issuance of a temporary protective order providing an equivalent stay. The Debtor documented tremendous harm, beginning if not concluding on September 29, 2022, if this matter was not decided on an emergency basis including not only catastrophic economic harm to Debtor but also serious harm to its patients.

The State wished to oppose, but given the documented harm, the Court could not provide its requested time for written opposition. Thus, the State was given two options: (1) file written opposition by noon on September 28, 2022, with the Court deciding the matter on the papers; or (2) refrain from withholding payment and otherwise take steps to ensure status quo maintenance in order to allow for its requested time for response and a hearing slightly more than a week later. The attorney for the State reasonably requested an opportunity to consult with his client, but, by the next morning, the Court was advised that the State elected the second option. Its papers are now due Monday; the hearing is on Thursday, October 6, 2022.

On September 29, 2022, however, the Debtor filed a supplemental

emergency request indicating that some third parties were, nonetheless, withholding payments and terminating contracts. The motion suggested lack of action by the State. The state promptly responded, advising that it sent appropriate notices and was not responsible for these actions.

The Court is strongly inclined resolve this interim dispute through an order that documents the State's agreement and advises third parties that:

(1) Declaration by this Court is not required for the automatic stay to come into effect. And the automatic stay arises in this case unless the Court finds that an exception to the stay exists. The Court is currently considering the matter and parties act at their own risk if they violate the stay while this decision is pending.

(2) Acts taken in violation of the automatic stay are void. *In re Schwartz*, 954 F.2d 569, 571 (9th Cir. 1992).

(3) Actions taken in violation of the stay may subject the violator to compensatory or coercive sanctions including reimbursement of Debtor's, no doubt reasonably large, attorneys' fees. *In re Pace*, 67 F.3d 187, 193 (9th Cir. 1995) (stating that courts have discretion under § 105(a) to sanction stay violators by awarding attorney's fees and costs to non-individuals, including bankruptcy trustees and corporate debtors, who do not qualify for an award of sanctions under § 362(h).).

(4) Given the notices provided by the State and the issuance of this order, violators cannot avoid sanction in reliance on the prepetition actions of the State.

KeyCite Red Flag - Severe Negative Treatment
Judgment Vacated by In re Verity Health System of California, Inc., Bankr.C.D.Cal., November 13, 2019

2019 WL 5585007
Only the Westlaw citation is currently available.
United States Bankruptcy Court, C.D. California,
Los Angeles Division.

IN RE: VERITY HEALTH SYSTEM
OF CALIFORNIA, INC., et al.,
Debtors and Debtors in Possession.
#Affects All Debtors

Lead Case No.: 2:18-bk-20151-ER
|
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Date: October 15, 2019, Time: 10:00 a.m.,
Location: Ctrm. 1568, Roybal Federal Building,
255 East Temple Street, Los Angeles, CA 90012
|
Signed October 23, 2019

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MEMORANDUM OF DECISION GRANTING DEBTORS' EMERGENCY MOTION TO ENFORCE THE SALE ORDER [DOC. NO. 3188]

Ernest M. Robles, United States Bankruptcy Judge

***1** Before the Court is the Debtors' motion to sell four not-for-profit hospitals free and clear of regulatory conditions which the California Attorney General claims authority to impose under Cal. Corp. Code § 5914. For the reasons set forth below, the Court finds that § 363 of the Bankruptcy Code authorizes a sale free and clear of the conditions which the Attorney General contends he is authorized to impose.

I. Facts

On August 31, 2018 (the "Petition Date"), Verity Health Systems of California ("VHS") and certain of its subsidiaries (collectively, the "Debtors") filed voluntary petitions for relief under Chapter 11 of the Bankruptcy Code. The Debtors' cases are being jointly administered.

As of the Petition Date, the Debtors operated six acute care hospitals in the state of California. On December 27, 2018, the Court authorized the Debtors to sell two of their hospitals —O'Connor Hospital and Saint Louise Regional Hospital— to Santa Clara County (the "Santa Clara Sale"). [1] The Santa Clara Sale closed on February 28, 2019.

On February 19, 2019, the Court entered an order establishing bidding procedures (the "Bidding Procedures Order") for the auction of the Debtors' four remaining hospitals—St. Francis Medical Center ("St. Francis"), St. Vincent Medical Center (including St. Vincent Dialysis Center) ("St. Vincent"), Seton Medical Center ("Seton"), and Seton Medical Center Coastside ("Seton Coastside") (collectively, the "Hospitals"). Under the Bidding Procedures Order, Strategic Global Management ("SGM") was designated as the stalking horse bidder. SGM's bid for all four of the Hospitals was $610 million.

The Hospitals were extensively marketed by the Debtors' investment banker, Cain Brothers, a division of KeyBank Capital Markets, Inc. ("Cain Brothers"). Cain Brothers notified ninety parties of the auction process. Sixteen of these parties requested continued access to a data room containing information about the Hospitals.

Notwithstanding Cain Brothers' thorough marketing efforts, the Debtors did not receive any qualified bids for all of the Hospitals. The Debtors received one bid to purchase only St. Vincent and one bid to purchase only St. Francis. After consulting with the Official Committee of Unsecured Creditors (the "Committee") and the largest secured creditors, the Debtors determined not to conduct an auction. On May 2, 2019, the Court entered an order finding that SGM was the winning bidder and approving the sale to SGM (the "SGM Sale").

In 2015, prior to the commencement of these cases, the Debtors' predecessor sought authorization from the California Attorney General (the "Attorney General"), pursuant to Cal. Corp. Code § 5914, to implement a *System Restructuring and Support Agreement* (the "Restructuring Agreement"). The Attorney General approved the Restructuring Agreement, subject to various conditions (the "2015 Conditions"). Among other things, the 2015 Conditions required capital expenditures to make the Hospitals seismically compliant, and required the Hospitals to maintain specified levels of emergency services, intensive care services, cardiac services, and various other services.

***2** Cal. Corp. Code § 5914 requires a non-profit entity operating a health facility to obtain approval from the Attorney General when selling a material amount of its assets to a for-profit entity. Pursuant to Cal. Corp. Code § 5914, the Debtors submitted the SGM Sale to the Attorney General for review.

The Asset Purchase Agreement under which SGM agreed to purchase the Hospitals (the "APA") provided that SGM would close the sale so long as any conditions imposed by the Attorney General under the review process set forth in Cal. Corp. Code § 5914 were substantially consistent with conditions that SGM had agreed to accept (the "Approved Conditions"). [2] In the event that the Attorney General sought to impose conditions materially different from the Approved Conditions (the "Additional Conditions"), the APA provided that the Debtors would have an opportunity to seek a determination from the Court that the Hospitals could be sold free and clear of the Additional Conditions under § 363(f) of the Bankruptcy Code. Under the APA, Additional Conditions imposing upon SGM costs of $5 million or more are conclusively deemed to be materially different from the Approved Conditions. Further, if the Debtors fail to obtain a final, non-appealable order authorizing the sale free and clear of the Additional Conditions, SGM is not obligated to close on the sale and is entitled to a refund of its good faith deposit.

On September 25, 2019, the Attorney General consented to the SGM Sale, subject to various conditions (the "2019 Conditions"). The 2019 Conditions are materially different from the Approved Conditions that SGM had agreed to accept. In particular, two of the 2019 Conditions impose an additional financial burden upon SGM of approximately $305 million. First, the 2019 Conditions require that SGM continue to operate St. Vincent as a licensed general acute care hospital through December 2024. SGM had agreed to maintain St. Vincent's general acute care license only through December 2020. SGM estimates that continuing to operate St. Vincent as a general acute care hospital for an additional four years would cost approximately $285 million. Second, the 2019 Conditions require St. Francis to provide annual charity care in an amount of $12,793,435 for six fiscal years. The required charity care amount is approximately $6.4 million more than the charity care that St. Francis provided in fiscal year 2019. The charity care requirement imposes an additional incremental cost of approximately $20 million.

SGM will not close the sale absent an order finding that the Hospitals can be sold free and clear of the Additional Conditions pursuant to § 363(f). If the SGM Sale does not close, the most likely outcome will be the closure of St. Vincent, Seton, and Seton Coastside. The Debtors would be required to close these three Hospitals to conserve resources to continue to operate St. Francis, the most solvent of the Hospitals, during the time it would take to obtain approval of a sale of St. Francis. The Debtors cannot continue to sustain operational losses of approximately $450,000 per day without the prospect of a prompt sale. There is no back-up bidder to purchase the Hospitals if the SGM Sale does not close.

***3** The Debtors are facing very significant liquidity constraints. Recently, the California Department of Health Care Services (the "DHCS") began withholding certain Medi-Cal fee-for-service payments owed to the Debtors, for the purposing of recovering alleged Medi-Cal overpayments. As of the beginning of October 2019, DHCS had withheld approximately $4.5 million. The Debtors do not have the ability to borrow under any debtor-in-possession financing facility. At this time, the Debtors' cases are being financed by a consensual cash collateral stipulation executed between the Debtors and the principal secured creditors (the "Cash Collateral Stipulation"). Termination of the APA constitutes an event of default under the Cash Collateral Stipulation.

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It is unclear whether the Debtors would be able to obtain alternative financing. Further, the Debtors must begin the expensive process of closing the Hospitals while they still possess a significant cash buffer.[3] In short, the Debtors' prediction that failure of the SGM Sale would necessitate the closure of St. Vincent, Seton, and Seton Coastside is not a bluff.

The Attorney General asserts that imposition of the 2019 Conditions will not result in the closure of St. Vincent, Seton, or Seton Coastside. The Attorney General points to a declaration from Kenneth Sim, M.D. (the "Sim Decl."), the Chairman of Allied Physicians of California, A Professional Medical Corporation ("Allied"). According to the Attorney General, the Sim Decl. shows that Allied is prepared to acquire Seton and Seton Coastside and operate both Hospitals in accordance with the 2019 Conditions.

Contrary to the Attorney General's characterization, the Sim Decl. provides no certainty that a sale of Seton and Seton Coastside will occur. The Sim Decl. states only that "Allied remains interested in purchasing Seton ...." Sim Decl. at ¶ 5. The Court further notes that Allied did not timely submit a qualified bid for Seton. At this late stage in the proceedings, Allied's vague statement that it is "interested" in purchasing Seton and Seton Coastside does nothing to dissuade the Court from its conclusion that absent consummation of the SGM Sale, Seton and Seton Coastside will most likely close.

The Attorney General also points to a bid for the Hospitals submitted by Prime Healthcare ("Prime"). The Attorney General overlooks the Prime did not submit a qualified bid. Among other things, Prime failed to submit the mandatory good faith deposit. In fact, Prime itself recognized that its "bid will not be formally considered at auction" and was submitted only "for reference."[4] Further, Prime stated that it did not want to serve as a back-up bidder.[5] In short, Prime's offer to purchase the Hospitals is just as illusory as Allied's.

Finally, the Attorney General points to an offer by AHMC Healthcare, Inc. ("AHMC Healthcare") to purchase St. Francis. The Attorney General is correct that AHMC submitted a qualified bid to purchase St. Francis. However, even assuming that AHMC would follow through on its prior bid to purchase St. Francis, that still would not prevent the closure of St. Vincent, Seton, and Seton Coastside. As discussed above, the Debtors lack sufficient cash to continue operating all four Hospitals during the time it would take for a sale of St. Francis to close. The Debtors would be required to close St. Vincent, Seton, and Seton Coastside to conserve the cash necessary to operate St. Francis during the sale process.

It is against this backdrop that the Debtors move for authorization to sell the Hospitals free and clear of the Additional Conditions, pursuant to § 363(f). The Debtors argue that the Additional Conditions constitute an "interest in property" within the meaning of § 363(f), and that a sale free and clear of the 2019 Conditions may be authorized under § 363(f)(1), (4), or (5), for the following reasons:

***4** • Pursuant to § 363(f)(1), the Hospitals may be sold under applicable nonbankruptcy law, because under California law, the purchaser of assets does not assume successor liability.

• Pursuant to § 363(f)(4), the validity of the Additional Conditions is subject to a *bona fide* dispute, because the Attorney General abused his discretion in imposing the Additional Conditions.

• Pursuant to § 363(f)(5), the Attorney General could be compelled to accept a money satisfaction of certain of the Additional Conditions, such as the condition that SGM provide specified levels of charitable care.

The Debtors assert that imposition of the Additional Conditions violates § 525, which prohibits government entities from discriminating against debtors who have failed to pay dischargeable debts when issuing licenses. According to the Debtors, the Additional Conditions constitute an attempt by the Attorney General to collect a dischargeable debt. The Debtors' theory is that Attorney General's refusal to approve the SGM Sale absent imposition of the Additional Conditions amounts to the discriminatory denial of licensure in contravention of § 525.

Finally, the Debtors request that the Court issue a writ of mandate compelling the Attorney General to approve the SGM Sale without imposition of the Additional Conditions, pursuant to Cal. Civ. Proc. Code § 1085 or § 1094.5. The Debtors assert that a writ of mandate is justified because the Attorney General abused his discretion by imposing the Additional Conditions.

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The Committee supports the Motion. The Committee argues that prompt closing of the SGM Sale is the best means of insuring a distribution to unsecured creditors.

The Attorney General opposes the Motion. He disputes the Debtors' contention that the Hospitals may be sold under applicable nonbankruptcy law, or that a bona fide dispute exists as to the Attorney General's authority to impose the Additional Conditions. The Attorney General denies that he abused his discretion in imposing the Additional Conditions. He notes that he considered an extensive record in arriving at the Additional Conditions, and states that the Debtors' dislike of the Additional Conditions does not mean that imposing the conditions was an abuse of discretion.

Service Employees International Union, United Healthcare Workers-West ("SEIU-UHW"), which represents approximately 1,303 employees at St. Vincent and St. Francis, opposes the Motion. SEIU-UHW contends that the Additional Conditions are economically feasible for SGM.

The United Nurses Association of California/Union of Health Care Professional ("UNAC"), which represents approximately 900 registered nurses at St. Francis, urges SGM, the Attorney General, and the Debtors to explore prospects for a consensual resolution with respect to the Additional Conditions.

II. Discussion

Section 363(d)(1) authorizes non-profit entities, such as the Debtors, to sell estate assets only if the sale is "in accordance with nonbankruptcy law applicable to the transfer of property by" a non-profit entity. Section 541(f) similarly provides that property held by debtors that are § 501(c)(3) corporations under the Internal Revenue Code may be transferred, but "only under the same conditions as would apply if the debtor had not filed a case under this title." Section 363(b) authorizes the Debtors to sell estate property out of the ordinary course of business, subject to court approval. The Debtors must articulate a business justification for the sale. *In re Walter*, 83 B.R. 14, 19–20 (9th Cir. BAP 1988). Whether the articulated business justification is sufficient "depends on the case," in view of "all salient factors pertaining to the proceeding." *Id.* at 19–20. Section 363(f) provides that a sale of estate property may be "free and clear of any interest in such property of an entity other than the estate," provided that certain conditions are satisfied.

A. The Additional Conditions are an "Interest in Property" Within the Meaning of § 363(f)

***5** As this Court has previously explained:

> The Bankruptcy Code does not define the phrase "interest in ... property" for purposes of § 363(f). The Third Circuit has held that the phrase "interest in ... property" is "intended to refer to obligations that are connected to, or arise from, the property being sold." *Folger Adam Sec., Inc. v. DeMatteis/MacGregor JV*, 209 F.3d 252, 259 (3d Cir. 2000). That conclusion is echoed by *Collier on Bankruptcy*, which observes a trend in caselaw "in favor of a broader definition [of the phrase] that encompasses other obligations that may flow from ownership of the property." 3 Alan N. Resnick & Henry J. Sommer, *Collier on Bankruptcy* ¶ 363.06[1] (16th ed. 2017).
>
> Courts have held that interests in property include monetary obligations arising from the ownership of property, even when those obligations are imposed by statute. For example, in *Mass. Dep't of Unemployment Assistance v. OPK Biotech, LLC (In re PBBPC, Inc.)*, 484 B.R. 860 (1st Cir. BAP 2013), the court held that taxes assessed by Massachusetts under its unemployment insurance statutes constituted an "interest in ... property." The taxes were computed based on the Debtor's "experience rating," which was determined by the number of employees it had terminated in the past. *Id.* at 862. Because the Debtor had terminated most of its employees prior to selling its assets, its experiencing rating, and corresponding unemployment insurance tax liabilities, were very high. *Id.* The *PBBPC* court held that the experience rating was an interest in property that could be cut off under § 363(f). *Id.* at 869–70. Similarly, in *United Mine Workers of Am. Combined Benefit Fund v. Leckie Smokeless Coal Co. (In re Leckie Smokeless Coal Co.)*, 99 F.3d 573, 581, the court held that monetary obligations imposed by the Coal Industry Retiree Health Benefit Act of 1992 constituted an "interest in ... property" within the meaning of § 363(f).

In re Gardens Reg'l Hosp. & Med. Ctr., Inc., 567 B.R. 820, 825–26 (Bankr. C.D. Cal. 2017), *appeal dismissed*, No. 2:16-

BK-17463-ER, 2018 WL 1229989 (C.D. Cal. Jan. 19, 2018) ("*Gardens I*").

The Additional Conditions are an "interest in property" within the meaning of § 363(f). First, the Additional Conditions are monetary obligations arising from the ownership of property. Similar to the "experience rating" at issue in *PBBPC, Inc.*, the Additional Conditions were calculated based upon the Hospitals' prior operating history. Among other things, the Additional Conditions require that SGM cause the Hospitals to provide specified levels of healthcare services. The required service levels have been set based upon the Hospitals' historical operations. For example, the Additional Conditions require that St. Francis "maintain and provide 24-hour emergency and trauma medical services at no less than current licensure and designation with the same types and/or levels of services ...." [6] St. Francis is required to maintain cardiac services, critical care services, neonatal intensive services, women's health services, cancer services, pediatric services, orthopedic and rehabilitation services, wound care services, behavioral health services, and perinatal services, all at "current licensures, types, and/or levels of services." [7] St. Vincent, Seton, and Seton Coastside are also required to maintain various healthcare services at current levels. [8]

***6** Second, the Attorney General's statutory authority to impose the Additional Conditions arises from the Debtors' operation of the Hospitals as non-profit entities. Had the Debtors not operated the Hospitals in this manner, there could be no contention that the SGM Sale is subject to the Attorney General's review pursuant to Cal. Corp. Code § 5914. In this sense as well, the Additional Conditions "arise from the property being sold," *In re Trans World Airlines, Inc.*, 322 F.3d 283, 290 (3d Cir. 2003), and therefore qualify as an "interest in ... property" within the meaning of § 363(f).

Third, the Attorney General is barred by the law of the case doctrine from asserting that the Additional Conditions are not an "interest in ... property." "Under the 'law of the case' doctrine, a court is ordinarily precluded from reexamining an issue previously decided by the same court, or a higher court, in the same case." *Richardson v. United States*, 841 F.2d 993, 996 (9th Cir.), *amended*, 860 F.2d 357 (9th Cir. 1988). "For the doctrine to apply, the issue in question must have been 'decided explicitly or by necessary implication in [the] previous disposition.' " *United States v. Lummi Indian Tribe*, 235 F.3d 443, 452 (9th Cir. 2000).

In connection with the Santa Clara Sale, the Court addressed the exact issue presented here—whether conditions that the Attorney General sought to impose upon the sale constituted an "interest in ... property" for purposes of § 363(f). [9] The Attorney General litigated the issue, and the Court overruled the Attorney General's arguments. [10] The Attorney General voluntarily dismissed his appeal of the order finding that the conditions he sought to impose were an "interest in ... property." The law of the case doctrine bars relitigation of the issue.

The doctrine of issue preclusion is a further bar to any attempt by the Attorney General to contest the Additional Conditions' status as an "interest in ... property." As explained by the Supreme Court, issue preclusion forecloses " 'successive litigation of an issue of fact or law actually litigated and resolved in a valid court determination essential to the prior judgment,' even if the issue recurs in the context of a different claim." *Taylor v. Sturgell*, 553 U.S. 880, 892, 128 S. Ct. 2161, 2171, 171 L. Ed. 2d 155 (2008) (internal citations omitted). The doctrine protects "against 'the expense and vexation attending multiple lawsuits, conserve[s] judicial resources, and foster[s] reliance on judicial action by minimizing the possibility of inconsistent decisions.' " *Id.* Issue preclusion applies if "(1) the issue at stake was identical in both proceedings; (2) the issue was actually litigated and decided in the prior proceedings; (3) there was a full and fair opportunity to litigate the issue; and (4) the issue was necessary to decide the merits." *Howard v. City of Coos Bay*, 871 F.3d 1032, 1041 (9th Cir. 2017).

The Attorney General has litigated the issue presented here, both in connection with the Santa Clara Sale and in connection with a sale in *Gardens I* (the "Gardens Sale"). Just as he did in the Santa Clara Sale, the Attorney General claimed in the Gardens Sale the regulatory authority to impose conditions. The Court found that the Attorney General's claim to regulatory authority was an "interest in ... property" for purposes of § 363(f). *Gardens I*, 567 B.R. at 826. The Attorney General is precluded from relitigating the issue of whether his claimed authority to impose conditions on the SGM Sale is an "interest in ... property."

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B. The Debtors May Sell the Hospitals Free and Clear of the Additional Conditions Pursuant to § 363(f)(1)

***7** Sale of the Hospitals may be free and clear of the Additional Conditions only upon satisfaction of one or more of the five disjunctive sub-factors set forth in § 363(f). Under § 363(f)(1), a sale free and clear may be approved if permitted by applicable nonbankruptcy law.

Applicable nonbankruptcy law permits a sale free and clear for two reasons. First, the Attorney General's attempt to impose the Additional Conditions upon SGM is equivalent to an attempt to impose successor liability upon SGM. California law does not authorize the imposition of successor liability upon SGM. Second, even if the Attorney General were authorized to impose successor liability under California law, the Attorney General abused his discretion in imposing the Additional Conditions, meaning that the Additional Conditions must be set aside.

1. California Law Does Not Authorize the Attorney General to Impose Successor Liability Upon SGM

i. The Additional Conditions Qualify as Successor Liability

The Attorney General's attempt to impose the Additional Conditions upon SGM qualifies as an attempt to impose successor liability upon SGM. The reason is that the Additional Conditions impose upon SGM many of the same obligations imposed upon the Debtors by the 2015 Conditions. By attempting to enforce the Additional Conditions, the Attorney General is attempting to enforce the obligations imposed by the 2015 Conditions against SGM.

It is true that the 2015 Conditions are not identical to the Additional Conditions. Some medical services required under the 2015 Conditions are no longer required under the Additional Conditions. And unlike the 2015 Conditions, the Additional Conditions do not impose obligations to fund pension plans. But for the most part the Additional Conditions reinstate obligations imposed by the 2015 Conditions. For example, both the 2015 Conditions and the Additional Conditions require that St. Francis maintain cardiac services, including designation as a STEMI Receiving Center; critical care services, including a minimum of 36 intensive care unit beds; neonatal intensive care services, including a minimum of 29 neonatal intensive care beds; women's health services, including women's imaging services; cancer services, including radiation oncology; orthopedic and rehabilitation services; and wound care services. The Additional Conditions do not reinstate St. Francis' obligation to maintain advanced certification as a Primary Stroke Center, and the Additional Conditions reduce St. Francis' pediatric services obligation from 14 beds to 5 beds.

The 2015 Conditions required St. Francis to maintain the specified healthcare services for ten years from the date of the closing of the Restructuring Agreement. The Additional Conditions require that the specified services be maintained for ten years from the date of the closing of the APA. That is, the Additional Conditions extend the term of the 2015 Conditions by approximately six years.

Considered within the overall scope of the obligations imposed, the differences between the 2015 Conditions and the Additional Conditions are comparatively inconsequential. The Attorney General relies upon these minor differences in support of his argument that the Additional Conditions do not impose successor liability. Such reliance is misplaced. The Additional Conditions still qualify as successor liability even though they are not exactly identical to the 2015 Conditions. Nor does the extension in the term of the reinstituted obligations remove the Additional Conditions from the category of successor liability.

***8** The Attorney General argues that the Additional Conditions do not impose successor liability because they are SGM's own obligations, going forward from the date of the sale. According to the Attorney General, the Additional Conditions are based upon healthcare impact reports prepared for each Hospital. The Attorney General asserts that it is not surprising that the Additional Conditions resemble the 2015 Conditions, which are only four years old and relate to the same Hospitals and communities. Citing *In re General Motors Corp.*, 407 B.R. 463, 508 (Bankr. S.D.N.Y. 2009), the Attorney General analogizes the Additional Conditions to the environmental remediation liabilities that would remain the obligation of a purchaser of contaminated real estate.

These arguments are not persuasive. In *General Motors*, the environmental remediation obligations were not successor liability because any entity purchasing contaminated property would have an obligation to comply with environmental law:

> Under section 363(f), there could be no successor liability imposed on

> the purchaser for the [seller's] ... monetary obligations related to cleanup costs, or any other obligations that were obligations of the seller. But the purchaser would have to comply with its environmental responsibilities starting with the day it got the property, and if the property required remediation as of that time, any such remediation would be the buyer's responsibility .... Those same principles will be applied here. Any Old GM properties to be transferred will be transferred free and clear of successor liability, but New GM will be liable from the day it gets any such properties for its environmental responsibilities going forward.

In re Gen. Motors Corp., 407 B.R. 463, 508 (Bankr. S.D.N.Y. 2009).

There is a key difference between the contaminated property at issue in *General Motors* and the Hospitals at issue here. Any entity that purchased the contaminated property at issue in *General Motors* would have been required to comply with environmental regulations going forward. A purchaser's duty to comply with environmental regulations would not vary based upon the identity of the purchaser or the identity of the seller. Here, by contrast, whether a purchaser is obligated to comply with Attorney General conditions can vary, depending upon either the identity of the purchaser or the identity of the seller. There is no general obligation imposed upon an entity that purchases a hospital in the State of California to operate that hospital in accordance with conditions asserted by the Attorney General. The Attorney General's regulatory authority applies only to non-profit hospitals, and only to certain types of sale transactions. Had the Hospitals been sold to a public entity, such as the County of Los Angeles, the Attorney General could not have reviewed the sale. *See Verity I*, 598 B.R. at 294 (holding that Cal. Corp. Code § 5914 did not apply where non-profit hospitals were sold to a public entity). Had the Hospitals been operated by a for-profit entity, the Attorney General could not have reviewed the sale. *See* Cal. Corp. Code § 5914(a) (requiring only nonprofit corporations to submit the sale of assets to Attorney General review).

Because the obligation to comply with the Additional Conditions is contingent upon the identity of the purchaser and the identity of the seller, the conditions cannot fairly be characterized as the purchaser's obligation to comply with applicable law on a going-forward basis. The Attorney General can claim authority to impose the Additional Conditions upon purchaser SGM only because the Debtors operated the Hospitals as non-profit entities. Since the Attorney General's alleged authority to impose the Additional Conditions derives from the manner in which the sellers operated the Hospitals, the Additional Conditions are appropriately characterized as successor liability.

ii. Successor Liability Cannot Be Imposed Under California Law

***9** Under California law, the general rule is "that where a corporation purchases, or otherwise acquires by transfer, the assets of another corporation, the acquiring corporation does not assume the selling corporation's debts and liabilities." *Fisher v. Allis-Chalmers Corp. Prod. Liab. Tr.*, 95 Cal. App. 4th 1182, 1188, 116 Cal. Rptr. 2d 310, 315 (2002). The general rule does not apply if "(1) there is an express or implied agreement of assumption, (2) the transaction amounts to a consolidation or merger of the two corporations, (3) the purchasing corporation is a mere continuation of the seller, or (4) the transfer of assets to the purchaser is for the fraudulent purpose of escaping liability for the seller's debts." *Id.*

None of the exceptions to the general rule are present here. First, SGM has not agreed to assume the Additional Conditions, either expressly or by implication. Second, the SGM Sale is not a consolidation or merger of the Debtors and SGM. A sale transaction is a consolidation or merger of two corporations "where one corporation takes all of another's assets without providing any consideration that could be made available to meet claims of the other's creditors or where the consideration consists wholly of shares of the purchaser's stock which are promptly distributed to the seller's shareholders in conjunction with the seller's liquidation." *Ray v. Alad Corp.*, 19 Cal. 3d 22, 28, 136 Cal.Rptr. 574, 560 P.2d 3 (1977) (internal citations omitted). Neither factor applies. SGM is paying for the Hospitals in cash (not stock), [11] and that cash will be distributed to the Debtors' creditors through a plan of liquidation. Third, SGM is not a mere continuation of the Debtors. A purchaser is a mere continuation of a seller if there is inadequate consideration for

the purchaser or if one or more persons are officers, directors, or stockholders or both corporations. *Id.* Consideration for the SGM Sale is adequate and no officers or directors of the Debtors are officers or directors of SGM.[12] Fourth, the Debtors are not selling the Hospitals for the purpose of escaping liabilities for their debts. In fact, the opposite is true—the objective of the SGM Sale is to generate proceeds to pay the Debtors' debts, to the extent possible. In sum, successor liability cannot be imposed on SGM under California common law.

Successor liability cannot be imposed under Cal. Corp. Code §§ 5914–5919. Cal. Corp. Code § 5914 authorizes the Attorney General to review transactions in which a non-profit healthcare facility seeks to transfer a material amount of its assets to a for-profit entity, and provides in relevant part:

> Any nonprofit corporation that is defined in Section 5046 and operates or controls a health facility, as defined in Section 1250 of the Health and Safety Code, or operates or controls a facility that provides similar health care, regardless of whether it is currently operating or providing health care services or has a suspended license, shall be required to provide written notice to, and to obtain the written consent of, the Attorney General prior to entering into any agreement or transaction to do either of the following:
>
> > (A) Sell, transfer, lease, exchange, option, convey, or otherwise dispose of, its assets to a for-profit corporation or entity or to a mutual benefit corporation or entity when a material amount of the assets of the nonprofit corporation are involved in the agreement or transaction.

Cal. Corp. Code § 5914(a)(1) (West).

The "Attorney General shall have discretion to consent to, give conditional consent to, or not consent to" the transaction. Cal. Corp. Code § 5917.

***10** Nothing within the statute authorizes the Attorney General to impose successor liability upon SGM, the for-profit entity that purchased the healthcare assets from the non-profit Debtors. Under the statute, the Attorney General is authorized to review transactions entered into by a "nonprofit corporation that ... operates or controls a health facility," Cal. Corp. Code § 5914(a)(1), and to "consent to, give conditional consent to, or not consent to" any such transactions, Cal. Corp. Code § 5917. These provisions do not grant the Attorney General authority to impose going-forward obligations on the assets that are the subject of the transaction. That is, the statute does not provide that the healthcare assets themselves are subject to regulation by the Attorney General. Rather, it is the non-profit status of the entity operating the healthcare assets that triggers the Attorney General's regulatory authority. Upon transfer of the healthcare assets from the non-profit entity to the for-profit entity, the Attorney General's regulatory authority over the assets terminates.

The issue of the Attorney General's authority to impose successor liability arose in the case of *In re La Paloma Generating Co.*, No. 16-12700, 2017 WL 5197116 (Bankr. D. Del. Nov. 9, 2017). In *La Paloma*, the debtor operated a power plant subject to a cap-and-trade emissions regulation. The regulation required "Covered Entities"—defined as entities engaging in operations that generated emissions—to surrender "Compliance Instruments" equal to the amount of emissions generated at specified times. At issue was whether a power plant could be sold "free and clear of, and without the purchaser assuming, any obligation to surrender compliance instruments under the California Cap-and-Trade Program for emissions generated by the Debtors and/or their facility during the period before the transfer of the assets." *Id.* at *2. The court found that "[u]nder the Regulation, only entities—and not assets—are Covered Entities" subject to the obligation to surrender Compliance Instruments. *Id.* at *5. As a result, the court found, the debtors could sell the power plant free and clear of the surrender obligations, pursuant to § 363(f)(1). *Id.* at *8. The court reasoned that the regulation did not impose successor liability on the purchaser, because it imposed liability only on "Covered Entities," and the purchaser would not become a Covered Entity until after it acquired the power plant. *Id.* at *7–*8. The regulation, the court held, was limited to Covered Entities, and could not be used to "impugn liability on the purchaser of ... the Covered Entity's assets." *Id.* at *8.

With respect to the imposition of successor liability, the statute at issue here operates in the same manner as the regulation examined in *La Paloma*. Similar to the regulation in *La Paloma*, Cal. Corp. Code § 5914–5919 permits the imposition of liability upon the Hospitals only because they are operated by a non-profit corporation. That is, independent of the fact that they are operated by a non-profit entity, nothing within Cal. Corp. Code § 5914–5919 authorizes the Attorney General to impose liabilities upon the Hospitals. Further, the Attorney General's regulatory authority under the statute

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does not extend to for-profit entities. As was the case in *La Paloma*, Cal. Corp. Code § 5914–5919 does not authorized the Attorney General to impose liability upon the for-profit purchaser of the Hospitals.

The Attorney General argues that the statute's implementing regulations authorize the imposition of successor liability. Specifically, the Attorney General points to Cal. Code Regs. Tit. 11, § 999.5, which provides in relevant part:

> It is the policy of the Attorney General, in consenting to an agreement or transaction involving a general acute care hospital, to require for a period of at least five years the continuation at the hospital of existing levels of essential healthcare services, including but not limited to emergency room services. The Attorney General shall retain complete discretion to determine whether this policy shall be applied in any specific transaction under review.

***11** Cal. Code Regs. tit. 11, § 999.5.

Significantly, the statute's implementing regulations do not differentiate between Cal. Corp. Code §§ 5914–5919, which codifies the Attorney General's authority to review transfers between a non-profit and a for-profit entity, and Cal. Corp. Code §§ 5920–5925, which codifies the Attorney General's authority to review transfers between a non-profit entity and a different non-profit entity. Where assets are transferred between two different non-profit entities, the structure of the statute clearly provides the Attorney General the authority to impose successor liability.

The Court construes Cal. Code Regs. Tit. 11, § 999.5 as implementing Cal. Corp. Code §§ 5920–5925, not as implementing Cal. Corp. Code §§ 5914–5919. Cal. Corp. Code §§ 5920–5925 does authorize the imposition of successor liability, whereas Cal. Corp. Code §§ 5914–5919 does not. This construction is appropriate because it harmonizes the language of the regulation with the language of the statute, while still giving full effect to every part of the regulation. *See Butts v. Bd. of Trustees of California State Univ.*, 225 Cal. App. 4th 825, 835, 170 Cal. Rptr. 3d 604, 612 (2014) ("The rules of statutory construction also govern our interpretation of regulations promulgated by administrative agencies. We give the regulatory language its plain, commonsense meaning. If possible, we must accord meaning to every word and phrase in the regulation, and we must read regulations as a whole so that all of the parts are given effect.").

Because the Attorney General's authority to review the sale arises under Cal. Corp. Code §§ 5914–5919, the Attorney General cannot rely upon Cal. Code Regs. tit. 11, § 999.5, which implements Cal. Corp. Code §§ 5920–5925, as the basis for imposing successor liability upon SGM.

2. Even if California Law Allowed the Attorney General to Impose Successor Liability Upon SGM, the Attorney General Abused his Discretion in Imposing the Additional Conditions

As set forth below, the Court finds that the Attorney General's decision to impose the Additional Conditions is subject to judicial review by administrative mandate under California law. This Court is empowered to conduct such judicial review pursuant to § 1221(e) of the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 ("BAPCPA"), which provides:

> Nothing in this section shall be construed to require the court in which a case under chapter 11 of title 11, United States Code, is pending to remand or refer any proceeding, issue, or controversy to any other court or to require the approval of any other court for the transfer of property.

Pub. L. No. 109-8, § 1221(e) (2005).[13] *See also In re HHH Choices Health Plan, LLC*, 554 B.R. 697, 700 (Bankr. S.D.N.Y. 2016) (construing New York state law to determine the appropriate disposition of a non-profit debtor's assets).

Upon review of the Attorney General's decision, the Court finds that the imposition of the Additional Conditions constituted an abuse of discretion, for the reasons explained below. Therefore, the Additional Conditions must be set aside, which means that the Debtors are authorized to sell the

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Hospitals free and clear of the Additional Conditions under applicable nonbankruptcy law.

i. The Attorney General's Imposition of the Additional Conditions is Subject to Judicial Review by Administrative Mandate

***12** Cal. Civ. Proc. Code § 1094.5 provides for judicial review by administrative mandate of decisions made by agencies or officers of the State of California. A writ of mandate may be issued if the agency or officer making the decision engaged in a "prejudicial abuse of discretion." Cal. Civ. Proc. Code § 1094.5(b). An "abuse of discretion is established if ... the order or decision is not supported by the findings, or the findings are not supported by the evidence." *Id.*

The Attorney General contends that administrative mandamus review is not available because the Additional Conditions were not issued subsequent to "a proceeding in which by law a hearing is required to be given, evidence is required to be taken, and discretion in the determination of facts is vested in the inferior tribunal." Cal. Civ. Proc. Code § 1094.5(a). The Attorney General acknowledges that he conducted "public meetings ... to hear comments from interested parties" as required by Cal. Corp. Code § 5922. However, the Attorney General asserts that such public meetings were not "hearings" within the meaning of Cal. Civ. Proc. Code § 1094.5(a), because public comments were not presented under oath and no effort was made to determine the accuracy of the information offered by members of the public. The Attorney General's position is that the Debtors are entitled only to traditional mandamus review under Cal. Civ. Proc. Code § 1085.

"Quasi-legislative acts are ordinarily reviewed by traditional mandate, and quasi-judicial acts are reviewed by administrative mandate. 'Generally speaking, a legislative action is the formulation of a rule to be applied to all future cases, while an adjudicatory act involves the actual application of such a rule to a specific set of existing facts.' " *Friends of the Old Trees v. Dep't of Forestry & Fire Prot.*, 52 Cal. App. 4th 1383, 1389, 61 Cal. Rptr. 2d 297, 303 (1997) (internal citation omitted).

The Court is not persuaded by the Attorney General's contention that administrative mandamus review is unavailable to the Debtors. In reviewing the SGM Sale, the Attorney General hired JD Healthcare, Inc. to prepare expert reports containing information on how the SGM Sale would affect the availability of healthcare services in the regions served by the Hospitals. The JD Healthcare expert reports contained recommendations regarding the conditions that the Attorney General should impose on the SGM Sale. Upon receiving the expert reports, the Attorney General asked the Debtors to respond to the conditions recommended by JD Healthcare. The Attorney General conducted public meetings, all of which were transcribed, at which members of the public commented on the SGM Sale. "[P]urely documentary proceedings can satisfy the hearing requirement of Code of Civil Procedure § 1094.5, so long as the agency is required by law to accept and consider evidence from interested parties before making its decision." *Friends of the Old Trees*, 52 Cal. App. 4th at 1391–92, 61 Cal.Rptr.2d 297. A "trial-type hearing" is not necessary. *Id.* at 1392, 61 Cal. Rptr. 2d 297.

The Attorney General's review involved "the actual application of ... a rule to a specific set of existing facts." *Friends*, 52 Cal. App. 4th at 1389, 61 Cal.Rptr.2d 297. The Attorney General received evidence from JD Healthcare, heard comments from members of the public, and elected to impose the Additional Conditions after considering all the evidence collected during the review process. The Attorney General's review of the SGM Sale was a quasi-judicial act subject to review by administrative mandate.

***13** The Attorney General next asserts that administrative mandamus review is unavailable because the Debtors have failed to produce the complete administrative record supporting the Attorney General's decision. This contention is without merit. For purposes of administrative mandamus review, a partial record is sufficient if it "accurately represent[s] the administrative proceedings, provide[s] the reviewing court with an understanding of what occurred below, and enable[s] that court to undertake an independent judicial review of the administrative decision." *Elizabeth D. v. Zolin*, 21 Cal. App. 4th 347, 349, 25 Cal. Rptr. 2d 852 (1993). The record before the Court consists of the expert reports prepared by JD Healthcare, partial transcripts of public meetings conducted by the Attorney General, and various letters submitted by stakeholders. The record on file provides the Court with an understanding of reasons for the Attorney General's decision.

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There are two tests for judicial review by administrative mandate. "The 'independent judgment' rule applies when the decision of an administrative agency will substantially affect a fundamental vested right." *Mann v. Dep't of Motor Vehicles*, 76 Cal. App. 4th 312, 320, 90 Cal. Rptr. 2d 277, 283 (1999). Under the "independent judgment" rule, the Court must "begin its review with a presumption of the correctness of administrative findings, and then, after affording the respect due to these findings, exercise independent judgment in making its own findings." *Fukuda v. City of Angels*, 20 Cal. 4th 805, 819, 85 Cal.Rptr.2d 696, 977 P.2d 693, 701 (1999). "[T]he presumption provides the trial court with a starting point for review but it is only a presumption, and may be overcome. Because the trial court ultimately must exercise its own independent judgment, that court is free to substitute its own findings after first giving due respect to the agency's findings." *Id.*

"The 'substantial evidence' rule applies when the administrative decision neither involves nor substantially affects a vested right. The trial court must then review the entire administrative record to determine whether the findings are supported by substantial evidence and whether the agency committed any errors of law ...." *Mann*, 76 Cal. App. 4th 312, 320, 90 Cal. Rptr. 2d 277, 283 (1999).

To determine whether an administrative decision affects a fundamental vested right, the Court examines "whether the affected right is deemed to be of sufficient significance to preclude its extinction or abridgement by a body lacking *judicial* power." *Interstate Brands v. Unemployment Ins. Appeals Bd.*, 26 Cal. 3d 770, 779, 163 Cal.Rptr. 619, 608 P.2d 707, 713 (1980) (emphasis in original). An administrative decision that would have the effect of shutting down a business affects a fundamental vested right. *See, e.g.*, *The Termo Co. v. Luther*, 169 Cal. App. 4th 394, 407–08, 86 Cal. Rptr. 3d 687, 697 (2008) ("The implementation of the Order and Decision would have the effect not only of shutting down a business that has been in existence for 20 years or more, but also of terminating the right to produce oil—an extraordinarily valuable resource, especially in the current economic era.... Certainly, a fundamental vested right is at issue."); *Goat Hill Tavern v. City of Costa Mesa*, 6 Cal. App. 4th 1519, 1529, 8 Cal. Rptr. 2d 385, 391 (1992) (holding that "the right to continue operating an established business in which [the owner] has made a substantial investment" is a fundamental vested right).

Imposition of the Additional Conditions will precipitate the collapse of the SGM Sale and require the Debtors to close three of the four Hospitals. The Debtors' rights to preserve the Hospitals' operations, by means of a sale to SGM, is a fundamental vested right that is abrogated by the Attorney General's attempt to impose the Additional Conditions. Consequently, the Court reviews the Attorney General's decision under the independent judgment test.

ii. In Imposing the Additional Conditions, the Attorney General Abused His Discretion

***14** Under certain circumstances, the sale of a not-for-profit healthcare facility is subject to review by the Attorney General. Cal. Corp. Code § 5914. The Legislature enacted Cal. Corp. Code § 5914 to ensure that the public was not deprived of the benefits of charitable health facilities as a result of the transfer of those facilities' assets to for-profit entities. In enacting § 5914, the Legislature found:

> Charitable, nonprofit health facilities have a substantial and beneficial effect on the provision of health care to the people of California, providing as part of their charitable mission uncompensated care to uninsured low-income families and under-compensated care to the poor, elderly, and disabled.
>
> Transfers of the assets of nonprofit, charitable health facilities to the for-profit sector, such as by sale, joint venture, or other sharing of assets, directly affect the charitable use of those assets and may affect the availability of community health care services....
>
> It is in the best interests of the public to ensure that the public interest is fully protected whenever the assets of a charitable nonprofit health facility are transferred out of the charitable trust and to a for-profit or mutual benefit entity.

1996 Cal. Legis. Serv. Ch. 1105 (A.B. 3101) (West).

The Attorney General has "discretion to consent to, give conditional consent to, or not consent to" the sale of a healthcare facility. Cal. Corp. Code § 5917. In exercising that discretion, the Attorney General "shall consider any factors that the Attorney General deems relevant," including but not limited to whether any of the following apply:

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a) The terms and conditions of the agreement or transaction are fair and reasonable to the nonprofit corporation.

b) The agreement or transaction will result in inurement to any private person or entity.

c) Any agreement or transaction that is subject to this article is at fair market value. In this regard, "fair market value" means the most likely price that the assets being sold would bring in a competitive and open market under all conditions requisite to a fair sale, the buyer and seller, each acting prudently, knowledgeably and in their own best interest, and a reasonable time being allowed for exposure in the open market.

d) The market value has been manipulated by the actions of the parties in a manner that causes the value of the assets to decrease.

e) The proposed use of the proceeds from the agreement or transaction is consistent with the charitable trust on which the assets are held by the health facility or by the affiliated nonprofit health system.

f) The agreement or transaction involves or constitutes any breach of trust.

g) The Attorney General has been provided, pursuant to Section 5250, with sufficient information and data by the nonprofit corporation to evaluate adequately the agreement or transaction or the effects thereof on the public.

h) The agreement or transaction may create a significant effect on the availability or accessibility of health care services to the affected community.

i) The proposed agreement or transaction is in the public interest.

j) The agreement or transaction may create a significant effect on the availability and accessibility of cultural interests provided by the facility in the affected community.

Cal. Corp. Code § 5917 (West).

Nothing in the record indicates that SGM's bid was other than for fair market value (factor (c)). The Hospitals were thoroughly marketed by Cain Brothers. SGM was the only bidder interested in purchasing the Hospitals. The Court must presume that a bid submitted after extensive marketing reflects the Hospital's fair market value. *See* *Bank of Am. Nat. Tr. & Sav. Ass'n v. 203 N. LaSalle St. P'ship*, 526 U.S. 434, 457, 119 S. Ct. 1411, 1423, 143 L. Ed. 2d 607 (1999) (stating that "the best way to determine value is exposure to a market").

***15** There is no indication that SGM, or any other party, took any actions to decrease the value of the Hospitals (factor (d)). In view of the extensive marketing, the terms of the sale are fair and reasonable to the Debtors (factor (a)). There is no evidence that any of the parties involved in the SGM sale have engaged in any conduct that would amount to a breach of trust (factor (f)), or that the SGM Sale will inure to the benefit of any private person or entity (factor (b)). Nor has there been any suggestion that the Debtors failed to provide the Attorney General with sufficient information to evaluate the SGM Sale (factor (g)). Factor (e) does not apply, because the proceeds of the SGM Sale are fully encumbered by the claims of creditors, leaving no remaining equity that could be devoted to charitable purposes.

The remaining factors are (1) the effect of the SGM Sale on the accessibility of healthcare services (factor (h)) and cultural interests (factor (j)) in the affected communities and (2) whether the SGM Sale is in the public interest (factor (i)). Applying the independent judgment standard of review, the Court finds that in electing to impose the Additional Conditions, the Attorney General abused his discretion with respect to these factors.

By letter dated August 23, 2019 (the "August Letter"), the Debtors advised the Attorney General that if the Additional Conditions were imposed, SGM would not complete the sale and the most likely outcome would be the closure of St. Vincent, Seton, and Seton Coastside. The August Letter advised the Attorney General that SGM had submitted the only offer for the Hospitals, and that the "Debtors cannot sustain incurring ongoing operational losses to maintain the going-concern value of St. Vincent and Seton without the realistic prospect of a purchaser." [14] The Debtors stated that upon the failure of the SGM Sale, they would be required to begin the process of closing St. Vincent, Seton, and Seton Coastside "almost immediately." [15]

Having overseen the Debtors' bankruptcy cases since their inception, the Court has become intimately familiar with the Debtors' operational and cash flow situation. As discussed

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above, the Debtors' statements regarding the necessity of closing certain of the Hospitals upon the failure of the SGM Sale are not an idle threat.

Imposition of the Additional Conditions will dramatically reduce the availability of healthcare services by causing the closure of three of the four Hospitals. In addition to the loss of healthcare services, closure of the Hospitals will destroy approximately 2900 jobs. Closure of the Hospitals will require the relocation of many patients suffering from critical conditions. None of this is in the public interest. [16]

The Court understands that the Additional Conditions were imposed with the laudable objective of increasing the amount of healthcare services provided by the Hospitals. The Court can only assume that the Attorney General does not believe the representation that imposition of the Additional Conditions will result in a collapse of the SGM Sale. Unfortunately, the dire economic circumstances in which the Debtors now find themselves leaves the Court with no doubt that if the SGM Sale is not completed, three of the Hospitals will almost certainly close.

Because the Additional Conditions will reduce health care services by resulting in the closure of three of the Hospitals, imposition of the Additional Conditions was an abuse of the Attorney General's discretion.

***16** Outside of bankruptcy, the finding that the Attorney General abused his discretion would result in the entry of a judgment commanding the issuance of a peremptory writ of mandate, followed by the issuance of the writ. The writ would command the Attorney General to set aside the 2019 Conditions, and would further command the Attorney General to exercise his discretion with respect to the review of the SGM Sale in a lawful manner. *See, e.g.*, *California Hosp. Assn. v. Maxwell-Jolly*, 188 Cal. App. 4th 559, 570, 115 Cal. Rptr. 3d 572, 581 (2010), *as modified on denial of reh'g* (Sept. 16, 2010).

BAPCPA § 1221(e) compels a different result inside bankruptcy. Section 1221(e) provides that the Court is not required "to remand or refer any proceeding, issue, or controversy to any other court or to require the approval of any other court for the transfer of property." In *In re HHH Choices Health Plan*, the Bankruptcy Court relied upon BAPCPA § 1221(e) to conclude that it had the authority to interpret a New York law governing the transfer of the assets of a nonprofit entity. The court observed that "[i]n the case of an insolvent not-for-profit corporation, section 511 of the New York Not-For-Profit Corporation Law ordinarily, would require the approval of the New York State Supreme Court for a transfer of assets." *HHH Choices Health Plan*, 554 B.R. at 700. The court rejected arguments advanced by certain of the parties "that the ordinary state court procedures must still be followed" with respect to the transfer of the assets. *Id.* Instead, the court held that substantive state law requirements remained applicable, but that it was the Bankruptcy Court that had authority to apply those requirements. *Id.*

Pursuant to BAPCPA § 1221(e), and consistent with the ruling in *HHH Choices Health Plan*, the Court is not required to issue a judgment and writ commanding the Attorney General to set aside the 2019 Conditions, and is not required to remand these proceedings to allow the Attorney General to conduct a further review of the SGM Sale in light of the Court's finding that the Attorney General abused his discretion. Instead, the Court is empowered to apply Cal. Corp. Code § 5914, and to determine the conditions under which the Debtors may sell the Hospitals to SGM.

Under the circumstances presented here, the only way that closure of three of the four Hospitals can be avoided is if a sale not subject to the Additional Conditions is approved. A decision by the Attorney General to not consent to the sale, or a decision to consent to the sale subject to conditions other than the Approved Conditions, would constitute an abuse of discretion. That is because SGM, the only entity willing to purchase and continue to operate the Hospitals, will do so only if it is permitted to operate the Hospitals in a manner consistent with the Approved Conditions.

In reaching this conclusion, the Court is not limiting or controlling the discretion vested in the Attorney General, in contravention of Cal. Code Civ. Proc. § 1094.5(f). The Hospitals have been financially distressed for years. A $100 million capital infusion made in connection with the 2015 Restructuring Agreement failed to stabilize the Hospitals' operations. A further capital infusion of $148 million in 2017 failed to restore the Hospitals to financial health. This demonstrates that it was not possible to successfully operate the Hospitals subject to the 2015 Conditions. It should come as no surprise that no buyer exists that is willing to purchase and operate the Hospitals if operations are constrained by Additional Conditions that are substantially similar to the 2015 Conditions. The Attorney General's continued attempts to impose conditions rendering sustainable operation of the Hospitals impossible amounts to an abuse of discretion.

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***17** The Attorney General contends that SGM, by refusing to purchase and operate the Hospitals subject to conditions other than the Approved Conditions, is attempting to divest the Attorney General of his regulatory authority by forcing him to accede to a transaction on SGM's terms. This argument ignores the financial and operational realities facing the Hospitals. SGM's refusal to accept the Additional Conditions is not an attempt to blackmail the Attorney General into approving the sale. Such refusal is instead dictated by economic reality.

iii. Even if the Attorney General's Decision is Subject to Traditional Mandamus Review Under Cal. Civ. Proc. Code § 1085, Imposition of the Additional Conditions Was an Abuse of Discretion

Even if the Attorney General's review of the sale transaction is a quasi-legislative decision, subject to traditional mandamus review under Cal. Civ. Proc. Code § 1085, the decision to impose the Additional Conditions was an abuse of discretion.

Under Cal. Civ. Proc. Code § 1085, a traditional mandate "may issue to correct the exercise of discretionary legislative power, *but only* if the action taken is so palpably unreasonable and arbitrary as to show an abuse of discretion as a matter of law." *Carrancho v. California Air Res. Bd.*, 111 Cal. App. 4th 1255, 1265, 4 Cal. Rptr. 3d 536, 545 (2003) (emphasis in original). In reviewing quasi-legislative decisions, the "authority of the court is limited to determining whether the decision of the agency was arbitrary, capricious, entirely lacking in evidentiary support, or unlawfully or procedurally unfair." *Fullerton Joint Union High Sch. Dist. v. State Bd. of Educ.*, 32 Cal. 3d 779, 786, 187 Cal.Rptr. 398, 654 P.2d 168, 172 (1982). The Court must ensure that the agency or officer making the decision "has adequately considered all relevant factors, and has demonstrated a rational connection between those factors, the choice made, and the purposes of the enabling statute." *W. States Petroleum Assn. v. Superior Court*, 9 Cal. 4th 559, 577, 38 Cal.Rptr.2d 139, 888 P.2d 1268, 1277 (1995). Traditional mandamus review of a quasi-legislative decision is therefore more deferential than administrative mandamus review of a quasi-judicial decision under the independent judgment standard.

Even applying this more deferential standard of review, the Court finds that the decision to impose the Additional Conditions was an abuse of discretion, and that a proper exercise of discretion required the Attorney General to consent to the sale subject only to the Approved Conditions. Preservation of access to healthcare is one of the factors the Attorney General must consider in reviewing the transaction. *See* Cal. Corp. Code § 5917(h) (requiring the Attorney General to consider whether the "agreement or transaction may create a significant effect on the availability or accessibility of health care services to the affected community"). At the hearing, the Attorney General stated that he imposed the Additional Conditions in furtherance of § 5917(h)'s objective of preserving healthcare access. [17] The effect of the Additional Conditions will be the closure of three of the four Hospitals, which will significantly reduce access to healthcare. There is no "rational connection" between the purpose of the Additional Conditions (preserving healthcare access) and the actual results of the conditions (a severe reduction in healthcare access). *See* *W. States Petroleum Ass'n*, 38 Cal.Rptr.2d 139, 888 P.2d at 1277. With respect to three of the four Hospitals, the Attorney General's decision will destroy the very charitable assets that he is charged with protecting.

***18** In sum, regardless of whether the Debtors are entitled to review of the Attorney General's decision under traditional mandamus or administrative mandamus, the Attorney General's decision to impose the Additional Conditions was an abuse of discretion. In the unique circumstances of this case, the Attorney General was required to consent to the SGM Sale without imposing the Additional Conditions. As a result, sale of the Hospitals to SGM free and clear of the Additional Conditions is authorized under applicable nonbankruptcy law. The Court approves the SGM Sale, free and clear of the Additional Conditions, pursuant to § 363(f)(1).

C. The Debtors May Sell the Hospitals Free and Clear of the Additional Conditions Pursuant to § 363(f)(4)

Under § 363(f)(4), the Hospitals may be sold free and clear of the Additional Conditions provided the Additional Conditions are "in bona fide dispute ..." A bona fide dispute exists if "there is an objective basis for either a factual or legal dispute as to the validity" of the interest at issue. *In re Octagon Roofing*, 123 B.R. 583, 590 (Bankr. N.D. Ill. 1991). The court "court need not determine the probable outcome of the dispute, but merely whether one exists." *Id.*

The Debtors dispute the Attorney General's authority to impose the Additional Conditions, on the grounds that the (1) Additional Conditions attempt to impose successor liability in a manner not authorized under California law and that (2) the Attorney General abused his discretion in issuing the Additional Conditions. As discussed above, the Debtors have shown that the Attorney General cannot impose the Additional Conditions for both of these reasons. The Debtors have easily satisfied § 363(f)(4), which does not require the Debtors to show that they will prevail upon the dispute—only that a dispute exists.

A bona fide dispute exists for yet another reason. The Debtors have shown that by imposing the Additional Conditions, the Attorney General violated § 525.

Section 525 provides in relevant part:

> [A] governmental unit may not deny, revoke, suspend, or refuse to renew a license, permit, charter, franchise, or other similar grant to, condition such a grant to, discriminate with respect to such a grant against, deny employment to, terminate the employment of, or discriminate with respect to employment against, a person that is or has been a debtor under this title ... or another person with whom such ... debtor has been associated, solely because such ... debtor is or has been a debtor under this title ... or has not paid a debt that is dischargeable in the case under this title ....

In *In re Aurora Gas, LLC*, the court held that the State of Alaska violated § 525 by refusing to approve the debtor's sale of oil and gas leases unless the purchaser posted a bond of $6 million to pay for the cost of plugging abandoned wells that the purchaser was not acquiring. *In re Aurora Gas, LLC*, No. A16-00130-GS, 2017 WL 4325560 (Bankr. D. Alaska Sept. 26, 2017). The court held that by conditioning approval of the sale upon the posting of a bond, the State was attempting to collect upon the debtor's obligation to pay for the costs of plugging the abandoned wells. Imposition of such a condition, the court found, constituted impermissible discrimination against the debtor and its affiliate, the purchaser of the gas leases, in violation of § 525.

The facts of this case are strikingly similar. Here, the Attorney General has conditioned approval of the SGM Sale upon SGM assuming the obligation to operate the Hospitals in accordance with conditions similar to the 2015 Conditions that are an obligation of the Debtors. As discussed, the Additional Conditions require that SGM maintain and operate the Hospitals at current licensure and service levels. The Additional Conditions amount to an attempt by the Attorney General to enforce the obligations imposed by the 2015 Conditions. The 2015 Conditions are liabilities that are dischargeable in bankruptcy. By conditioning the transfer of the Hospitals upon the assumption of the Additional Conditions, which impose obligations equal to or in excess of the 2015 Conditions, the Attorney General is impermissibly discriminating against the Debtors in violation of § 525.

***19** The fact that the Additional Conditions can be characterized as a regulatory obligation does not change the analysis. Regulatory obligations such as the Additional Conditions qualify as a "debt" under the Bankruptcy Code's broad definition of the term:

> Under the Bankruptcy Code, "debt" means "liability on a claim," 11 U.S.C. § 101(12), and "claim," in turn, includes any "right to payment," § 101(5)(A). We have said that "[c]laim" has "the broadest available definition," *Johnson v. Home State Bank*, 501 U.S. 78, 83, 111 S.Ct. 2150, 115 L.Ed.2d 66 (1991), and have held that the "plain meaning of a 'right to payment' is nothing more nor less than an enforceable obligation, regardless of the objectives the State seeks to serve in imposing the obligation," *Pennsylvania Dept. of Public Welfare v. Davenport*, 495 U.S. 552, 559, 110 S.Ct. 2126 [109 L.Ed.2d 588] (1990). See also *Ohio v. Kovacs*, 469 U.S. 274, 105 S.Ct. 705, 83 L.Ed.2d 649 (1985). In short, a debt is a debt, even when the obligation to pay it is also a regulatory condition.

F.C.C. v. NextWave Pers. Commc'ns Inc., 537 U.S. 293, 302–03, 123 S. Ct. 832, 839, 154 L. Ed. 2d 863 (2003).

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D. The Debtors May Sell the Hospitals Free and Clear of Certain of the Additional Conditions Pursuant to § 363(f)(5)

Under § 363(f)(5), property may be sold free and clear of an interest, if the entity holding the interest "could be compelled, in a legal or equitable proceeding, to accept a money satisfaction of such interest."

An interest "that can be reduced to a specific monetary value" falls within the scope of § 363(f)(5). *In re Trans World Airlines, Inc.*, 322 F.3d 283, 291 (3d Cir. 2003); *see also In re Vista Marketing Grp. Ltd.*, 557 B.R. 630, 635 (Bankr. N.D. Ill. 2016) ("[O]ne would be hard-pressed to present a clearer example of a situation where the interest-holder could be compelled to accept a money satisfaction of its interest under subsection (f)(5) than the calculable monetary obligation asserted by the District in its surcharge bill and disconnection notice.").

Among the Additional Conditions are requirements that each of the Hospitals provide specified levels of charity care and community benefit services. The Additional Conditions allow any shortfalls in charity care or community benefit services to be satisfied through deficiency payments to tax-exempt entities within the Hospitals' service area. The charity care and community benefit obligations can easily be reduced to a specific monetary value. The Debtors may sell the Hospitals free and clear of these obligations pursuant to § 363(f)(5).

E. Section 363(d)(1) Does Not Bar the Sale

As noted, § 363(d)(1) provides that non-profit entities, such as the Debtors, may sell estate assets only if the sale is "in accordance with nonbankruptcy law applicable to the transfer of property by" a non-profit entity.

For the reasons discussed in Section II.B., above, the Debtors are authorized to sell the Hospitals, free and clear of the Additional Conditions, under applicable nonbankruptcy law.

Even if the Debtors were not authorized to sell the Hospitals free and clear under applicable nonbankruptcy law, § 363(d)(1) does not limit the Debtors' ability to sell the Hospitals free and clear of the Additional Conditions under § 363(f)(4) or (5).[18] Basic principles of statutory construction dictate this result. "Statutory construction ... is a holistic endeavor." *United Sav. Ass'n of Texas v. Timbers of Inwood Forest Assocs., Ltd.*, 484 U.S. 365, 371, 108 S. Ct. 626, 630, 98 L. Ed. 2d 740 (1988). The Court must look "to the provisions of the whole law, and to its object and policy." *John Hancock Mut. Life Ins. Co. v. Harris Tr. & Sav. Bank*, 510 U.S. 86, 94–95, 114 S. Ct. 517, 523, 126 L. Ed. 2d 524 (1993). Absent a "clear intention otherwise," specific provisions addressing an issue apply instead of more generalized provisions covering the same issue. *Morton v. Mancari*, 417 U.S. 535, 550–51, 94 S. Ct. 2474, 2483, 41 L. Ed. 2d 290 (1974). This rule applies "regardless of the priority of enactment" of the provisions. *Id.*

***20** Section 363(f) sets forth specific circumstances under which assets may be sold free and clear. Section 363(f) is not limited by a non-profit debtor's general obligation under § 363(d)(1) to comply with nonbankruptcy law. The general requirement set forth in § 363(d)(1) makes no reference to § 363(f), which more specifically delineates the circumstances in which assets may be sold free and clear. Without a "clear intention otherwise," *Morton*, 417 U.S. at 550–51, 94 S.Ct. 2474, the general requirement of § 363(d)(1) does not repeal the specifics of free and clear sales under § 363(f), even though § 363(d)(1) was enacted subsequent to § 363(f).

F. Section 541(f) Does Not Bar the Sale

Section 541(f) provides:

> Notwithstanding any other provision of this title, property that is held by a debtor that is a corporation described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code may be transferred to an entity that is not such a corporation, but only under the same conditions as would

> apply if the debtor had not filed a case under this title.

The Attorney General asserts that § 541(f)'s initial clause, "[n]otwithstanding any other provision of this title," is broad enough to trump § 363(f). According to the Attorney General, § 541(f) requires that the SGM Sale comply with applicable California law. As a result, the Attorney General argues, the SGM Sale can occur only if SGM agrees to accept all of the 2019 Conditions, including the Additional Conditions.

The language of § 541(f) is similar, but not identical to, the language of § 363(d)(1). Section 363(d)(1) requires that non-profit entities transfer property "in accordance with nonbankruptcy law applicable to the transfer of property by" the non-profit entity; § 541(f) requires that such transfers occur "only under the same conditions as would apply if the debtor had not filed a case under this title."

"[W]here Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion." *Russello v. United States*, 464 U.S. 16, 23, 104 S. Ct. 296, 300, 78 L. Ed. 2d 17 (1983). Therefore, the Court cannot assume that § 541(f) has the same meaning as § 363(f). That is, § 541(f) cannot mean that the Debtors are required to transfer property "in accordance with nonbankruptcy law applicable to the transfer of [such] property," since that is the language used in § 363(d)(1).

There is no legislative history to guide the Court in construing the phrase "under the same conditions" in § 541(f). Nor has the Court been able to locate any cases interpreting this section. In the absence of legislative history, phrases are construed in accordance with their "ordinary or natural meaning." *F.D.I.C. v. Meyer*, 510 U.S. 471, 476, 114 S. Ct. 996, 1001, 127 L. Ed. 2d 308 (1994). According to *Roget's 21st Century Thesaurus* (3d ed. 2013), a synonymous phrase for "under the same conditions" is "in these circumstances."

Here, the Debtors have complied with § 541(f)'s mandate. That is, "[n]otwithstanding any other provisions" of the Bankruptcy Code, they have sought to transfer the Hospitals in the same manner as the transfer would have occurred under applicable nonbankruptcy law. The Debtors submitted the transfer to the review of the Attorney General, paid for the expert healthcare impact statements required under the statute, and waited for 135 days for the Attorney General to review the transaction. The transfer has been subject to the same conditions that would have applied had the Debtors not sought bankruptcy protection.

***21** Even if the Attorney General were correct that § 541(f) had the same meaning as § 363(d)(1), the Debtors would still be able to sell the Hospitals free and clear of the Additional Conditions, pursuant to § 363(f)(1), (4), and (5). Contrary to the Attorney General's contention, the "notwithstanding" clause does not mean that § 541(f) trumps § 363(f). The Ninth Circuit has held:

> In examining specific statutes, we have not, however, always accorded universal effect to the "notwithstanding" language, standing alone. *See* *Or. Natural Res. Council v. Thomas*, 92 F.3d 792, 796 (9th Cir.1996) ("We have repeatedly held that the phrase 'notwithstanding any other law' is not always construed literally." (citing *E.P. Paup Co. v. Dir., Office of Workers Comp. Programs*, 999 F.2d 1341, 1348 (9th Cir.1993); *Kee Leasing Co. v. McGahan (In re The Glacier Bay)*, 944 F.2d 577, 582 (9th Cir.1991); *Golden Nugget, Inc. v. Am. Stock Exch., Inc.*, 828 F.2d 586, 588–89 (9th Cir.1987) (per curium))). Instead, we have determined the reach of each such "notwithstanding" clause by taking into account the whole of the statutory context in which it appears.

United States v. Novak, 476 F.3d 1041, 1046 (9th Cir. 2007).

Relying upon the "common-sense principle of statutory construction that sections of a statute generally should be read to give effect, if possible, to every clause," the Ninth Circuit has held that a "notwithstanding" provision should not be given its broadest possible interpretation if doing so would render other statutory provisions ineffectual. *Oregon Nat. Res. Council v. Thomas*, 92 F.3d 792, 797 (9th Cir. 1996).

According the "notwithstanding" clause the broad construction advocated by the Attorney General would render § 363(f) of the Bankruptcy Code ineffectual with respect to non-profit debtors. Section 541(f) was added to the

Bankruptcy Code by the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005, Pub. L. No. 109-8, § 1221(e) ("BAPCPA"). BAPCPA made no changes to § 363(f). The Court cannot find that Congress intended § 541(f) to trump § 363(f) with respect to non-profit debtors.

G. The Court Certifies a Direct Appeal of its Decision to the Ninth Circuit Court of Appeals

Title 28 U.S.C. § 158(d)(2) provides that the Bankruptcy Court, acting on its motion, may certify a direct appeal of an order to the Court of Appeals if the order "involves a matter of public importance" or if an immediate appeal of the order will "materially advance the progress of the case or proceeding."

Certification is warranted here. The interplay between the sale provisions of the Bankruptcy Code and the authority of the Attorney General to regulate the sale of assets subject to a charitable trust is a matter of public importance. The issue has previously arisen in *Gardens I* and *Verity I*, and will continue to arise in future cases.

A direct appeal will materially advance the progress of the case. Closing of the SGM Sale is the lynchpin of the Debtors' plan of reorganization. However, under the APA, SGM is not obligated to close the sale unless the Debtors obtain a final, non-appealable order authorizing a sale free and clear. The Debtors are facing severe liquidity constraints and cannot afford to continue to operate the Hospitals for much longer. A direct appeal will facilitate resolution of this case by providing certainty regarding the permissibility of a sale free and clear far sooner than would otherwise be possible. If the Court's order is upheld, SGM can proceed to close the sale. If not, the Debtors can commence shutting down St. Vincent, Seton, and Seton Coastside.

III. Conclusion

***22** Based upon the foregoing, the Court finds that the Debtors may sell the Hospitals to SGM, free and clear of the Additional Conditions. The sale may proceed under applicable nonbankruptcy law pursuant to § 363(f)(1) because (1) the Additional Conditions qualify as successor liability that may not be imposed against SGM under California law and because (2) the Attorney General abused his discretion in attempting to impose the Additional Conditions, which therefore must be set aside. A bona dispute as to the Attorney General's authority to impose the Additional Conditions exists under § 363(f)(4), because the Debtors (1) have shown that the Additional Conditions are not authorized under California law and that (2) the attempted imposition of the Additional Conditions violates § 525. Pursuant to § 363(f)(5), the sale is free and clear of the charity care and community benefit obligations, which can be reduced to a monetary valuation.

The Court will prepare and enter an order certifying this matter for a direct appeal to the Ninth Circuit. The Debtors shall submit an order granting the Motion within seven days of the issuance of this Memorandum of Decision.

All Citations

Slip Copy, 2019 WL 5585007

Footnotes

1 For a description of the Santa Clara Sale, see *In re Verity Health Sys. of California, Inc.*, 598 B.R. 283 (Bankr. C.D. Cal. 2018) ("*Verity I*").

2 The Approved Conditions are set forth in Schedule 8.6 of the APA.

3 For a description of the difficulties associated with closing a much smaller hospital, see *In re Gardens Reg'l Hosp. & Med. Ctr., Inc.*, 567 B.R. 820, 829 (Bankr. C.D. Cal. 2017), *appeal dismissed*, No. 2:16-BK-17463-ER, 2018 WL 1229989 (C.D. Cal. Jan. 19, 2018).

4 April 3, 2019 E-mail from Prime to the Debtors [Doc. No. 3333, Ex. 6].

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5 *Id.*

6 St. Francis Conditions at § IV [Doc. No. 3188, Ex. B].

7 *Id.* at § VI.

8 *See* St. Vincent Conditions at § VI (setting forth a list of healthcare services that St. Vincent must maintain at current levels); *see also* Seton and Seton Coastside Conditions at § VI (same).

9 *See Verity I*, 598 B.R. at 293 ("The Conditions [imposed by the Attorney General] are an 'interest in property' within the meaning of § 363(f). The Conditions provide that any owner of the Hospitals must furnish specified levels of emergency services, intensive care services, cardiac services, and various other services. The required service levels were derived based upon the historical experience of the prior operator. As such, the Conditions are monetary obligations arising from the ownership of property.").

10 *See generally Verity I*.

11 *See* APA at § 1.1(a)(i) [Doc. No. 2305, Part 1].

12 As nonprofit public benefit corporations, the Debtors do not have stockholders.

13 This provision of BAPCPA does not appear in the Bankruptcy Code itself.

14 August Letter at 14.

15 *Id.*

16 SEIU-UHW contends that it is economically feasible for SGM to operate the Hospitals while complying with the Additional Conditions. The record does not support SEIU-UHW's contention. SGM was the only bidder willing to purchase the Hospitals and has stated unequivocally that it will not complete its purchase if the Additional Conditions are imposed. These facts show that the Additional Conditions render operation of the Hospitals economically infeasible.

17 Specifically, counsel for the Attorney General explained that in imposing the conditions, the Attorney General "is weighing the impact on the affected community, and making a determination as to what would be the best outcome for this community in order to ensure that it is not being adversely impacted, and not inappropriately losing access to these nonprofit hospitals ...." Hearing Transcript [Doc. No. 3416] at 24. Counsel further stated that the Attorney General's "obligation is ... to do what's needed to preserve access to healthcare, in particular for disadvantaged populations, which is clearly what we're dealing with here." *Id.* at 12.

18 Under § 363(f)(4), the Debtors are authorized to sell the Hospitals free and clear of all of the Additional Conditions. *See* Section II.C., above. Under § 363(f)(5), the Debtors are authorized to sell the Hospitals free and clear of the charity care and community benefit obligations. *See* Section II.D., above.

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598 B.R. 283
United States Bankruptcy Court, C.D. California, Los Angeles Division.

IN RE: VERITY HEALTH SYSTEM OF CALIFORNIA, INC., et al., Debtors and Debtors in Possession.
Affects All Debtors
Affects Verity Health System of California, Inc.
Affects O'Connor Hospital
Affects Saint Louise Regional Hospital
Affects St. Francis Medical Center
Affects St. Vincent Medical Center
Affects Seton Medical Center
Affects O'Connor Hospital Foundation
Affects Saint Louise Regional Hospital Foundation
Affects St. Francis Medical Center of Lynwood Medical Foundation
Affects St. Vincent Foundation
Affects St. Vincent Dialysis Center, Inc.
Affects Seton Medical Center Foundation
Affects Verity Business Services
Affects Verity Medical Foundation
Affects Verity Holdings, LLC
Affects De Paul Ventures, LLC
Affects De Paul Ventures - San Jose Dialysis, LLC, Debtors and Debtors in Possession.,

Lead Case No.: 2:18-bk-20151-ER
|
Jointly Administered With: Case No. 2:18-bk-20162-ER
|
Case No. 2:18-bk-20163-ER, Case No. 2:18-bk-20164-ER, Case No. 2:18-bk-20165-ER, Case No. 2:18-bk-20167-ER, Case No. 2:18-bk-20168-ER, Case No. 2:18-bk-20169-ER, Case No. 2:18-bk-20171-ER, Case No. 2:18-bk-20172-ER, Case No. 2:18-bk-20173-ER, Case No. 2:18-bk-20175-ER, Case No. 2:18-bk-20176-ER, Case No. 2:18-bk-20178-ER, Case No. 2:18-bk-20179-ER, Case No. 2:18-bk-20180-ER, Case No. 2:18-bk-20181-ER
|
Date: December 19, 2018, Time: 10:00 a.m., Location: Ctrm. 1568, Roybal Federal Building, 255 East Temple Street, Los Angeles, CA 90012
|

Signed December 26, 2018

Synopsis

Background: Chapter 11 debtor-nonprofit entities filed motion for authorization to sell hospitals to county free and clear of conditions imposed by state attorney general in connection with predecessor's restructuring agreement. State attorney general objected.

Holdings: The Bankruptcy Court, Ernest M. Robles, J., held that:

[1] state attorney general waived his ability to contest debtors' sale of hospitals free and clear of conditions imposed in connection with predecessor's restructuring agreement;

[2] state attorney general was equitably estopped from contesting debtors' ability to sell hospitals free and clear of conditions imposed in connection with predecessor's restructuring agreement;

[3] conditions imposed by state attorney general in connection with debtors' predecessor's restructuring agreement were an "interest in property" within meaning of Bankruptcy Code provision allowing sale of estate property free and clear of any interest in such property;

[4] debtors' sale of hospitals was not subject to state attorney general's review under California law; and

[5] state attorney general's request for 14-day stay of sale order would be denied.

Objection overruled.

Procedural Posture(s): Motion to Sell Property Free and Clear of Interests; Motion to Use, Sell, or Lease Property Outside the Ordinary Course of Business.

West Headnotes (18)

[1] **Estoppel** Nature and elements of waiver
Estoppel Implied waiver and conduct constituting waiver

"Waiver" is the voluntary relinquishment of a known right or conduct such as to warrant an

inference to that effect; it implies knowledge of all material facts and of one's rights, together with a willingness to refrain from enforcing those rights.

[2] **Estoppel** Implied waiver and conduct constituting waiver

Waiver occurs when a party's acts are so inconsistent with an intent to enforce the right as to induce a reasonable belief that such right has been relinquished.

1 Case that cites this headnote

[3] **Bankruptcy** Order of court and proceedings therefor in general

State attorney general waived his ability to contest Chapter 11 debtor-nonprofit entities' sale of hospitals, free and clear of conditions imposed by state attorney general in connection with predecessor's restructuring agreement, by filing response to the court's briefing order that stated the state attorney general did not object to the sale; state attorney general knew that the debtors were seeking approval of a sale free and clear of the conditions, because the asset purchase agreement (APA) contained unequivocal language to that effect.

1 Case that cites this headnote

[4] **Bankruptcy** Order of court and proceedings therefor in general

Bankruptcy court would not consider the testimony of chief assistant attorney general and assistant county counsel in determining whether state attorney general's filing of response to the court's briefing order, stating the state attorney general did not object to the sale Chapter 11 debtors' sale of hospitals to county free and clear of conditions imposed by state attorney general in connection with predecessor's restructuring agreement, effected a waiver of the attorney general's objections to sale; when litigating with a sophisticated party such as the state attorney general, interested parties were entitled to presume that representations made by the state attorney general in papers filed with the court accurately reflected his position, and allowing the state attorney general to qualify statements through the subsequent introduction of parol evidence would unduly hamper the court's ability to adjudicate matters arising in the case. Fed. R. Evid. 403.

1 Case that cites this headnote

[5] **Bankruptcy** Procedure

Bankruptcy court has the inherent power to manage its own affairs so as to achieve the orderly and expeditious disposition of matters coming before it.

[6] **Bankruptcy** Evidence; witnesses

Parol evidence rule bars consideration of extrinsic evidence in connection with the interpretation of an integrated contract.

[7] **Estoppel** Essential elements

Party may be equitably estopped from asserting a position if the following conditions apply: (1) the party to be estopped must know the facts, (2) he must intend that his conduct shall be acted on or must so act that the party asserting the estoppel has a right to believe it is so intended, (3) the latter must be ignorant of the true facts, and (4) he must rely on the former's conduct to his injury.

[8] **Estoppel** Particular state officers, agencies or proceedings

State attorney general was equitably estopped from contesting Chapter 11 debtors' ability to sell hospitals to county free and clear of conditions imposed by state attorney general in connection with predecessor's restructuring agreement, as state attorney general knew that debtors and county would upon his representation in response to court's briefing order that he had no objection to the sale, and debtors and county relied upon representation to their detriment, as they would have more vigorously contested the state attorney general's

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arguments regarding the binding effect of the conditions.

[9] **Bankruptcy** Time for sale; emergency and sale outside course of business

Debtors must articulate a business justification for sale of estate property out of the ordinary course of business. 11 U.S.C.A. § 363(b).

[10] **Bankruptcy** Time for sale; emergency and sale outside course of business

Whether debtor's articulated business justification for sale of estate property out of the ordinary course of business is sufficient depends on the case, in view of all salient factors pertaining to the proceeding. 11 U.S.C.A. § 363(b).

[11] **Bankruptcy** Adequate protection; sale free of liens

Conditions imposed by state attorney general in connection with Chapter 11 debtors-nonprofits' predecessor's restructuring agreement, including that any owner of predecessor's hospitals must furnish specified levels of emergency services, intensive care services, cardiac services, and various other services, were an "interest in property" within meaning of Bankruptcy Code provision allowing sale of estate property free and clear of any interest in such property; conditions were monetary obligations arising from the ownership of property. 11 U.S.C.A. § 363(f).

1 Case that cites this headnote

[12] **Attorney General** Representation of state in general

Bankruptcy Adequate protection; sale free of liens

Chapter 11 debtor-nonprofit entities' sale of hospitals to county, free and clear of conditions imposed by state attorney general in connection with debtors' predecessor's restructuring agreement, including that any owner of predecessor's hospitals must furnish specified levels of emergency services, intensive care services, cardiac services, and various other services, was not subject to state attorney general's review under California law, because the hospitals were being sold to a public entity, not a for-profit corporation or mutual benefit corporation. Cal. Corp. Code §§ 5914, 5926.

1 Case that cites this headnote

[13] **Statutes** Intent

Under California law, the ultimate task in statutory interpretation is to ascertain the legislature's intent.

[14] **Statutes** Language and intent, will, purpose, or policy

Under California law, ordinarily, the words of the statute provide the most reliable indication of legislative intent.

[15] **Statutes** In general; factors considered

Statutes Plain, literal, or clear meaning; ambiguity

Under California law, only where the statutory language is ambiguous may the court consider evidence of the legislature's intent beyond the words of the statute, such as the statutory scheme of which the provision is a part, the history and background of the statute, the apparent purpose, and any considerations of constitutionality.

[16] **Statutes** Plain language; plain, ordinary, common, or literal meaning

Under California law, when statutory language is clear and unambiguous there is no need for construction, and courts should not indulge in it.

[17] **Statutes** Relation to plain, literal, or clear meaning; ambiguity

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Under California law, the language of a statute should not be given a literal meaning if doing so would result in absurd consequences which the legislature did not intend.

[18] **Bankruptcy** Order of court and proceedings therefor in general

State attorney general's request for 14-day stay of sale order, authorizing Chapter 11 debtor-nonprofit entities' sale of hospitals to county free and clear of conditions imposed by state attorney general in connection with debtors' predecessor's restructuring agreement, would be denied, so that the sale could close as expeditiously as possible; state attorney general's appeal of the sale order would not likely be rendered moot by the court's waiver of the 14-day stay, and debtors, the county, and the estate would benefit in being able to begin performing the significant work that was a prerequisite to the closing. Fed. R. Bankr. P. 6004(h).

Attorneys and Law Firms

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MEMORANDUM OF DECISION OVERRULING OBJECTIONS OF THE CALIFORNIA ATTORNEY GENERAL TO THE DEBTORS' SALE MOTION

Ernest M. Robles, United States Bankruptcy Judge

To adjudicate objections asserted by the California Attorney General (the "Attorney General") to the Debtors' motion for authorization to sell Saint Louise Regional Hospital ("St. Louise") and O'Connor Hospital ("O'Connor," and together with St. Louise, the "Hospitals") to the County of Santa Clara ("Santa Clara"), the Court ordered the Debtors, the Attorney General, Santa Clara, and the Official Committee of Unsecured Creditors (the "Committee") to respond to the Court's *Preliminary Findings and Conclusions* (the "Preliminary Findings"). [1] In the Preliminary Findings, the Court stated that it intended to authorize the Debtors to sell the Hospitals to Santa Clara, free and clear of certain conditions imposed by the Attorney General in connection with a 2015 restructuring transaction, pursuant to § 363(f)(1). [2] Having reviewed the briefing submitted in response to the Court's order, [3] the Court ***287** maintains its Preliminary Findings, and for the reasons set forth below will authorize the Debtors to sell the Hospitals free and clear of the conditions imposed by the Attorney General in connection with the 2015 restructuring transaction.

I. Background

On August 31, 2018 (the "Petition Date"), Verity Health Systems of California ("VHS") and certain of its subsidiaries (collectively, the "Debtors") filed voluntary petitions for relief under Chapter 11 of the Bankruptcy Code. On August 31, 2018, the Court entered an order granting the Debtors' motion for joint administration of the Debtors' Chapter 11 cases. [4]

On October 31, 2018, the Court entered an order establishing auction procedures for the sale of the Hospitals (the "Bidding Procedures Order," and the motion for entry of the Bidding Procedures Order, the "Bidding Procedures Motion"). [5] Pursuant to an Asset Purchase Agreement (the "APA") [6] dated October 1, 2018, Santa Clara was designated as the stalking horse bidder (the "Stalking Horse Bidder"). The Bidding Procedures Order set a hearing on December 19, 2018 to consider the Debtors' motion for entry of an order (the "Sale Order") approving the sale of the Hospitals (the "Sale Motion," and the hearing on the Sale Motion, the "Sale Hearing"). The Debtors expect that the sale will close no earlier than February 28, 2019.

The Hospitals were vigorously marketed by the Debtors' investment banker, Cain Brothers, a division of KeyBank Capital Markets, Inc. ("Cain"). Twenty-five parties executed non-disclosure agreements and were granted access to a data room containing information about the Hospitals. [7] Cain sent a direct e-mail communication to over 170 interested

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potential purchasers ***288** which contained key information about the Hospitals.[8] Cain actively followed up with two serious potential purchasers, assisting those parties with due diligence and making itself available to answer questions.[9] Notwithstanding these thorough marketing efforts, no party emerged willing to place a bid for the Hospitals.[10]

In 2015, the Debtors' predecessor, Daughters of Charity Ministry Services Corporation ("Daughters"), sought authorization from the Attorney General, pursuant to Cal. Corp. Code § 5914 (West 2018), to implement a *System Restructuring and Support Agreement* (the "Restructuring Agreement"). The Attorney General approved the Restructuring Agreement, subject to various conditions (each, a "Condition," and collectively, the "Conditions").[11] O'Connor was subject to 21 Conditions; St. Louise was subject to 22 Conditions.

Among other things, the Conditions require the Hospitals to maintain specified levels of emergency services, intensive care services, cardiac services, and various other services. The Conditions purport to be binding upon "any and all current and future owners" of the Hospitals.[12]

On October 10, 2018, the Attorney General filed an objection to the Bidding Procedures Motion.[13] The Attorney General objected to the Debtors' proposal to sell the Hospitals free and clear of the Conditions, contending that the Conditions remained binding upon any purchaser of the Hospitals. The Court did not address the Attorney General's objection when adjudicating the Bidding Procedures Motion, finding the objection to be premature. The Bidding Procedures Order provided that the Attorney General's objection was "preserved for the Sale Hearing and may be raised at that time."[14]

On November 2, 2018, Santa Clara asked the Attorney General to provide clarification regarding his position as to the applicability of certain of the Conditions.[15] Santa Clara asserted that its status as a government entity made it impossible to comply with certain Conditions without violating its obligations under California law and the California Constitution. On November 9, 2018, the Attorney General responded, advising that five of the Conditions would not be enforced against Santa Clara.[16] Specifically, the Attorney General waived enforcement of Conditions requiring the Hospitals to furnish specified amounts of charity care and community benefits, Conditions pertaining to pension ***289** obligations, and Conditions pertaining to the composition of the Board of Trustees of each Hospital.

On December 14, 2018, the Attorney General filed a response to the Debtors' memorandum in support of the Sale Motion (the "Response").[17] The Response provided:

> The California Attorney General does not object to the sale to the County of Santa Clara, in light of the conditions as clarified in the Attorney General's November 9, 2018 letter to the County of Santa Clara and as may be subsequently further clarified or modified by the Attorney General. The Attorney General and the County are presently engaged in further discussions about the Conditions not addressed by the Attorney General's November 9, 2018 letter, and as such, the Attorney General will continue to consider any further requests for clarification or modification presented by the County.[18]

The APA provides that Santa Clara is not required to accept a Sale Order that does not provide for the sale of the Hospitals free and clear of all liens, claims, and interests (including the Conditions).[19] The Attorney General's Response did not state that the Attorney General objected to sale of the Hospitals free and clear of the Conditions.

At the Sale Hearing, the Attorney General stated that the Response was "inartfully drafted," and that the Attorney General did in fact object to sale of the Hospitals free and clear of the Conditions. The Debtors and Santa Clara asked the Court to approve the sale free and clear of the Conditions, asserting that the Attorney General had waived its objections and/or was estopped from asserting such objections. Santa Clara's counsel explained that in order for the County to be able to proceed with the closing—anticipated to occur at the end of February 2019—it was necessary for any uncertainty regarding the applicability of the Conditions to be immediately resolved. Santa Clara stated that if an order

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providing for a sale free and clear of the Conditions was not entered by the January 2, 2019 deadline set forth in the APA, it would be Santa Clara's position that a breach of the APA had occurred.

II. Findings and Conclusions

A. The Attorney General Has Waived His Ability to Contest a Sale Free and Clear of the Conditions

[1] **[2]** "Waiver is the voluntary relinquishment of a known right or conduct such as to warrant an inference to that effect. It implies knowledge of all material facts and of one's rights, together with a willingness to refrain from enforcing those rights." *Hauk v. JP Morgan Chase Bank USA*, 552 F.3d 1114, 1119 (9th Cir. 2009). Waiver also occurs when a "party's acts are so inconsistent with an intent to enforce the right as to induce a reasonable belief that such right has been relinquished." *Salyers v. Metro. Life Ins. Co.*, 871 F.3d 934, 938 (9th Cir. 2017).

[3] The Response filed by the Attorney General on December 14, 2018 waived the Attorney General's right to object to a sale free and clear of the Conditions. The Response provided: "The California Attorney General *does not object* to the sale to the County of Santa Clara ...." (emphasis added). [20] It contained no reservation of the ***290** Attorney General's right to object in the event that the contemplated "further requests for clarification or modification presented by the County" [21] did not yield results acceptable to the Attorney General. The Attorney General knew that the Debtors were seeking approval of a sale free and clear of the Conditions, because the APA contained unequivocal language to that effect. By filing the Response, the Attorney General voluntary relinquished his right to object to a sale free and clear.

In addition, the filing of the Response was so inconsistent with an intent to continue to enforce the Conditions against Santa Clara as to induce Santa Clara to reasonably believe that the Attorney General had abandoned his position as to the enforceability of the Conditions. *See* *Salyers*, 871 F.3d at 938.

In support of his contention that the Response did not waive his objections, the Attorney General points to conversations between the Attorney General's counsel and Santa Clara's counsel that took place contemporaneously with the filing of the Response. Angela Sierra, Chief Assistant Attorney General of the Public Rights Division at the California Department of Justice, testifies that she had a short conversation with Douglas M. Press, Santa Clara's Assistant County Counsel, on December 14, 2018. [22] According to Ms. Sierra:

> Shortly before the Attorney General Office's filing of the AG Response, my Office had proposed incorporating our previously lodged objections into [the] AG Response by way of a footnote. After further consideration of an issue raised by the County, I determined that such incorporation was not necessary, given that we had not withdrawn our objections. Approximately ten minutes before the noon filing deadline on December 14, 2018, I had a short conversation with Assistant County Counsel Doug Press, during which I explained that the language that my Office was poised to file meant that we did not object to the sale as long as the conditions as currently or subsequently clarified remained in place. Doug Press stated that he disagreed with that interpretation.
>
> I participated in several discussions with Assistant County Counsel Doug Press regarding the AG Conditions following the filing of the AG Response on December 14, 2018. These discussions continued through December 18, 2018. At no time during those discussions did our Office communicate that we had waived the applicability of the AG Conditions. [23]

Mr. Press disputes Ms. Sierra's characterization of the December 14, 2018 conversation. Mr. Press' account of the conversation is as follows:

> On ... December 14, 2018, the California Attorney General's Office proposed language to be inserted in a response that day that would have asserted that its approval of the sale was conditional, but we agreed to remove that conditional language. Instead, we agreed to the unconditional language that appears in the Attorney General's response ... that ... "[t]he California Attorney General does not object to the sale to the County of Santa Clara, ***in light of*** the conditions as clarified in the Attorney General's November 9, 2018 letter to the County of Santa Clara and as may be subsequently further clarified or modified ***291** by the Attorney General." [Emphasis Added.] The unconditional "in light of" language was meant, as the County understood it, to reflect that the California Attorney General would no longer object to the sale, although we also agreed to continue to discuss, post-sale, how to address the other conditions under a

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> variety of approaches. But the message to the Court and the community was meant to be clear, that the California Attorney General, in its Response, ... was expressing that it was not opposed to the sale even though ongoing discussions with the County about the other conditions were contemplated outside the Court process. [24]

[4] The Court declines to consider the testimony of Ms. Sierra and Mr. Press in determining whether the filing of the Response effected a waiver of the Attorney General's objections. When litigating with a sophisticated party such as the Attorney General, the Debtors, Santa Clara, and other interested parties are entitled to presume that representations made by the Attorney General in papers filed with the Court accurately reflect his position. Allowing the Attorney General, or any other party, to qualify statements made in papers through the subsequent introduction of parol evidence would unduly hamper the Court's ability to adjudicate matters arising in this case. More than 63 separate papers have been filed in connection with the Bidding Procedures Motion and Sale Motion. The papers raise multiple discrete and complicated issues, including whether the sale could be free and clear of obligations imposed in connection with various collective bargaining agreements; whether the Debtors sufficiently marketed the Hospitals; whether the bidding procedures proposed by the Debtors would yield the maximum price for the estate; whether the Debtors had articulated sufficient business justification for the sale; whether the sales price is fair and reasonable; whether the APA was negotiated in good faith and at arms-length; whether the Debtors' Medicare and Medi-Cal Provider Agreements are properly characterized as an executory contract or a statutory entitlement; and whether the Debtors are entitled to assume and assign various unexpired leases and executory contracts. [25] Even if only a fraction of the parties who have filed papers were allowed to introduce supplemental evidence establishing what their papers really meant, the adjudicative process would grind to a halt.

[5] **[6]** Pursuant to FRE 403, the Court may exclude evidence if consideration thereof would result in undue delay. Exclusion of the declarations of Ms. Sierra and Mr. Press is warranted under FRE 403, particularly where, as here, the consideration of such evidence would require the Court to consider similar evidence submitted by other parties dissatisfied by the Court's rulings. In addition, the Court has the inherent power to "manage [its] own affairs so as to achieve the orderly and expeditious disposition" of matters coming before it. *Chambers v. NASCO, Inc.*, 501 U.S. 32, 43, 111 S.Ct. 2123, 2132, 115 L.Ed.2d 27 (1991). Finally, in the same way that the parol evidence rule bars consideration of extrinsic evidence in connection with the interpretation of an integrated contract, *see Casa del Caffe Vergnano S.P.A. v. ItalFlavors, LLC*, 816 F.3d 1208, 1213 (9th Cir. 2016), the Court finds it appropriate to similarly decline to consider extrinsic evidence when interpreting papers submitted by a sophisticated litigant such as the Attorney General.

***292 B. The Attorney General is Equitably Estopped from Contesting a Sale Free and Clear of the Conditions**

[7] A party may be equitably estopped from asserting a position if the following conditions apply:

> 1) [T]he party to be estopped must know the facts;
>
> 2) he must intend that his conduct shall be acted on or must so act that the party asserting the estoppel has a right to believe it is so intended;
>
> 3) the latter must be ignorant of the true facts; and
>
> 4) he must rely on the former's conduct to his injury.

Gabriel v. Alaska Elec. Pension Fund, 773 F.3d 945, 955 (9th Cir. 2014).

[8] Under the circumstances, the Attorney General is equitably estopped from contesting the Debtors' ability to sell the Hospitals free and clear of the Conditions. The Attorney General knew that the Debtors and Santa Clara would rely upon the Response's representation that he had no objection to the sale. The Debtors and Santa Clara had no way of knowing that when the Attorney General stated that he did "not object to the sale to the County of Santa Clara," [26] what he really meant was that he did not object except to the extent that he did object. The Debtors and Santa Clara relied upon the Attorney General's representation to their detriment. Had they been aware of the Attorney General's true position, the Debtors and Santa Clara would have more vigorously contested the Attorney General's arguments regarding the binding effect of the Conditions.

Relying upon *Jordan v. California Dep't of Motor Vehicles*, 100 Cal. App. 4th 431, 453, 123 Cal.Rptr.2d 122 (2002), *as modified on denial of reh'g* (Aug. 20, 2002), the Attorney General argues that equitable estoppel may not

be invoked where, as here, "it would operate to defeat the effective operation of a policy adopted to protect the public." *Id.* at 453, 123 Cal.Rptr.2d 122. This argument fails because, as discussed in Section II.C., below, the Attorney General has not identified a statutory basis for his assertion that the Conditions remain enforceable against Santa Clara. Consequently, the Attorney General has failed to show that continued enforcement of the Conditions is supported by California law.

C. Even if the Doctrines of Waiver and Equitable Estoppel Did Not Apply, a Sale of the Hospitals Free and Clear of the Conditions is Authorized under § 363(f)(1)

[9] **[10]** Section 363(d)(1) authorizes non-profit entities, such as the Debtors, to sell estate assets only if the sale is "in accordance with nonbankruptcy law applicable to the transfer of property by" a non-profit entity. Section 363(b) permits the Debtors to sell estate property out of the ordinary course of business, subject to court approval. The Debtors must articulate a business justification for the sale. *In re Walter*, 83 B.R. 14, 19–20 (9th Cir. BAP 1988). Whether the articulated business justification is sufficient "depends on the case," in view of "all salient factors pertaining to the proceeding." *Id.* at 19–20. Section 363(f)(1) provides that a sale of estate property may be "free and clear of any interest in such property of an entity other than the estate, only if applicable nonbankruptcy law permits sale of such property free and clear of such interest ...."

1. The Conditions Are an Interest in Property Within the Meaning of § 363

As this Court has previously explained:

> ***293** The Bankruptcy Code does not define the phrase "interest in ... property" for purposes of § 363(f). The Third Circuit has held that the phrase "interest in ... property" is "intended to refer to obligations that are connected to, or arise from, the property being sold." *Folger Adam Sec., Inc. v. DeMatteis/MacGregor JV*, 209 F.3d 252, 259 (3d Cir. 2000). That conclusion is echoed by *Collier on Bankruptcy*, which observes a trend in caselaw "in favor of a broader definition [of the phrase] that encompasses other obligations that may flow from ownership of the property." 3 Alan N. Resnick & Henry J. Sommer, *Collier on Bankruptcy* ¶ 363.06[1] (16th ed. 2017).
>
> Courts have held that interests in property include monetary obligations arising from the ownership of property, even when those obligations are imposed by statute. For example, in *Mass. Dep't of Unemployment Assistance v. OPK Biotech, LLC (In re PBBPC, Inc.)*, 484 B.R. 860 (1st Cir. BAP 2013), the court held that taxes assessed by Massachusetts under its unemployment insurance statutes constituted an "interest in ... property." The taxes were computed based on the Debtor's "experience rating," which was determined by the number of employees it had terminated in the past. *Id.* at 862. Because the Debtor had terminated most of its employees prior to selling its assets, its experiencing rating, and corresponding unemployment insurance tax liabilities, were very high. *Id.* The *PBBPC* court held that the experience rating was an interest in property that could be cut off under § 363(f). *Id.* at 869–70. Similarly, in *United Mine Workers of Am. Combined Benefit Fund v. Leckie Smokeless Coal Co. (In re Leckie Smokeless Coal Co.)*, 99 F.3d 573, 581 [(4th Cir. 1996)], the court held that monetary obligations imposed by the Coal Industry Retiree Health Benefit Act of 1992 constituted an "interest in ... property" within the meaning of § 363(f).
>
> *In re Gardens Reg'l Hosp. & Med. Ctr., Inc.*, 567 B.R. 820, 825–26 (Bankr. C.D. Cal. 2017), *appeal dismissed*, No. 2:16-BK-17463-ER, 2018 WL 1229989 (C.D. Cal. Jan. 19, 2018).

[11] The Conditions are an "interest in property" within the meaning of § 363(f). The Conditions provide that any owner of the Hospitals must furnish specified levels of emergency services, intensive care services, cardiac services, and various other services. The required service levels were derived based upon the historical experience of the prior operator. As such, the Conditions are monetary obligations arising from the ownership of property.

2. The Debtors May Sell the Hospitals Free and Clear of the Conditions under Applicable Nonbankruptcy Law

[12] Under certain circumstances, the sale of a not-for-profit healthcare facility is subject to review by the Attorney General. Cal. Corp. Code § 5914 provides in relevant part (emphasis added):

> Any nonprofit corporation that is defined in Section 5046 and operates or controls a health facility, as defined in Section 1250 of the Health and Safety Code, or operates

> or controls a facility that provides similar health care, regardless of whether it is currently operating or providing health care services or has a suspended license, shall be required to provide written notice to, and to obtain the written consent of, the Attorney General prior to entering into any agreement or transaction to do either of the following:
>
> (A) Sell, transfer, lease, exchange, option, convey, or otherwise dispose of, its assets to a *for-profit corporation* ***294** *or entity or to a mutual benefit corporation or entity* when a material amount of the assets of the nonprofit corporation are involved in the agreement or transaction.
>
> (B) Transfer control, responsibility, or governance of a material amount of the assets or operations of the nonprofit corporation to any *for-profit corporation or entity or to any mutual benefit corporation or entity*.

Here, the sale is not subject to Attorney General review because the Hospitals are being sold to Santa Clara, which is a public entity, not a for-profit corporation or mutual benefit corporation. Notwithstanding its inability to review the sale, the Attorney General contends that the Conditions—which were imposed in connection with the Attorney General's § 5914 review authority—nonetheless remain binding upon any subsequent purchaser of the Hospitals. In support of this contention, the Attorney General cites Cal. Corp. Code § 5926, which provides: "The Attorney General may enforce conditions imposed on the Attorney General's consent to an agreement or transaction pursuant to Section 5914 or 5920 to the fullest extent provided by law."

The Court finds that neither Cal. Corp. Code § 5926 nor any of the other provisions set forth in Cal. Corp. Code §§ 5914–30 provide the Attorney General with authority to enforce the Conditions against Santa Clara if Santa Clara acquires the Hospitals. In reaching this conclusion, the Court construes the California Corporations Code consistent with California's rules of statutory construction. *See* *Fed. Sav. & Loan Ins. Corp. v. Butler*, 904 F.2d 505, 510 (9th Cir. 1990) (applying California's rules of statutory construction to interpret Cal. Civ. Proc. Code § 877).

[13] **[14]** **[15]** **[16]** **[17]** Under California law, the "ultimate task" in statutory interpretation "is to ascertain the Legislature's intent." *People v. Massie*, 19 Cal.4th 550, 569, 79 Cal.Rptr.2d 816, 967 P.2d 29 (1998). "Ordinarily, the words of the statute provide the most reliable indication of legislative intent." *Pac. Gas & Elec. Co. v. Cty. of Stanislaus*, 16 Cal.4th 1143, 1152, 69 Cal.Rptr.2d 329, 947 P.2d 291 (1997). Only where the statutory language is ambiguous may the Court consider "evidence of the Legislature's intent beyond the words of the statute," such as the "statutory scheme of which the provision is a part, the history and background of the statute, the apparent purpose, and any considerations of constitutionality ...." *Hughes v. Bd. of Architectural Examiners*, 17 Cal.4th 763, 776, 72 Cal.Rptr.2d 624, 952 P.2d 641 (1998). "When statutory language is ... clear and unambiguous there is no need for construction, and *courts should not indulge in it*." *Delaney v. Superior Court*, 50 Cal.3d 785, 800, 268 Cal.Rptr. 753, 789 P.2d 934 (1990) (emphasis in original). However, the "language of a statute should not be given a literal meaning if doing so would result in absurd consequences which the Legislature did not intend." *Younger v. Superior Court*, 21 Cal.3d 102, 113, 145 Cal.Rptr. 674, 577 P.2d 1014 (1978).

The Legislature enacted Cal. Corp. Code § 5914 to ensure that the public was not deprived of the benefits of charitable health facilities as a result of the transfer of those facilities' assets to for-profit entities. In enacting § 5914, the Legislature found:

> Charitable, nonprofit health facilities have a substantial and beneficial effect on the provision of health care to the people of California, providing as part of their charitable mission uncompensated care to uninsured low-income families and under-compensated care to the poor, elderly, and disabled.
>
> ***295** Transfers of the assets of nonprofit, charitable health facilities to the for-profit sector, such as by sale, joint venture, or other sharing of assets, directly affect the charitable use of those assets and may affect the availability of community health care services.... It is in the best interests of the public to ensure that the public interest is fully protected whenever the assets of a charitable nonprofit health facility are transferred out of the charitable trust and to a for-profit or mutual benefit entity.

1996 Cal. Legis. Serv. Ch. 1105 (A.B. 3101) (West).

As discussed, the sale of a nonprofit health facilities' assets to a public entity (such as Santa Clara) is not subject to Attorney General review. This exception is consistent with the statute's objective of ensuring that nonprofit health assets are

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operated consistent with a charitable mission and in the public interest, because public entities are required by law to furnish healthcare services to those in need. Cal. Welf. & Inst. Code § 17000 requires public entities to provide support, including healthcare, to indigent members of the public:

> Every county and every city and county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions.

As one court has explained, "[s]ection 17000 imposes various obligations on counties with respect to their indigent residents. Among other obligations, courts have interpreted section 17000 as requiring counties to provide indigent residents with emergency and medically necessary care." *Fuchino v. Edwards-Buckley*, 196 Cal. App. 4th 1128, 1134, 126 Cal.Rptr.3d 886, 890 (2011).

As set forth above, the Attorney General's position is that the Conditions remain binding upon Santa Clara, notwithstanding the Attorney General's inability to review the sale. The Attorney General's reliance upon Cal. Corp. Code § 5926 in support of this position is unavailing. Section 5926 provides only that the Attorney General may enforce the Conditions to the fullest extent provided by law. However, the Attorney General has not identified the specific provisions of California law that permit the continued enforcement of the Conditions.[27] This omission is particularly glaring in view of the Attorney General's lack of authority to review the sale.

In reaching this conclusion, the Court finds it significant that the Attorney General has failed to identify the statutory basis for its position even after being afforded an opportunity to respond to the Court's Preliminary Findings. The Preliminary Findings advised the Attorney General that because he had failed to identify the statutory authority for continued enforcement of the Conditions, the Court intended to authorize the Debtors to sell the Hospitals free and clear of the Conditions. ***296** In response to the Preliminary Findings, the Attorney General cited to provisions in the Conditions that purport to make the Conditions legally binding upon any entity acquiring the Hospitals. Notably, the Attorney General did not cite to any provision of California law entitling him to enforce successorship liability under the circumstances of this case.

The Attorney General's reliance upon provisions purporting to make the Conditions binding upon all successors, regardless of the circumstances under which such successors acquire the Hospitals, is an impermissible attempt to expand his regulatory authority over the Hospitals. Provisions within the Conditions are enforceable only to the extent that they are supported by California law.

Furthermore, the Attorney General's contention that the Conditions remain binding upon Santa Clara is inconsistent with the Cal. Corp. Code § 5914 and its legislative history. The concern motivating enactment of the statute was to prevent charitable assets from falling into the hands of for-profit entities who would not continue to use those assets for charitable purposes. The concern has no applicability where the assets are transferred to a public entity, which has independent statutory obligations to maintain the assets' charitable character, as discussed above.

Because the Attorney General has no authority to review the sale of the Hospitals to Santa Clara, and because the Attorney General has identified no statutory provision permitting his continued enforcement of the Conditions under the circumstances, the Court finds that the Debtors may sell the Hospitals free and clear of the Conditions under applicable nonbankruptcy law.

D. The Attorney General's Request for a 14-day Stay of the Sale Order is Denied

[18] Bankruptcy Rule 6004(h) provides that an "order authorizing the ... sale ... of property ... is stayed until the expiration of 14 days after entry of the order, unless the court orders otherwise." The Attorney General requests that the stay imposed by Bankruptcy Rule 6004(h) remain in effect. According to the Attorney General, a 14-day stay is necessary because the "proposed sale will have a significant impact on the health and safety of the surrounding communities."[28] Debtors assert that the 14-day stay should not apply so that the sale may close as expeditiously as possible. The sale is currently projected to close at the end of February 2019.

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The 1999 Advisory Committee Note to Bankruptcy Rule 6004 states that the rule is intended "to provide sufficient time for a party to request a stay pending appeal of an order authorizing the ... sale ... of property under § 363(b) of the Code before the order is implemented."

To enable the sale to close expeditiously, the Sale Order shall be effective immediately upon entry, notwithstanding Bankruptcy Rule 6004(h). Because the sale will not close until the end of February 2019, in the Court's view, the Attorney General's appeal of the Sale Order will not likely be rendered moot by the Court's waiver of the 14-day stay. [29] Accordingly, the Attorney General will suffer no prejudice from waiver of the stay. On the other hand, waiving the stay will benefit the Debtors, Santa Clara, and the estate by enabling the parties to immediately begin performing ***297** the significant work that is a prerequisite to the closing.

III. Conclusion

Based upon the foregoing, the Attorney General's objections to the Sale Motion are overruled, and the Debtors are authorized to sell the Hospitals free and clear of the Conditions, pursuant to § 363(f)(1). The Court will enter the proposed Sale Order submitted by the Debtors.

All Citations

598 B.R. 283, 66 Bankr.Ct.Dec. 166

Footnotes

1 *See* Order Providing Notice of the Court's Intent to Authorize the Debtors to Sell Hospitals Free and Clear of the 2015 Conditions Asserted by the California Attorney General [Doc. No. 1125] (the "Briefing Order").

2 Unless otherwise indicated, all "Civil Rule" references are to the Federal Rules of Civil Procedure, Rules 1–86; all "Bankruptcy Rule" references are to the Federal Rules of Bankruptcy Procedure, Rules 1001–9037; all "Evidence Rule" references are to the Federal Rules of Evidence, Rules 101–1103; all "LBR" references are to the Local Bankruptcy Rules of the United States Bankruptcy Court for the Central District of California, Rules 1001-1–9075-1; and all statutory references are to the Bankruptcy Code, 11 U.S.C. §§ 101–1532.

3 The following papers were submitted in response to the Briefing Order:

1) County of Santa Clara's Response to Order Providing Notice of the Court's Intent to Authorize the Debtors to Sell Hospitals Free and Clear of the 2015 Conditions Asserted by the California Attorney General [Doc. No. 1136];

2) Official Committee of Unsecured Creditors' Response to the Court's Order Providing Notice of the Court's Intent to Authorize the Debtors to Sell Hospitals Free and Clear of the 2015 Conditions Asserted by the California Attorney General [Doc. No. 1137];

3) Debtors' Response to Order Providing Notice of the Court's Intent to Authorize the Debtors to Sell Hospitals Free and Clear of the 2015 Conditions Asserted by the California Attorney General [Doc. No. 1139];

4) Attorney General Response to the Court's Preliminary Findings and Conclusions Re: Court's Order Providing Notice of the Court's Intent to Authorize the Debtors to Sell Hospitals Free and Clear of the 2015 Conditions Asserted by the California Attorney General [Doc. No. 1140]; Notice of Errata Re: Attorney General's Response Filed on December 24, 2018 [Doc. No. 1144]; and

5) Declaration of Douglas M. Press in Response to the Filing by the California Attorney General [Docket No. 1140] and in Support of Entry of the Order (1) Approving Sale of Certain Assets to Santa Clara

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County Free and Clear of All Encumbrances; (2) Approving of Debtors' Assumption and Assignment of Certain Unexpired Leases and Executory Contracts and Determining Cure Amounts and Approving of Debtors' Rejection of Those Unexpired Leases and Executory Contracts Which Are Not Assumed and Assigned; (3) Waiving the 14-day Stay Periods Set Forth in Bankruptcy Rules 6004(h) and 6006(d); and (4) Granting Related Relief [Doc. No. 1141] (the "Press Decl.").

4 Doc. No. 17.

5 *See* Doc. No. 724 (Bidding Procedures Order) and Doc. No. 365 (Bidding Procedures Motion).

6 The APA [Doc. No. 365, Ex. A] defines the assets being sold as follows: "all assets, businesses, real property, personal property, equipment, supplies, software, contracts, leases, licenses/permits, books, records, offices, facilities, and all other tangible and intangible property (a) whatsoever and wherever located that is owned, leased, or used primarily in connection with the Businesses by a Hospital Seller, (b) located in Santa Clara County, California that is owned, leased, or used primarily in connection with the Businesses by Verity Holdings, and (c) whatsoever and wherever located that is owned, leased, or used by Verity primarily in connection with the Businesses, in each case, except for the Excluded Assets." APA at ¶ 1.8.

7 Decl. of James M. Moloney [Doc. No. 1041] (the "Moloney Decl.") at ¶ 6.

8 *Id.* at ¶ 7.

9 *Id.* at ¶¶ 7–8.

10 *Id.* at ¶ 9.

11 The Conditions are memorialized in documents captioned *Conditions to Change in Control and Governance of O'Connor Hospital and Approval of the System Restructuring and Support Agreement by and among Daughters of Charity Ministry Services Corporation, Daughters of Charity Health System, Certain Funds Managed by BlueMountain Capital Management, LLC, and Integrity Healthcare, LLC* [Doc. No. 256, Ex. A, at 176–187] (the "O'Connor Conditions") and *Conditions to Change in Control and Governance of Saint Louise Regional Hospital and Approval of the System Restructuring and Support Agreement by and among Daughters of Charity Ministry Services Corporation, Daughters of Charity Health System, Certain Funds Managed by BlueMountain Capital Management, LLC, and Integrity Healthcare, LLC* [Doc. No. 256, Ex. A, at 261–273] (the "St. Louise Conditions").

12 O'Connor Conditions at 176–77 and St. Louise Conditions at 261–62.

13 Doc. No. 463.

14 Bidding Procedures Order [Doc. No. 724] at ¶ 3.

15 Doc. No. 1066, Ex. 1.

16 Doc. No. 1066, Ex. 2.

17 Doc. No. 1066.

18 Response at 2.

19 APA at ¶ 6.2.6.

20 Response at 2.

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21 *Id.*

22 Declaration of Angela Sierra [Doc. No. 1144] (the "Sierra Decl.") at ¶ 6.

23 Sierra Decl. at ¶¶ 6–7.

24 Press Decl. [Doc. No. 1141] at ¶ 5.

25 Adjudication of certain of these issues will take place on January 30, 2019.

26 Response at 2.

27 The Attorney General asserts that Art. V, § 13 of the California Constitution grants him authority to enforce the Conditions. Art. V, § 13 is a general provision stating only that the Attorney General has the authority to "see that the laws of the State are uniformly and adequately enforced"; it contains nothing specifically addressing the situation presented here. The Attorney General's reliance upon *D'Amico v. Board of Medical Examiners*, 11 Cal. 3d 1, 14, 112 Cal.Rptr. 786, 520 P.2d 10 (1974) is similarly misplaced. *D'Amico* states that the Attorney General possesses extensive statutory powers to protect the public interest but does not specifically address any of the legal issues presented here.

28 Doc. No. 1140 at 15.

29 Of course, only the appellate court has the authority to determine whether any appeal of the Sale Order is moot.

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KeyCite Red Flag - Severe Negative Treatment
Decision Vacated by In re Verity Health System of California, Inc., Bankr.C.D.Cal., December 9, 2019

606 B.R. 843
United States Bankruptcy Court, C.D. California, Los Angeles Division.

IN RE: VERITY HEALTH SYSTEM OF CALIFORNIA, INC., et al., Debtors and Debtors in Possession.
#Affects All Debtors
☐ Affects Verity Health System of California, Inc.
☐ Affects O'Connor Hospital
☐ Affects Saint Louise Regional Hospital
☐ Affects St. Francis Medical Center
☐ Affects St. Vincent Medical Center
☐ Affects Seton Medical Center
☐ Affects O'Connor Hospital Foundation
☐ Affects Saint Louise Regional Hospital Foundation
☐ Affects St. Francis Medical Center of Lynwood Medical Foundation
☐ Affects St. Vincent Foundation
☐ Affects St. Vincent Dialysis Center, Inc.
☐ Affects Seton Medical Center Foundation
☐ Affects Verity Business Services
☐ Affects Verity Medical Foundation
☐ Affects Verity Holdings, LLC
☐ Affects De Paul Ventures, LLC
☐ Affects De Paul Ventures - San Jose Dialysis, LLC, Debtors and Debtors in Possession.,

Lead Case No.: 2:18-bk-20151-ER
|
Jointly Administered With: Case No. 2:18-bk-20162-ER
|
Case No. 2:18-bk-20163-ER, Case No. 2:18-bk-20164-ER, Case No. 2:18-bk-20165-ER, Case No. 2:18-bk-20167-ER, Case No. 2:18-bk-20168-ER, Case No. 2:18-bk-20169-ER, Case No. 2:18-bk-20171-ER, Case No. 2:18-bk-20172-ER, Case No. 2:18-bk-20173-ER, Case No. 2:18-bk-20175-ER, Case No. 2:18-bk-20176-ER, Case No. 2:18-bk-20178-ER, Case No. 2:18-bk-20179-ER, Case No. 2:18-bk-20180-ER, Case No. 2:18-bk-20181-ER
|
Date: September 25, 2019, Time: 10:00 a.m.,
Location: Ctrm. 1568, Roybal Federal Building, 255 East Temple Street, Los Angeles, CA 90012
|
Signed September 26, 2019

Synopsis
Background: Chapter 11 debtors sought authorization to sell provider agreements to purchaser of debtors' hospitals free and clear of all interests.

Holdings: The Bankruptcy Court, Ernest M. Robles, J., held that:

[1] provider agreements between hospitals owned by debtors and the California Department of Health Care Services (DHCS) were in nature of statutory entitlements, and not contracts, and did not need to be assumed to be transferred

[2] provider agreements could be sold, outside the ordinary course of debtors' business, in same fashion as other estate assets; and

[3] agreements could be transferred to purchaser of debtors' assets free and clear of all liabilities which the DHCS alleged had attached thereto, including hospitals' obligation for past-due Hospital Quality Assurance (HQA) fees.

Authorization granted.

Procedural Posture(s): Motion to Sell Property Free and Clear of Interests.

West Headnotes (10)

[1] **Bankruptcy** Executory nature in general
"Executory contract," as that term is used in the Bankruptcy Code, is a contract that neither party has finished performing. 11 U.S.C.A. § 365.

[2] **Bankruptcy** Executory nature in general
Provider agreements between hospitals owned by Chapter 11 debtors and the California Department of Health Care Services (DHCS)

could qualify as "executory contracts," such as could be transferred to purchaser of debtors' assets if debtors assumed the agreements after curing their alleged defaults thereunder, only if these provider agreements constituted "contracts" in the first place and not, as asserted by debtors, mere statutory entitlements. 11 U.S.C.A. § 365.

[3] **Bankruptcy** Construction and Operation

Terms not defined in the Bankruptcy Code have the meaning accorded to them under nonbankruptcy law.

[4] **Bankruptcy** Effect of state law in general

Property interests in bankruptcy are created and defined by state law.

[5] **Bankruptcy** Effect of state law in general

Unless some federal interest requires a different result, there is no reason why state law property interests should be analyzed differently simply because an interested party is involved in a bankruptcy proceeding.

[6] **Bankruptcy** Contracts Assumable; Assignability

Provider agreements between hospitals owned by Chapter 11 debtors and the California Department of Health Care Services (DHCS) were in nature of statutory entitlements, and not contracts, and did not need to be assumed by debtors, after debtors cured their defaults thereunder or provided adequate assurance of such a cure, in order to be transferred to purchaser of debtors' assets; provider agreements did not impose any obligations on the DHCS, but merely allowed hospitals to obtain reimbursement from government for providing healthcare services. 11 U.S.C.A. § 365.

[7] **Contracts** Mutuality of Obligation

Key feature of all contracts is obligations imposed on both parties to the agreement.

[8] **Contracts** Necessity in general

Agreement to comply with applicable law is a gratuitous promise, which does not provide the consideration necessary to make a contract enforceable.

[9] **Bankruptcy** Licenses and permits

Bankruptcy Time for sale; emergency and sale outside course of business

Provider agreements between hospitals owned by Chapter 11 debtors and the California Department of Health Care Services (DHCS), which agreements allowed hospitals to obtain reimbursement from government for providing healthcare services, were akin to licenses issued by government agency, and qualified as interests in property, which were included in bankruptcy estates, and which could be sold, outside the ordinary course of debtors' business, in same fashion as other estate assets. 11 U.S.C.A. § 363(b).

[10] **Bankruptcy** Adequate protection; sale free of liens

Provider agreements between hospitals owned by Chapter 11 debtors and the California Department of Health Care Services (DHCS), which agreements allowed hospitals to obtain reimbursement from government for providing healthcare services, could be transferred to purchaser of debtors' assets free and clear of all liabilities which the DHCS alleged had attached to these provider agreements, including hospitals' obligation for past-due Hospital Quality Assurance (HQA) fees, pursuant to bankruptcy statute allowing sales free and clear of such interests if, among other things, interest holder "could be compelled, in a legal or equitable proceeding, to accept a money

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satisfaction of such interest." 11 U.S.C.A. § 363(f)(5).

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MEMORANDUM OF DECISION AUTHORIZING DEBTORS TO SELL MEDI-CAL PROVIDER AGREEMENTS, FREE AND CLEAR OF INTERESTS ASSERTED BY THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, PURSUANT TO § 363(F)(5)

Ernest M. Robles, United States Bankruptcy Judge

At issue is whether Medi-Cal Provider Agreements (the "Provider Agreements") entered into between four hospitals and the California Department of Health Care Services (the "DHCS") are executory contracts which must be transferred pursuant to § 365 of the Bankruptcy Code, or statutory entitlements that may be transferred free and clear of successor liability under § 363 of the Bankruptcy Code. [1] If the Provider ***846** Agreements are executory contracts, the DHCS may be entitled to receive payments potentially in excess of $50 million in connection with the transfer of the Provider Agreements to the purchaser of the Hospitals. By contrast, if the Provider Agreements are statutory entitlements, they can be transferred to the purchaser free and clear of claims and interests under § 363, meaning that the DHCS would receive no payments in connection with the transfer. For the reasons set forth below, the Court finds that the Provider Agreements are statutory entitlements. [2]

I. Facts

On August 31, 2018 (the "Petition Date"), Verity Health System of California ("VHS") and certain of its subsidiaries (collectively, the "Debtors") filed voluntary petitions for relief under Chapter 11 of the Bankruptcy Code. On August 31, 2018, the Court entered an order granting the Debtors' motion for joint administration of the Debtors' Chapter 11 cases. [3]

On May 2, 2019, the Court entered an order approving the sale of substantially all of the assets of four of the Debtors' hospitals—St. Francis Medical Center, St. Vincent Medical Center, St. Vincent Dialysis Center, and Seton Medical Center (collectively, the "Hospitals")—to Strategic Global Management, Inc. ("SGM"). [4]

Each of the Hospitals has executed a Provider Agreement with the DHCS. The Asset ***847** Purchase Agreement (the "APA") [Doc. No. 2305-1] which governs the sale of the Hospitals to SGM provides that the sale cannot close unless issues regarding alleged financial defaults existing under each Provider Agreement have been resolved. [5]

Pursuant to Cal. Welf. & Inst. Code § 14169.52(a), each of the Hospitals is required to pay a quarterly Hospital Quality Assurance Fee (an "HQA Fee") to the DHCS, which is assessed regardless of whether the hospital participates in the Medi-Cal Program. *See* Cal. Welf. & Inst. Code § 14169.52(a) (imposing the HQA Fee upon "each general acute care hospital that is not an exempt facility"). As this Court has previously explained, the "HQA Fee allows California to obtain more healthcare funds from the federal government, which generally matches state Medi–Cal contributions dollar-for-dollar." *In re Gardens Reg'l Hosp. & Med. Ctr., Inc.*, 569 B.R. 788, 791 (Bankr. C.D. Cal. 2017), *aff'd*, No. 2:16-BK-17463-ER, 2018 WL 1354334 (9th Cir. BAP Mar. 12, 2018) ("*Gardens II*").

According to the DHCS, the Debtors are liable for approximately $30 million in HQA Fees attributable to the Hospitals. DHCS asserts that the Provider Agreements associated with each Hospital cannot be transferred to SGM unless the Debtors first assume the Provider Agreements under § 365 of the Bankruptcy Code. In the process of assuming the Provider Agreements, the Debtors would be required to cure the unpaid HQA Fees, or provide adequate

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assurance that the unpaid HQA Fees would be promptly cured.

The Debtors receive Medi-Cal fee-for-service payments on account of medical services provided to Medi-Cal beneficiaries by the Hospitals. DHCS asserts that the Debtors are liable for approximately $25 million in Medi-Cal fee-for-service overpayments, and that such overpayments must also be cured in connection with the assumption of the Provider Agreements. The Debtors dispute the validity of the audit that resulted in the calculation of the overpayments.

The Debtors contend that the Provider Agreements are not contracts and that it is therefore unnecessary for the Debtors to assume the Provider Agreements under § 365 in order to transfer the agreements to SGM. According to the Debtors, the Provider Agreements are a statutory entitlement to participate in the Medi-Cal program and should be treated as licenses that can be sold, free and clear of claims, interests, and encumbrances, pursuant to § 363(f). In support of the contention that the Provider Agreements are not contracts, Debtors argue that the Provider Agreements do not impose any obligations upon the DHCS. Debtors maintain that the only obligations existing under the Provider Agreements are those that are already imposed under applicable law, and that an agreement to comply with applicable law "is a gratuitous promise which does not provide the consideration necessary to make a contract enforceable." *Gardens II*, 569 B.R. at 797.

The Official Committee of Unsecured Creditors (the "Committee") agrees with the Debtors that the Provider Agreements are not contracts. Like the Debtors, the Committee takes the position that the Provider Agreements are assets of the Debtors' respective estates that can be sold free and clear of all interests pursuant to § 363(f).

II. Discussion

If the Provider Agreements are executory contracts, they can be transferred to ***848** SGM only if they are first assumed by the Debtors. To assume an executory contract, the Debtors must either cure all defaults under the contract, or provide adequate assurance that the defaults will be cured promptly. § 365(b).

[1] **[2]** An executory contract is "a contract that neither party has finished performing." *Mission Prod. Holdings, Inc. v. Tempnology, LLC*, —— U.S. ——, 139 S. Ct. 1652, 1657, 203 L. Ed. 2d 876 (2019). Of course, an agreement that is not a contract can never qualify as an executory contract.

[3] **[4]** **[5]** Terms not defined in the Bankruptcy Code have the meaning accorded to such terms under nonbankruptcy law. *See* *Mission Prod. Holdings*, 139 S.Ct. at 1661 ("And 'breach' is neither a defined nor a specialized bankruptcy term. It means in the Code what it means in contract law outside bankruptcy."). The Bankruptcy Code does not define the term "contract," so the term has the same meaning under § 365 of the Bankruptcy Code as it does under non-bankruptcy law. As the Supreme Court has explained, "[p]roperty interests are created and defined by state law. Unless some federal interest requires a different result, there is no reason why such interests should be analyzed differently simply because an interested party is involved in a bankruptcy proceeding." *Butner v. United States*, 440 U.S. 48, 55, 99 S. Ct. 914, 918, 59 L. Ed. 2d 136 (1979).

A. The Provider Agreements Are Not Contracts

[6] The first issue the Court must confront, then, is whether the Provider Agreements are contracts. The Court finds that they are not. [6]

The Court's determination of whether the Provider Agreements are contracts is informed by decisions involving Medicare Provider Agreements. For purposes of this issue, there are no meaningful differences between the Provider Agreements and a Medicare Provider Agreement. Both types of agreements allow hospitals to obtain reimbursement from the government for providing healthcare services. In both cases, the hospitals' reimbursement entitlement is dictated by the Medicare statute and the regulations promulgated thereunder. [7]

***849** In *PAMC, Ltd. v. Sebelius*, 747 F.3d 1214, 1221 (9th Cir. 2014), the Ninth Circuit declined to apply the contract doctrine of "substantial compliance" to a Medicare Provider Agreement. In that case, PAMC, a hospital, appealed the decision of the Secretary of the Department of Health and Human Services to reduce the reimbursements for which PAMC was eligible. *Id.* at 1215–16. PAMC's reimbursements had been reduced because it had submitted certain required

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data 28 minutes late. *Id.* at 1216. In challenging the Secretary's decision to reduce its reimbursement eligibility, PAMC argued, among other things, that it had substantially complied with the terms of its Medicare Provider Agreement. *Id.* at 1220. The Ninth Circuit rejected PAMC's attempt to avail itself of the contract doctrine of "substantial compliance":

> [T]he whole notion of importing contract doctrines into an area that is a complex statutory and regulatory scheme is problematic. We have, on occasion, stated that providers and others have contracts with the government in this area, but our decisions have turned on the regulatory regime rather than on contract principles. *See, e.g.*, *United States v. Bourseau*, 531 F.3d 1159, 1162, 1169–70 (9th Cir.2008); *Pac. Coast Med. Enters. v. Harris*, 633 F.2d 123, 125 n. 1, 133–35 (9th Cir.1980). As the Eleventh Circuit Court of Appeals held when hospitals complained of legislative impairment of their contract rights in this area because they had agreements with the Secretary: "Upon joining the Medicare program, however, the hospitals received a statutory entitlement, not a contractual right." *Mem'l Hosp. v. Heckler*, 706 F.2d 1130, 1136 (11th Cir.1983); *see also* *Bennett v. Ky. Dep't of Educ.*, 470 U.S. 656, 669, 105 S.Ct. 1544, 1552, 84 L.Ed.2d 590 (1985) (stating that while states had "grant agreements" with the federal government and those had a "contractual aspect," the program should not be viewed like a "bilateral contract" and should not "be construed most strongly against the drafter" (internal quotation marks omitted)); *cf.* *Sebelius v. Auburn Reg'l Med. Ctr.*, [568] U.S. [145, 159–63],133 S.Ct. 817, 828–29, 184 L.Ed.2d 627 (2013) (declining to apply equitable tolling principles to time set by Secretary for appealing to the Board); *Kaiser Found. Hosps.* [*v. Sebelius*], 649 F.3d [1153]at 1160[(9th Cir. 2011)] (declining to apply excusable neglect equitable analysis to Board's dismissal of case for "failure to timely submit a position paper").

PAMC, Ltd. v. Sebelius, 747 F.3d 1214, 1221 (9th Cir. 2014).

Other courts have been even more explicit in stating that a Medicare Provider Agreement is not a contract. In *Mem'l Hosp. v. Heckler*, cited with approval in *PAMC*, hospitals argued that new legislation reducing their Medicare reimbursement entitlements constituted "an unconstitutional taking of their property without just compensation in violation of the fifth amendment, because it would abrogate a vested contractual right to Medicare reimbursement." *Heckler*, 706 F.2d 1130, 1136 (11th Cir. 1983). The *Heckler* court squarely rejected the hospitals' contention that their Medicare Provider Agreements were contracts: "Upon joining the Medicare program, however, the hospitals received a statutory entitlement, not a contractual right." *Heckler*, 706 F.2d at 1136.

Significantly, the *Heckler* court observed that "[c]ourts have upheld retroactive adjustments in the Medicare reimbursement ***850** system." *Id.* It emphasized that such retroactive adjustments were permissible precisely because Medicare Provider Agreements were not contracts. *Id.* A similar result was reached in *Germantown Hosp. & Med. Ctr. v. Heckler*, 590 F. Supp. 24, 30–31 (E.D. Pa. 1983), *aff'd sub nom. Germantown Hosp. & Med. Ctr. v. Schweiker*, 738 F.2d 631 (3d Cir. 1984), in which the court held:

> There is no contractual obligation requiring [the Department of Health and Human Services] to provide Medicare reimbursement. Rather, upon joining the Medicare program, providers gain a statutory entitlement to reimbursement. Thus the amount of reimbursement is governed not by contract but by statute; specifically the Medicare Act's "reasonable cost" provisions.

Germantown, 590 F.Supp. at 30–31. *See also Greater Dallas Home Care All. v. United States*, 10 F. Supp. 2d 638, 647 (N.D. Tex. 1998) ("Plaintiffs argue that the Medicare participation agreements ... are essentially contracts. The Court disagrees and finds that the participation agreements are not contracts, for the right to receive payments under the Medicare Act is a manifestation of Government policy and, as such, is a statutory rather than a contractual right.").

Similarly, in *Guzman v. Shewry*, the Ninth Circuit held that a Medi-Cal Provider Agreement was not a contract. 552 F.3d 941 (9th Cir. 2009). In *Guzman*, a physician sought a preliminary injunction to prevent the DHCS from temporarily suspending him from the Medi-Cal program. *Id.* at 946. Among other things, the physician argued that because his suspension deprived him of the ability to receive reimbursement for treating Medi-Cal patients, he had been

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deprived of his right to contract with the state. *Id.* at 954. Rejecting this argument, the court held that "[p]articipation in the Medi-Cal program entitles Guzman to reimbursement for treating patients who receive Medi-Cal benefits; it does not involve bidding on government contracts." *Id.*

[7] **[8]** In addition, the Provider Agreements lack a key feature found in all contracts—obligations imposed on both parties to the agreements. The Provider Agreements impose no obligations upon the DHCS. The only obligations spoken of in the Provider Agreements pertain to the Debtors. Even these obligations do not constitute consideration for contract purposes, since they merely restate the Debtors' pre-existing legal obligations.[8] As this Court has previously held, "an agreement to comply with applicable law is a gratuitous ***851** promise which does not provide the consideration necessary to make a contract enforceable." *Gardens II*, 569 B.R. at 797.

DHCS cites a number of cases in which courts have held that Medicare Provider Agreements are executory contracts. These authorities are not persuasive, because the issue of whether the provider agreements were executory contracts versus statutory entitlements was not litigated. Instead, the courts simply assumed, without meaningful analysis, that the provider agreements were executory contracts.

For example, in *In re University Medical Center*, 973 F.2d 1065 (3d Cir. 1992), the Third Circuit assumed that a Medicare Provider Agreement was an executory contract, even though the Third Circuit had ruled eight years prior in *Germantown Hosp. & Med. Ctr. v. Schweiker*, 738 F.2d 631, 632 (3d Cir. 1984) that Medicare Provider Agreements are statutory entitlements, not contracts. In *Germantown*, the court rejected the argument that a reduction in Medicare reimbursement rates impaired the contract rights of the Medicare providers. *Id.* The *University Medical Center* decision contained no discussion of *Germantown* and made no attempt to reconcile *Germantown*'s holding that reductions to Medicare reimbursement rates did not amount to a breach of contract. Similarly, in *In re Heffernan Memorial Hospital District*, 192 B.R. 228, 231 n.4 (Bankr. S.D. Cal. 1996), the issue was not litigated and the debtor appeared to concede that the provider agreement was an executory contract. Likewise, in *In re St. Johns Home Health Agency, Inc.*, 173 B.R. 238 (Bankr. S.D. Fla. 1994), the debtor conceded that the provider agreement was an executory contract, and the Bankruptcy Court disregarded prior binding Eleventh Circuit precedent rejecting the contention that a provider agreement gave the provider "a vested contractual right to Medicare reimbursement." *Mem'l Hosp. v. Heckler*, 706 F.2d 1130, 1136 (11th Cir. 1983).

B. The Provider Agreements Can Be Sold Free and Clear of Liens, Claims, and Interests Pursuant to § 363(f)(5)

[9] Having found that the Provider Agreements are not contracts and therefore are not subject to assumption and assignment under § 365, the Court must determine whether the Provider Agreements can be sold free and clear of liens, claims, and interests under § 363(f).

Courts have held that interests such as the Provider Agreements constitute "property of the estate" under § 541 that may be sold under § 363. In *Matter of Fugazy Exp., Inc.*, 124 B.R. 426, 430 (S.D.N.Y. 1991), the court held that a license issued by the Federal Communications Commission was property of the estate, notwithstanding a provision within the Federal Communications Act providing that the Act did not create ownership rights in licenses. The holding is consistent with Ninth Circuit precedent stating that "[g]overnment licenses, as a general rule, are considered to be 'general intangibles' under the Uniform Commercial Code, 'i.e., personal property interests in which security interests may be perfected.' " *MLQ Inv'rs, L.P. v. Pac. Quadracasting, Inc.*, 146 F.3d 746, 749 (9th Cir. 1998).

The Court finds that the Provider Agreements are akin to a license issued by a government agency, and therefore that the Provider Agreements may be sold under § 363. The Provider Agreements create a statutory entitlement to bill the Medi-Cal program for providing services to Medi-Cal beneficiaries. *See* *Guzman*, 552 F.3d at 954 (stating that "[p]articipation in the Medi-Cal program entitles [physician] Guzman to reimbursement for treating patients who receive Medi-Cal benefits"). This right ***852** to receive reimbursement for providing healthcare services is a property interest.

DHCS contends that the Hospitals hold no property interest in the Provider Agreements and that as a result, the Provider Agreements cannot be sold under § 363. In support of

its position, DHCS cites *Erickson v. U.S. ex rel. Dep't of Health & Human Servs.*, 67 F.3d 858, 862 (9th Cir. 1995), in which the court held that a physician convicted of submitting false claims to Medicare did "not possess a property interest in continued participation in Medicare, Medicaid, or the federally-funded state health care programs." *Id.*

DHCS ignores the difference between a property interest in the right to *continue* to participate in Medi-Cal and a property interest in the *existing* right to bill Medi-Cal for providing services. *Erickson* stands for the unremarkable proposition that a provider who engages in criminal conduct has no right to continue as a provider. No one disputes that if the Hospitals violated Medi-Cal statutes or regulations, their right to continue as Medi-Cal Providers could be suspended. But at present, the Provider Agreements are in good standing and the Hospitals have the right to receive reimbursements for providing services to Medi-Cal beneficiaries. It is this right that amounts to a property interest.

[10] The Provider Agreements may be sold free and clear of the liabilities which DHCS contends attach to the Provider Agreements. This includes the alleged liabilities for approximately $30 million in unpaid HQA Fees and $25 million in Medi-Cal overpayments (collectively, the "Liabilities"). [9]

Section 363(f)(1) provides that a sale of estate property may be "free and clear of any interest in such property of an entity other than the estate" if certain conditions are satisfied. As this Court has previously explained:

> The Bankruptcy Code does not define the phrase "interest in ... property" for purposes of § 363(f). The Third Circuit has held that the phrase "interest in ... property" is "intended to refer to obligations that are connected to, or arise from, the property being sold." *Folger Adam Sec., Inc. v. DeMatteis/MacGregor JV*, 209 F.3d 252, 259 (3d Cir. 2000). That conclusion is echoed by *Collier on Bankruptcy*, which observes a trend in caselaw "in favor of a broader definition [of the phrase] that encompasses other obligations that may flow from ownership of the property." 3 Alan N. Resnick & Henry J. Sommer, *Collier on Bankruptcy* ¶ 363.06[1] (16th ed. 2017).
>
> Courts have held that interests in property include monetary obligations arising from the ownership of property, even when those obligations are imposed by statute. For example, in *Mass. Dep't of Unemployment Assistance v. OPK Biotech, LLC (In re PBBPC, Inc.)*, 484 B.R. 860 (1st Cir. BAP 2013), the court held that taxes assessed by Massachusetts under its unemployment insurance statutes constituted an "interest in ... property." The taxes were computed based on the Debtor's "experience rating," which was determined by the number ***853** of employees it had terminated in the past. *Id.* at 862. Because the Debtor had terminated most of its employees prior to selling its assets, its experiencing rating, and corresponding unemployment insurance tax liabilities, were very high. *Id.* The *PBBPC* court held that the experience rating was an interest in property that could be cut off under § 363(f). *Id.* at 869–70. Similarly, in *United Mine Workers of Am. Combined Benefit Fund v. Leckie Smokeless Coal Co. (In re Leckie Smokeless Coal Co.)*, 99 F.3d 573, 581 [(4th Cir. 1996)], the court held that monetary obligations imposed by the Coal Industry Retiree Health Benefit Act of 1992 constituted an "interest in ... property" within the meaning of § 363(f).
>
> *In re Gardens Reg'l Hosp. & Med. Ctr., Inc.*, 567 B.R. 820, 825–26 (Bankr. C.D. Cal. 2017), *appeal dismissed*, No. 2:16-BK-17463-ER, 2018 WL 1229989 (C.D. Cal. Jan. 19, 2018).

The Liabilities are an "interest in property" within the meaning of § 363(f). The Liabilities arise because the Hospitals have elected to exercise their statutory entitlement to provide medical services, and receive reimbursement for providing such services, under the Provider Agreements. As such, the Liabilities are a monetary obligation arising from the ownership of property (the property being the reimbursement rights associated with the Provider Agreements).

The Provider Agreements may be sold free and clear of the Liabilities only if one or more of the conditions specified in § 363(f)(1)–(5) is satisfied. Here, the Court finds that § 363(f)(5) is satisfied. Under § 363(f)(5), property may be sold free and clear of an interest, if the entity holding the interest "could be compelled, in a legal or equitable proceeding, to accept a money satisfaction of such interest."

The interest that DHCS holds in the Provider Agreements is its right to receive payment of the Liabilities. DHCS could be compelled to accept a money satisfaction of its

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interest in a legal or equitable proceeding. In fact, receiving a money satisfaction is and has been DHCS' objective all along. Throughout these cases, DHCS has withheld funds payable to the Hospitals to recover the Liabilities.[10] That DHCS would accept a money satisfaction is apparent in its briefing. DHCS states that the Debtors must "pay the debt through the proceeds of the sale" or "within five days of the closing of the sale," and that the Debtors "must establish and maintain a trust account in the amount of $70 million for 36 months for potential reimbursement to [DHCS] of any Medi-Cal overpayment ...."[11]

The case of *In re P.K.R. Convalescent Centers, Inc.*, 189 B.R. 90, 91 (Bankr. E.D. Va. 1995) is directly on point. In *In re PKR Convalescent Centers*, the court approved the sale of a nursing home, free and clear of the interest held by the Virginia Department of Medical Assistance Service (the "DMAS"), pursuant to § 363(f)(5). The interest in question was DMAS' right under Virginia law to recapture, upon the sale of the nursing home, depreciation payments it had previously made to the operators of the nursing home. The court held that DMAS' interest would be extinguished if it received the $1.7 million in depreciation recapture payments it was owed under the statute, and that accordingly, DMAS could be compelled, in a legal ***854** or equitable proceeding, to accept a money satisfaction of its interest. *Id.* at 94.

As was the case in *PKR Convalescent Centers*, DHCS' interest in the Provider Agreements would be extinguished if it received the payments it contends it is owed on account of the Liabilities. Consequently, DHCS could be compelled to accept a money satisfaction of its interest. The Provider Agreements may be sold free and clear of DHCS' interest under § 363(f)(5).

The Debtors request that the order on the Motion state that DHCS' recoupment rights against SGM, if any, must be first exercised against payments due to the Debtors from Medi-Cal, then against funds held by the Debtors generated by past interim Medi-Cal payments, and then against any sale proceeds generated by the sale of the Provider Agreement. The issue of the applicability of recoupment subsequent to the sale of the Provider Agreements free and clear of claims and interests has not been sufficiently briefed. The Court declines to decide the issue at present, without prejudice to the ability of interested parties to raise the issue by way of motion.

DHCS requests that the order on the Motion be stayed for 14 days, pursuant to Bankruptcy Rule 6004(h). The purpose of Bankruptcy Rule 6004(h) is to provide sufficient time for an objecting party to appeal before an order can be implemented. The sale to SGM is not expected to close until mid-to-late October 2019. Because the Provider Agreements will not be transferred to SGM until the sale closes, the stay imposed by Bankruptcy Rule 6004(h) is not necessary to protect DHCS' right to appeal.

III. Conclusion

Based upon the foregoing, the Debtors are authorized to sell the Provider Agreements to SGM, free and clear of claims, interests, and encumbrances, pursuant to § 363(f)(5). The Debtors shall submit an order consistent with this Memorandum of Decision.

All Citations

606 B.R. 843, 67 Bankr.Ct.Dec. 204

Footnotes

1 Unless otherwise indicated, all "Civil Rule" references are to the Federal Rules of Civil Procedure, Rules 1–86; all "Bankruptcy Rule" references are to the Federal Rules of Bankruptcy Procedure, Rules 1001–9037; all "Evidence Rule" references are to the Federal Rules of Evidence, Rules 101–1103; all "LBR" references are to the Local Bankruptcy Rules of the United States Bankruptcy Court for the Central District of California, Rules 1001-1–9075-1; and all statutory references are to the Bankruptcy Code, 11 U.S.C. §§ 101–1532.

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2 The Court considered the following papers in adjudicating this matter:

1) Debtors' Memorandum in Support of Entry of an Order: (A) Authorizing the Sale of Property Free and Clear of all Claims, Liens and Encumbrances; (B) Authorizing the Assumption and Assignment of Designated Executory Contracts and Unexpired Leases; and (C) Granting Related Relief [Doc. No. 2115] (the "Sale Motion");

2) Creditor California Department of Health Care Services's Objection to Notice to Counterparties to Executory Contracts and Unexpired Leases of the Debtors that May be Assumed and Assigned [Doc. No. 1879];

3) Creditor California Department of Health Care Services's Supplemental Objection to (1) Debtors' Motion for the Entry of an Order Authorizing the Sale of Property Free and Clear of All Claims, Liens, and Encumbrances; (2) Approving Form of Asset Purchase Agreement [Doc. No. 3043];

4) Official Committee of Unsecured Creditors' Reply to Creditor California Department of Health Care Services's Supplemental Objection to Sale [Doc. No. 3093];

5) Debtors' Reply to California Department of Health Care Services Objection to Debtors' Sale of Assets to Strategic Global Management [Doc. No. 3095];

a) Objection to Declaration of Hanh Vo in Support of Creditor California Department of Health Care Services's Supplemental Objection to (1) Debtors' Motion for the Entry of an Order Authorizing the Sale of Property Free and Clear of All Claims, Liens, and Encumbrances; (2) Approving Form of Asset Purchase Agreement [Doc. No. 3115];

b) Declaration of Anita Chou in Support of Debtors' Reply to the California Department of Health Care Services' Objection to Debtors' Sale of Assets to Strategic Global Management [Doc. No. 3112]; and

c) Notice of Debtors' Request to Bifurcate Hearing Regarding California Department of Health Care Services' Objection to Debtors' Sale of Assets to Strategic Global Management [Doc. No. 3113].

3 Doc. No. 17.

4 Doc. No. 2306 (the "SGM Sale Order").

5 APA at ¶ 8.7.

6 In *Gardens II*, the Court found that under the principle of equitable recoupment, DHCS could withhold Medi-Cal and supplemental quality assurance payments owed to a debtor, for the purpose of recovering unpaid hospital quality assurance fees owed by the debtor. *Gardens II* did not decide whether a Medi-Cal Provider Agreement was a contract or a statutory entitlement akin to a license, as the issue did not affect the outcome of the decision:

> The Court finds that, regardless of whether the Provider Agreement is considered a license or contract, the Debtor's HQA Fee liability and entitlement to Medi-Cal Payments would still arise from the same transaction or occurrence.... As discussed previously, the Debtor's acknowledgment in the Provider Agreement that unpaid HQA Fees could be withheld from its Medi-Cal Payments establishes the necessary logical relationship between the Debtor's fee liabilities and its payment entitlements. That logical relationship exists whether the Provider Agreement is classified as a license or a contract.

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Gardens II, 569 B.R. at 799.

In support of its argument that the Provider Agreements are executory contracts, DHCS cites the observation made in *Gardens II* that Medicare Provider Agreements "are similar in many respects to ... [a] Medi-Cal Provider Agreement." *Gardens II*, 569 B.R. at 799 n.12. DHCS then cites decisions holding that Medicare Provider Agreements are executory contracts. As discussed in greater detail below, the Court does not find the decisions cited by DHCS to be persuasive, because they reached the conclusion that Medicare Provider Agreements are executory contracts without meaningful analysis.

7 Because the Medi-Cal program is funded in part by federal funds, reimbursement entitlements under Medi-Cal must be consistent with the provisions of the Medicare statute. *See generally* 42 U.S.C. § 1396a (setting forth requirements applicable to state medical assistance plans such as Medi-Cal).

8 DHCS cites a number of provisions within the Provider Agreement that it claims constitute consideration sufficient to render the Provider Agreements contractual in nature. But all of the following provisions cited by DHCS are restatements of legal obligations imposed upon the Debtors by federal law, federal regulations, state law, or state regulations:

1) Debtors will be subject to the sanctions available to DHCS if they fail to comply with applicable law.

2) To submit a treatment authorization request, the Debtors must use a National Provider Identifier ("NPI") that is appropriately registered and is compliant with all NPI requirements.

3) Debtors cannot engage in conduct inimical to public health, morals, welfare, or safety.

4) Debtors cannot refuse healthcare services based upon race, color, ancestry, marital status, national origin, gender, age, economic status, or physical or mental disability.

5) Only qualified medical personnel may provide healthcare services.

6) Any overpayments must be repaid by the Debtors in accordance with applicable statutes and regulations.

7) Debtors are subject to certain automatic and permissive suspensions and mandatory and permissive exclusions.

9 The Debtors object to declaration testimony submitted by Hanh Vo with respect to the amount of the Liabilities. As a result of its determination that the Provider Agreements may be sold free and clear of the Liabilities, it is not necessary for the Court to adjudicate the amount of the Liabilities at this time. Because the Court has not considered the Vo declaration in reaching its decision, the Court does not rule upon the Debtors' evidentiary objection. *See* *Operating Engineers' Pension Trust Fund v. Clark's Welding & Mach.*, 688 F. Supp. 2d 902, 907 (N.D. Cal. 2010) ("Because the Court does not rely on the statements in this declaration, it is not necessary for the Court to rule on these objections.").

10 DHCS asserts that its withholdings are authorized under the equitable principle of recoupment. As the issue is not presently before it, the Court expresses no opinion on whether the withholdings are permissible under recoupment principles.

11 Doc. No. 3043 at 10.

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United States Bankruptcy Court, C.D. California.

IN RE: VERITY HEALTH SYSTEM OF CALIFORNIA, INC., et al., Debtors and Debtors in Possession.

#Affects All Debtors
☐Affects Verity Health System of California, Inc.
☐Affects O'Connor Hospital
☐Affects Saint Louise Regional Hospital
☐Affects St. Francis Medical Center
☐Affects St. Vincent Medical Center
☐Affects Seton Medical Center
☐Affects O'Connor Hospital Foundation
☐Affects Saint Louise Regional Hospital Foundation
☐Affects St. Francis Medical Center of Lynwood Medical Foundation
☐Affects St. Vincent Foundation
☐Affects St. Vincent Dialysis Center, Inc.
☐Affects Seton Medical Center Foundation
☐Affects Verity Business Services
☐Affects Verity Medical Foundation
☐Affects Verity Holdings, LLC
☐Affects De Paul Ventures, LLC
☐Affects De Paul Ventures - San Jose Dialysis, LLC, Debtors and Debtors in Possession.,

Lead Case No.: 2:18-bk-20151-ER
|
Jointly Administered With: Case No. 2:18-bk-20162-ER; Case No. 2:18-bk-20163-ER; Case No. 2:18-bk-20164-ER; Case No. 2:18-bk-20165-ER; Case No. 2:18-bk-20167-ER; Case No. 2:18-bk-20168-ER; Case No. 2:18-bk-20169-ER; Case No. 2:18-bk-20171-ER; Case No. 2:18-bk-20172-ER; Case No. 2:18-bk-20173-ER; Case No. 2:18-bk-20175-ER; Case No. 2:18-bk-20176-ER; Case No. 2:18-bk-20178-ER; Case No. 2:18-bk-20179-ER; Case No. 2:18-bk-20180-ER; Case No. 2:18-bk-20181-ER;
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Signed January 9, 2020
|
Date: January 8, 2020, Time: 10:00 a.m., Location: Ctrm. 1568, Roybal Federal Building, 255 East Temple Street, Los Angeles, CA 90012

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MEMORANDUM OF DECISION GRANTING DEBTORS' EMERGENCY MOTION FOR AUTHORIZATION TO CLOSE ST. VINCENT MEDICAL CENTER

Ernest M. Robles, United States Bankruptcy Judge

***1** Before the Court is the Debtors' emergency motion (the "Motion") for authorization to implement a plan to close St. Vincent Medical Center and St. Vincent Dialysis Center, Inc. (collectively, "St. Vincent"). The Court conducted a hearing on the Motion at the above-captioned date and time. Because the Motion was heard on an emergency basis, the Court allowed parties who had not filed a written opposition to the Motion to present arguments at the hearing. [1] For the reasons set forth below, the Motion is GRANTED.

I. Facts

On August 31, 2018 (the "Petition Date"), Verity Health System of California ("VHS") and certain of its subsidiaries (collectively, the "Debtors") filed voluntary petitions for relief under Chapter 11 of the Bankruptcy Code. The Debtors' cases are being jointly administered.

As of the Petition Date, the Debtors operated six acute care hospitals in the state of California. On December 27, 2018, the Court authorized the Debtors to sell two of their hospitals —O'Connor Hospital and Saint Louise Regional Hospital—

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to Santa Clara County (the "Santa Clara Sale"). [2] The Santa Clara Sale closed on February 28, 2019.

On February 19, 2019, the Court entered an order establishing bidding procedures (the "Bidding Procedures Order") [3] for the auction of the Debtors' four remaining hospitals—St. Francis Medical Center ("St. Francis"), St. Vincent Medical Center (including St. Vincent Dialysis Center) ("St. Vincent"), Seton Medical Center ("Seton"), and Seton Medical Center Coastside ("Seton Coastside") (collectively, the "Hospitals"). Under the Bidding Procedures Order, Strategic Global Management ("SGM") was designated as the stalking horse bidder. SGM's bid for all four of the Hospitals was $610 million. The Bidding Procedures Order approved an Asset Purchase Agreement (the "APA") between the Debtors and SGM.

***2** The Hospitals were extensively marketed by the Debtors' investment banker, Cain Brothers, a division of KeyBank Capital Markets, Inc. ("Cain Brothers"). Cain Brothers notified ninety parties of the auction process. Sixteen of these parties requested continued access to a data room containing information about the Hospitals.

Notwithstanding Cain Brothers' thorough marketing efforts, the Debtors did not receive any qualified bids for all of the Hospitals. The Debtors received one bid to purchase only St. Vincent and one bid to purchase only St. Francis. After consulting with the Official Committee of Unsecured Creditors (the "Committee") and the largest secured creditors, the Debtors determined not to conduct an auction. On May 2, 2019, the Court entered an order finding that SGM was the winning bidder and approving the sale to SGM (the "SGM Sale"). [4]

On November 27, 2019, the Court entered a memorandum of decision and accompanying order finding that as of November 19, 2019, all conditions precedent under the APA to SGM's obligation to close the SGM Sale had been satisfied. [5] The Court found that pursuant to § 1.3 of the APA, SGM was obligated to close the SGM Sale by no later than December 5, 2019. *Id.* SGM did not close the sale by December 5, 2019. [6] On December 27, 2019, the Debtors sent SGM a notice terminating the APA and asserting that SGM had materially breached the APA. [7]

The Debtors seek authorization to implement a plan to close St. Vincent (the "Closure Plan"). The Debtors assert that there is no buyer interested in purchasing St. Vincent as a going-concern; that the operating losses generated by St. Vincent threaten the viability of the entire Verity Health System; and that if the Debtors do not immediately begin implementing the Closure Plan, they will lack sufficient funds to conduct an orderly closure.

The timeline contemplated by the Closure Plan is as follows (all dates are calculated with reference to entry of an order granting the Motion):

- Order + 1 day: Notify Emergency Medical Services and place St. Vincent on diversion protocol for all patients. Begin process of transferring patients, along with their medical information, to a hospital of their choice.
- Order + 3 days: Complete closure of emergency department.
- Order + 5 days: Cease scheduling all elective procedures.
- Order + 7 days: Conclude and cease all elective surgeries and other procedures.
- Order + 21 days: Complete closure of the dialysis department.
- Order + 30 days: Complete closure of the transplant department.
- Order + 30 days: Complete closure and cease clinical operations.

Summary of the California Nurses Association's Opposition to the Motion

***3** The California Nurses Association (the "CNA"), which represents registered nurses employed at St. Vincent, opposes the Motion. The CNA makes the following arguments and representations in support of its opposition:

The Debtors have not demonstrated that they have provided the notice of the contemplated closure that is required under California law. Specifically, the contemplated closure violates the following provisions of the Cal. Health & Safety Code:

- Cal. Health & Safety Code § 1255.1(a) requires that any hospital providing emergency medical services give 90 days' advance notice of the elimination of such services to "the state department, the local government entity in charge of the provision of health services, and all health care service plans or other entities under contract with

the hospital to provide services to enrollees of the plan or other entity."

- Cal. Health & Safety Code § 1225.1(b) requires a hospital to provide 90 days' advance notice of the closure "in a manner that is likely to reach a significant number of residents of the community" serviced by the hospital.

- Cal. Health & Safety Code § 1255.25(a)(1) requires that not less than 30 days prior to the closure, the hospital (1) post notice of the closure "at the entrance to all affected facilities" and (2) provide notice of the closure to the department and the board of supervisors of the county in which the hospital is located.

- Cal. Health & Safety Code § 1255.25(b)(2) requires that not less than 30 days prior to closure, the hospital provide notice to Medicare and Medi-Cal beneficiaries, including information on the nearest available facilities providing similar healthcare services.

The notification requirements serve a vital role in helping underserved communities prepare for the devastating loss of essential healthcare services. As set forth in a January 7, 2020 letter from California State Senator Maria Elena Durazo and California State Assembly Member Wendy Carrillo, who represent constituents in the district in which St. Vincent is located, closure of the hospital will be "devastating" for the district, and the public notice requirement "is crucial because it gives [the public] time to figure out where patients should be going to receive care in the area" and "ensure[s] workers are not left unemployed ...."

In *Norris Square Civic Ass'n v. St. Mary Hosp. (In re St. Mary Hosp.)*, the Bankruptcy Court enjoined a hospital from closing because it had failed to comply with applicable notice requirements imposed by state law. 86 B.R. 393, 400 (Bankr. E.D. Pa. 1988). The Motion should be denied based on the Debtors' failure to comply with the notice requirements imposed by California law.

The timeframe proposed by the Debtors for closing the emergency department creates an unreasonable risk to public safety. The Debtors plan to close the emergency department within three days after entry of an order granting the Motion. Even if ambulances are placed on diversion status, many residents of the community will still drive to the emergency department to receive care. Based on the most recent filing with the California Office of Statewide Health Planning and Development, the emergency department receives approximately 83 visits per day.

II. Discussion

A. CNA's Opposition to the Motion is Overruled

***4** CNA asserts that the Closure Plan cannot be approved because the Debtors have failed to provide notification of the closure in accordance with the provisions of the Cal. Health & Safety Code. CNA's argument incorrectly assumes that the Cal. Health & Safety Code's notice provisions are controlling within the bankruptcy context.

Title 28 U.S.C. § 959(b) requires the Debtors to "manage and operate the property" in their possession "according to the requirements of the valid laws of the State in which such property is situated, in the same manner that the owner or possessor thereof would be bound to do if in possession thereof." However, § 959(b) applies only to property used in connection with an operating business; it does not apply to property where business operations have ceased and the assets are being liquidated. In *In re Gardens Reg'l Hosp. & Med. Ctr., Inc.*, this Court held that § 959(b) did not apply to the sale of a closed hospital. 567 B.R. 820, 829 (Bankr. C.D. Cal. 2017). *See also* *S.E.C. v. Wealth Mgmt. LLC*, 628 F.3d 323, 334 (7th Cir. 2010) ("Modern courts have ... concluded that § 959(b) does not apply to liquidations"); *Alabama Surface Min. Comm'n v. N.P. Min. Co. (In re N.P. Min. Co., Inc.)*, 963 F.2d 1449, 1460 (11th Cir. 1992) ("A number of courts have held that section 959(b) does not apply when a business's operations have ceased and its assets are being liquidated"); *Saravia v. 1736 18th St., N.W., Ltd. P'ship*, 844 F.2d 823, 827 (D.C. Cir. 1988) (viewing § 959(b) "as applying only to operating businesses, not ones that were in the process of being liquidated").

Upon initiation of the Closure Plan, St. Vincent will enter the process of liquidation and will no longer be an operating business. Therefore, § 959(b) does not require the Debtors to comply with the notice deadlines of the Cal. Health & Safety Code when implementing the Closure Plan.

This case provides a compelling illustration of why the Bankruptcy Court's authority to supervise the use of estate property under § 363(b) must trump the Cal. Health & Safety Code. The Debtors worked to close the SGM Sale, which would have allowed St. Vincent to continue operating, until December 27, 2019. Compliance with the Cal. Health &

Safety Code's notice requirements would have required the Debtors to provide notice that St. Vincent would be closing at a time when the Debtors reasonably expected that the SGM Sale would close. The provision of such notice would have interfered with St. Vincent's operations, disrupting the Debtors' efforts to close the SGM Sale. Premature publication of notice of closure would have harmed employee retention and morale, confused patients, and caused vendors to cease furnishing critical supplies. These serious harms would have undercut the central objective of the § 363 sale process—providing the Debtors the opportunity to realize the optimal value of their assets. *Simantob v. Claims Prosecutor, LLC (In re Lahijani)*, 325 B.R. 282, 288–89 (9th Cir. BAP 2005).

CNA's opposition suffers from an additional defect. As a party in interest, CNA "may appear and be heard on any issue" in these cases. § 1109(b). However, the Court must still assess whether CNA has standing to assert that the Closure Plan violates the Cal. Health & Safety Code. The Court finds that it does not.

The provisions of the Cal. Health & Safety Code cited by CNA are enforced by the California Department of Public Health (the "CDPH"). CDPH did not file a written opposition to the Motion.[8] CNA's opposition essentially seeks to enforce various provisions of the Cal. Health & Safety Code against the Debtors on CDPH's behalf. That is not appropriate, because the Health & Safety Code does not create a private right of action. The California Supreme Court has explained that a private right of action exists under the following circumstances:

> ***5** A violation of a state statute does not necessarily give rise to a private cause of action. Instead, whether a party has a right to sue depends on whether the Legislature has "manifested an intent to create such a private cause of action" under the statute....
>
> A statute may contain " 'clear, understandable, unmistakable terms,' " which strongly and directly indicate that the Legislature intended to create a private cause of action. For instance, the statute may expressly state that a person has or is liable for a cause of action for a particular violation. (See, e.g., Civ.Code, § 51.9 ["A person is liable in a cause of action for sexual harassment" when a plaintiff proves certain elements]; Health & Saf.Code, § 1285, subd. (c) ["Any person who is detained in a health facility solely for the nonpayment of a bill has a cause of action against the health facility for the detention"].) Or, more commonly, a statute may refer to a remedy or means of enforcing its substantive provisions, i.e., by way of an action.

Lu v. Hawaiian Gardens Casino, Inc., 50 Cal. 4th 592, 597, 236 P.3d 346, 348 (2010) (internal citations omitted).

None of the sections cited by CNA contains language expressly creating a private right of action. Further, there is no indication that the legislature intended for private entities to have the ability to enforce those provisions against hospitals. *See Lu*, 50 Cal. 45th at 600 (providing that if a statute does not expressly create a private right of action, there must be a "clear indication" that the legislature intended to do so). To the contrary, the structure of the statute indicates that the legislature delegated enforcement responsibilities solely to the CDPH. The provisions cited by CNA are contained within the chapter of the statute pertaining to licensure. That chapter also contains provisions setting forth the circumstances under which a health facility's license may be revoked, including the manner in which the CDPH must conduct hearings on license revocation. *See* Cal. Health & Safety Code § 1294 (the "state department may suspend or revoke any license or special permit issued under the provisions of this chapter upon any of the following grounds ...."); *id.* at § 100171 (containing procedures for hearings on licensure).

***6** In addition, at least one court has held that a provision contained within Division 2 of the Health & Safety Code (the same division containing the provisions cited by CNA) does not create a private right of action. *See* *John Muir Health v. Glob. Excel Mgmt.*, No. C-14-04226 DMR, 2014 WL 6657656, at *4 (N.D. Cal. Nov. 21, 2014) (dismissing a claim brought under Cal. Health & Safety Code § 13714(b) because the provision did not create a standalone private right of action).

B. The Debtors Are Authorized to Implement the Closure Plan to Effect an Orderly Closure of St. Vincent

Section 363(b) authorizes a debtor to use property of the estate outside the ordinary course of business upon court approval. The debtor must articulate a "business justification" to use property outside the ordinary course of business. *In re Walter*, 83 B.R. 14, 19–20 (B.A.P. 9th Cir. 1988). Whether the articulated business justification is sufficient "depends on the case," in view of "all salient factors pertaining to the proceeding." *Id.* at 19–20.

The Debtors' decision to close St. Vincent constitutes a "use" of estate property within the meaning of § 363(b). The Debtors have articulated a sufficient business justification for closing St. Vincent. The following facts have been established by the declarations submitted in support of the Motion:

- No buyer has presented a realistic bid to purchase St. Vincent as a stand-alone hospital. Moloney Decl. at ¶ 4. Although James M. Moloney, the Debtors' investment banker, had a telephone conversation with a potential bidder on January 6, 2020, that bidder had conducted limited due diligence and did not have experience with the regulatory approval process required to purchase a hospital. *Id.* Further, the bidder's intended use for St. Vincent was as a real-estate investment if the bidder's hospital operating partner could not develop a viable plan to profitably operate St. Vincent. *Id.*

- St. Vincent is generating substantial operating losses. As of the Petition Date, St. Vincent accounted for approximately 23% of the patient volume of the entire Verity Health System, but was responsible for 60% of the operating losses. Chadwick Decl. at ¶ 6. If the Debtors do not implement the Closure Plan rapidly, they will lack sufficient funds to conduct an orderly closure of St. Vincent. Adcock Decl. at ¶ 7.

- The Debtors lack sufficient funds to continue to subsidize St. Vincent's operating losses. Absent the closure of St. Vincent, the Debtors will be unable to continue operating their other hospitals. Chadwick Decl. at ¶ 9.

Since it is not feasible for the Debtors to continue St. Vincent's operations, implementation of the Closure Plan is necessary to sustain public health and welfare. Public safety would be jeopardized if the Debtors allowed St. Vincent to remain open while lacking sufficient funds to support its operations. In this respect, the Court notes that the Debtors do not have the ability to borrow under any debtor-in-possession financing facility. The Debtors' cases are being financed by a consensual cash collateral stipulation executed between the Debtors and the principal secured creditors (the "Cash Collateral Stipulation"). Under the Cash Collateral Stipulation, the Debtors' ability to use cash collateral terminates on January 31, 2020.

CNA asserts that the Debtors are entitled to damages from SGM for its failure to perform under the APA, and that St. Vincent's operations could be funded from these breach damages. CNA overlooks the fact that the Court has not made a finding as to whether SGM has breached the APA. The issue of SGM's alleged breach is subject to ongoing litigation, which will not be resolved in the near term. Sustaining St. Vincent's operations requires immediately available liquidity, which the Debtors lack. The speculative possibility of a future cash infusion based upon SGM's alleged breach is not a solution to St. Vincent's current funding crisis. Nor is pursuing a sale, another alternative suggested by CNA. There are no firm expressions of interest. Even if a buyer was identified, the sale process and review by the Attorney General's office would take months to conclude.

***7** The Closure Plan preserves patient safety. Acute care patients will be transferred to Good Samaritan Hospital, which is located approximately one mile from St. Vincent. Adcock Decl. at ¶ 8. St. Joseph Hospital has agreed to assume care of the kidney transplant patients who are part of the St. Vincent Transplant Program, subject to approval of the United Network for Organ Sharing. *Id.*

1. The Timeline Set Forth in the Closure Plan is Approved, Except that the Deadline for Physicians to Vacate St. Vincent's Medical Office Facilities is Extended by 30 Days

At the hearing, multiple parties testified regarding the impact of the Closure Plan upon physicians, employees, patients, and other stakeholders. Having considered the evidence before it, the Court approves the deadlines set forth in the Closure Plan, with the exception of the deadline for physicians to vacate St. Vincent's medical office facilities, which is extended by 30 days to April 30, 2020.

The Court places substantial weight upon the testimony of Dr. Jacob Nathan Rubin, the Court-appointed Patient Care Ombudsman. Dr. Rubin testified as follows:

- To protect patient safety, St. Vincent must be closed as quickly as possible following the announcement of the hospital's closure. Once closure is announced, key members of St. Vincent's medical staff will immediately leave to seek employment elsewhere. Replacing experienced staff with temporary workers is not feasible because the temporary workers will be unfamiliar with St. Vincent's systems, procedures, and electronic medical records. There will not be a sufficient number of experienced staff remaining to adequately train the large influx of temporary workers. The result

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of the rapid departure of experienced staff will be a marked decline in the quality of patient care, seriously jeopardizing patient safety.

- The transfer of existing patients to other hospitals will not impair patient safety. Patients are routinely transferred from one hospital to another, and the hospital resources within St. Vincent's immediate vicinity are more than sufficient to accommodate St. Vincent's patients.

Alice Kirchner, director of Dialysis Services at St. Vincent, asserted that the Closure Plan did not provide sufficient notice to enable the smooth relocation of patients. Ms. Kirchner stated that the Closure Plan's deadlines were creating stress and trauma for affected patients, staff, and physicians. Ms. Kirchner requested that the Dialysis Unit be provided a minimum of 30 days to relocate patients before being shut down.

In view of Dr. Rubin's testimony, the Court does not find it appropriate to extend the deadlines set forth in the Closure Plan. In fact, Dr. Rubin testified that if the deadlines were to be modified, they should be shortened, not extended. The Court understands the difficulties that the Closure Plan's deadlines place upon stakeholders. However, the Court's first priority must be protecting patient safety, and that requires a rapid closure.

St. Vincent leases office space to physicians who provide outpatient services. Dr. Marc Girsky, St. Vincent's Chief of Staff, stated that the March 31, 2020 deadline for physicians to vacate the office space would not provide physicians adequate time to relocate their practices. Dr. Girsky requested that physicians be provided at least six months to relocate. Dr. Samuel Lee, St. Vincent's former Chief of Staff, and Ryan Yant, counsel for St. Vincent Independent Physicians Association, made statements in support of Dr. Girsky's request. The Court also received a letter signed by numerous physicians who lease office space at St. Vincent requesting that the deadline to relocate by extended to June 30, 2020. [9]

***8** In response to the physicians' requests, the Debtors proposed extending the relocation deadline by 30 days, to **April 30, 2020**. The Court finds the compromise proposed by the Debtors to be appropriate. The April 30 deadline provides physicians approximately four months to relocate.

III. Conclusion

The Court is fully cognizant of the hardship that closure of St. Vincent will have upon employees and members of the surrounding community. The absence of any serious purchaser willing to acquire St. Vincent as a going-concern has placed all constituencies in this case in a difficult position. However, forcing the Debtors to keep St. Vincent open when there is insufficient money to operate it would only make the situation far worse for St. Vincent and for the patients of the Debtor's other hospitals.

The Motion is **GRANTED** to the extent set forth herein. Notwithstanding Bankruptcy Rule 6004(h), the order granting the Motion shall take effect immediately upon entry. By no later than **January 23, 2020**, the Debtors shall submit a Status Report regarding implementation of the Closure Plan. Subsequent Status Reports shall be submitted every fourteen days until the Closure Plan has been fully implemented. [10] The Court will enter an order consistent with this Memorandum of Decision.

All Citations

Slip Copy, 2020 WL 223909

Footnotes

1 In addition to the oral presentations made at the hearing, the Court considered the following papers in adjudicating the Motion:

1) Debtors' Emergency Motion for Authorization to Close St. Vincent Medical Center (the “Motion”) [Doc. No. 3906];

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a) Order Setting Hearing on Debtors' Emergency Motion for Authorization to Close St. Vincent Medical Center [Doc. No. 3907];

b) Notice of Hearing on Debtors' Emergency Motion for Authorization to Close St. Vincent Medical Center [Doc. No. 3909];

c) Declaration of Service by Kurtzman Carson Consultants, LLC Regarding Docket Numbers 3906, 3907 and 3909 [Doc. No. 3913];

2) Opposition by California Nurses Association to Debtors' Emergency Motion for Authorization to Close St. Vincent Medical Center [Doc. No. 3914];

3) Opposition to Emergency Motion Filed by Marc Girsky, M.D., Chief of Staff of St. Vincent Medical Center [Doc. No. 3916]; and

4) Opposition to Emergency Motion Filed by Samuel K. Lee [Doc. No. 3926].

2 For a description of the Santa Clara Sale, see *In re Verity Health Sys. of California, Inc.*, 598 B.R. 283 (Bankr. C.D. Cal. 2018) ("*Verity I*").

3 *See* Order (1) Approving Form of Asset Purchase Agreement for Stalking Horse Bidder and for Prospective Overbidders, (2) Approving Auction Sale Format, Bidding Procedures and Stalking Horse Bid Protections, (3) Approving Form of Notice To Be Provided to Interested Parties, (4) Scheduling a Court Hearing to Consider Approval of the Sale to the Highest Bidder and (5) Approving Procedures Related to the Assumption of Certain Executory Contracts and Unexpired Leases; and (II) An Order (A) Authorizing the Sale of Property Free and Clear of All Claims, Liens and Encumbrances [Doc. No. 1572].

4 *See* Order (A) Authorizing the Sale of Certain of the Debtors' Assets to Strategic Global Management, Inc. Free and Clear of Liens, Claims, Encumbrances, and Other Interests; (B) Approving the Assumption and Assignment of Unexpired Leases Related Thereto; and (C) Granting Related Relief [Doc. No. 2306].

5 *See* Memorandum of Decision Finding that SGM is Obligated to Close the SGM Sale By No Later than December 5, 2019 [Doc. No. 3723] and Order (1) Finding that SGM is Obligated to Close the SGM Sale By No Later than December 5, 2019 and (2) Setting Continued Hearing on Debtors' Motion for Approval of Disclosure Statement [Doc. No. 3274].

6 *Id.*

7 *See* Notice Re Termination of Asset Purchase Agreement with Strategic Global Management, Inc. [Doc. No. 3899].

8 At the hearing, Deputy Attorney General Kenneth K. Wang, who represents the California Department of Health Care Services, alleged that the Motion had not been properly served upon the CDPH. The Court finds that the CDPH received sufficient notice of the Motion. On January 6, 2020, the Motion was served upon Deputy Attorney General David K. Eldan, Deputy Attorney General Kenneth K. Wang, and Deputy Attorney General Scott Chan, via e-mail. Doc. No. 3913, Ex. B. On January 6, 2020, the Debtors provided telephonic notice of the hearing to Attorney General Xavier Becerra and Deputy Attorney General Kenneth K. Wang. *Id.* at Ex. A. On January 6, 2020, the Debtors served the Motion, via overnight mail, upon Attorney General Xavier Becerra, Deputy Attorney General Kenneth K. Wang, Deputy Attorney General David Eldan, the Office of the Attorney General located in Los Angeles, and the Consumer Law Section of the Office of the Attorney General. *Id.* at Ex. D. On January 7, 2020, at 5:48 p.m. (Pacific Time), the Debtors served the Motion electronically upon the CDPH, at seven different e-mail addresses. Doc. No. 3924. On that same date, the Debtors provided telephonic notice of the Motion and the hearing date to counsel to the CDPH. *Id.* CDPH

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had sufficient notice of the Motion to have a team of representatives onsite at St. Vincent preparing for the contemplated closure at the same time that the hearing was being conducted, as represented by Debtors' counsel at the hearing.

9 Doc. No. 3926.

10 No hearings will be conducted in connection with the Status Report unless otherwise ordered by the Court.

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

Samuel R. Maizel[*]
Michael B. Potere[**]

ABSTRACT

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

INTRODUCTION

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

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The authors are grateful to Lori K. Mihalich-Levi, a Partner in Dentons US LLP's Washington, D.C. office, and to Andy Jinnah, an Associate in Dentons US LLP's Los Angeles office, for their assistance in the preparation of this article.

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

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

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

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

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

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

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

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

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

A. Section 405(h) and Its Legislative History

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[29] *Id.*

[30] *See id.* at 1141–42.

[31] *Id.* at 1142.

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

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

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

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

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

[35] *Id*.

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

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

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

[39] *Id.* at *7.

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

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

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

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

A. Steps in the Medicare Appeals Process

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

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

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

[43] 42 C.F.R. § 405.942(a) (2015).

[44] 42 C.F.R. § 405.962(a).

[45] 42 C.F.R. § 405.1000.

[46] 42 C.F.R. § 405.1100.

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

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

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

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

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

[48] 42 C.F.R. § 413.20.

[49] 42 C.F.R. § 405.1803.

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

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

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

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

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

B. A Hospital's Dilemma

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

61 9 B.R. 644.

62 *Id.* at 646.

63 *Id.*

64 *Id.*

65 *Id.* at 649–50, 652.

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

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

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

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

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

[69] *Id.*

[70] *Id.* at 647–48.

[71] *Id.* at 648.

[72] *Id.*

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

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

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

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

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

2. In re St. Johns Home Health Agency

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

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[76] *Id.* at 649.

[77] *Id.* at 650–52.

[78] *Id.* at 650.

[79] *Id.*

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

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

[82] *Id.*

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

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

3. In re Healthback

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

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

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

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

[86] 173 B.R. at 242, 243–44.

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

[88] *Id.* at 469–71, 473–74.

[89] *Id.* at 472–73.

[90] *Id.* at 469–70.

[91] *Id*.

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

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

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

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92 *Id.* at 470.

93 *Id.*

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

95 *Id.* at 471.

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

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

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

B. The In re Bayou Shores *Decisions*

1. The Facts of Bayou Shores

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[115] *Id.* at 341.

[116] *Id.*

4. Bayou Shores's Appeal

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

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

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

The case is currently pending in the Eleventh Circuit.

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

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

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

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

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

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

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

120 *Id.*

121 *Id.* at 592.

122 *Id.* at 592–93, 594–96.

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

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

125 *Id.* at 595–96.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[133] *Id*.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

V. INTERPRETING MEDICARE'S JURISDICTIONAL BAR

A. Discussion of Plain Language Argument

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

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

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

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

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

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

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

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

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

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

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

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

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

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

153 *Id.*

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

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

156 135 S. Ct. 2480 (2015).

157 *Id.* at 2489.

158 *Id.* at 2492–94.

159 *Id.* at 2490–91.

160 *Id.* at 2492.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[176] *Clawson*, 9 B.R. at 648–49.

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

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

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

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

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

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

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

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

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

B. Discussion of the "Legislative History" Argument

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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188 *Id.* § 2664(b) (emphasis added).

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

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

191 Deficit Reduction Act § 2664(b).

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

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

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

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

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

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

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

197 *Id.*

198 *Id.* at 393.

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

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

2. Federal Jurisdiction: Claims Against the United States

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

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

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

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

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

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

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

[203] 28 U.S.C. § 2401 (1952).

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

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

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

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

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

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

3. Federal Jurisdiction: Bankruptcy Jurisdiction

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

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

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

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

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

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

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

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

[210] 28 U.S.C. § 41(19) (1934).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

218 458 U.S. at 73.

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

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

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

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

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

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

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

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

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

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

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

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

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

[224] *Id.*

affect any right,' the Reconversion Unemployment Benefits for Seamen program is still federal law."[225]

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

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

5. "Before That Date" Language

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

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

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

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

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

6. Courts Lack Power to Correct Technical Errors

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

CONCLUSION

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

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

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

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

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

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

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

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

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

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

INTRODUCTION

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

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

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

3. *See infra* note 29.

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

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

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

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

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

6. 11 U.S.C. § 365 (2012).

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

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

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

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

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

Medicare Provider Agreements

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

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

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

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

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

13. *See* 42 U.S.C. § 1395cc.

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

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

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

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

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

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

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

18. 42 C.F.R. § 489.18 (2016).

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

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

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

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

Government Arguments that Medicare Provider Agreements Are Not Contracts

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

32. 42 U.S.C. § 1395 (2012).

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

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

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

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

37. *Id*. at 200.

38. *Id*.

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

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

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

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

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

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

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

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

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

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

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

Discussion of Section 365 as Applied to the Medicare Provider Agreement

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

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

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

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

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

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

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

52. *See supra* note 5.

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

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

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

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

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

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

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

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

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

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

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

60. RESTATEMENT (SECOND) OF CONTRACTS § 21.

61. *See supra* note 59.

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

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

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

Government Position that Medicare Provider Agreements Are Contracts

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

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

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

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

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

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

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

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

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

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

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

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

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

74. *Id.*

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

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

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

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

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

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

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

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

79. *Id.* at *12–13.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Why Does It Matter?

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

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

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

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

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

Estoppel

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

113. *Id.*

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

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

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

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

Transfer of Medicare Provider Agreement Under Section 363 or Section 365

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

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

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

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

118. *Id.*

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

120. 11 U.S.C. § 365(a) (2012).

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

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

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

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

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

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

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

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

124. 11 U.S.C. § 363 (2012).

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

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

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

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

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

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

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

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

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

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

132. *Id.* at *2.

133. *Id.* at *1–2.

134. *Id.* at *4.

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

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

Impact on Government's Setoff and Recoupment Rights

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

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

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

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

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

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

138. 11 U.S.C. § 362(a) (2012).

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

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

141. *Id.* at 719.

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

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

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

143. *See supra* note 140.

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

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

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

Impact on Successor Liability

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

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

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

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

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

149. 11 U.S.C. § 363(f) (2012).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

167. *Id.* at 869.

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

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

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

Section 525 Impact

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

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

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

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

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

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

170. 11 U.S.C. § 525(a) (2012).

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

M. Elaine Hammond bio

M. Elaine Hammond is a United States Bankruptcy Judge for the Northern District of California in San Jose. A native of North Carolina, she received her undergraduate degree from Duke University, and her JD with honors from the University of North Carolina School of Law. Prior to taking the bench in 2012, Judge Hammond's practice focused on representing debtors and creditors in commercial bankruptcy cases and out-of-court restructurings. She was a partner with the San Francisco firm Friedman Dumas and Springwater LLP. Prior to that she was an associate with Murphy, Sheneman, Julian & Rogers LLP. Judge Hammond began her legal career as a law clerk for the Judge Edward D. Jellen (ret.), also of the Northern District of California.

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- U.S. Court of Appeals for the Ninth Circuit
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- UC Berkeley School of Law, J.D.
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PROFESSIONAL RECOGNITION

- Recognized in *The Best Lawyers in America*: Bankruptcy and Creditor Debtor Rights / Insolvency and Reorganization Law, 2023

For more than 20 years, Paul Jasper has represented clients in bankruptcy, corporate restructuring, transactional, and complex litigation matters. Paul represents debtors, creditor committees, secured and unsecured creditors, and asset purchasers in nationwide bankruptcy cases and out-of-court workouts and restructurings. He also advises creditors, assignees for the benefit of creditors, trustees, receivers, and asset purchasers in receiverships, assignments for benefit of creditors, and other state insolvency matters.

Paul recently led Perkins Coie's representation of the Official Committee of Unsecured Creditors in the Watsonville Hospital Chapter 11 bankruptcy case, in which the Committee negotiated a settlement with the debtors' pre-petition secured lender resulting in the lender providing DIP financing, consenting to sale of the hospital to a newly formed political subdivision of the State of California, and a substantial recovery for unsecured creditors notwithstanding that the Hospital had lost approximately $32.5 million in the year prior to filing its bankruptcy case.

Paul advises major financial institutions in their capacity as indenture trustee or agent in connection with bond and loan facility defaults. He has counseled financial institutions acting as indenture trustees or agents in complex restructuring and liquidation scenarios with respect to:

- Exercising their post-default rights and obligations under debt indentures and loan agreements and under governing federal or state law, and in cross-border insolvency proceedings
- Assessing, negotiating, and protecting noteholder interests in connection with issuer reorganizations, restructurings, debtor-in-possession (DIP) financings, and asset sales

Paul draws on his experience with defaulted corporate trust transactions to advise corporate trustees and other deal parties such as monoline insurers, portfolio managers, and bondholders, on defaulted corporate bonds, structured finance, asset-backed, and other complex financings. These include post-default servicing, enforcement of remedies, and out-of-court restructurings, as well as related risk mitigation and litigation strategies.

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Tania is the Chair of the US Region Restructuring, Insolvency and Bankruptcy Group and the US Region Co-Chair of the Global Restructuring, Insolvency and Bankruptcy Group, and leads Dentons' Practice Group Diversity Partners Initiative for the Group.

Tania specializes in corporate restructuring, including out-of-court workouts and formal insolvency proceedings. Her representations span a broad range of clients across many sectors, all of which require strategic advice and creative solutions. She has extensive experience representing companies, secured creditors, committees of unsecured creditors and equity committees, liquidating trustees, sellers, and principals in a variety of industries, including health care, agriculture, retail, entertainment, trucking, real estate, and restaurant franchise industries. Her health care clients have included nonprofit hospitals, continuing care retirement communities, and other health care related entities nationwide.

Prior to joining Dentons, Tania gained experience in complex Chapter 11 cases at top-ranked national firms for business restructuring and bankruptcy. Tania also served as a judicial and appellate law clerk to the Honorable Christopher M. Klein, former Chief Judge for the United States Bankruptcy Court for the Eastern District of California and former member of the Bankruptcy Appellate Panel of the Ninth Circuit Court of Appeals.

Experience

- **FGMC:** Currently leads a broad team of Dentons Restructuring and Capital Markets lawyers in the Chapter 11 cases filed by home mortgage originator First Guaranty Mortgage Corporation ("FGMC") and an affiliated entity in the District of Delaware. The Dentons team negotiated and obtained approval of two DIP facilities; one providing financing for FGMC's cash flow for operations, and one, with Barclays, providing financing to fund the loans in the pipeline. The cash flow DIP financing provided, among other things, a facility that would allow FGMC to draw up to $125 million to fund mortgages that were in the approval pipeline at the time of the Chapter 11 filings. In parallel with the DIP financings, Dentons obtained first-day relief allowing FGMC to continue in business and obtained Court approval of the Key Employee Retention Plan and Key Employee Incentive Plan. The Dentons team also coordinated and negotiated settlements of complex claims with Government Sponsored Entities, including Freddie Mac and Fannie Mae, allowing FGMC to sell mortgage servicing rights and mortgage loans to both private purchasers and the GSEs. The case is ongoing.
- **Verity Health System of California, Inc.** (Chapter 11)**:** Tania co-led the representation of Verity Health System of California, Inc., and 16 related entities (collectively, "Verity"), including 6 acute care operating hospitals, in their chapter 11 cases—the second largest hospital bankruptcy case in American history with more than $1.4 billion of debt. During the cases, the Court approved the sale of Verity's hospitals and senior living facility, and confirmed the joint plan of liquidation, which resolved complex litigation and created a liquidating trust for the benefit of

creditors. The sale of Verity Health's nonprofit assets raised unique issues related to the transfer of healthcare assets in bankruptcy, including the scope of the powers of the Attorney General and the transfer of medical provider agreements, which led to groundbreaking decisions. During the cases, Verity also collaborated with the Attorneys for the California Governor's Office of Emergency Services to reopen St. Vincent Medical Center in Los Angeles, and to set aside beds at Seton Medical Center in the Bay Area to treat COVID-19 patients.

- **Agspring Mississippi Region, LLC, et al.:** Represented agricultural debtors in chapter 11 cases in Delaware.
- **Air Force Village West, Inc. dba Altavita** (Chapter 11 – California): Represented Air Force Village West, Inc., in chapter 11 proceedings that paved the way for the sale of its continuing care retirement community. Dentons lined up a stalking horse bidder, with the consent of the secured creditors, to sell the 220-acre facility for $58 million in cash and assumption of certain liabilities. The sale closed in mid-2019 and the case dismissed shortly thereafter.
- **Gardens Regional Medical Center & Hospital, Inc.** (Chapter 11 - Central District of California, June 2016-October 2018): Tania played a pivotal role in representing this 137-bed not-for-profit hospital in connection with the California Attorney General's appeal of the Bankruptcy Court's sale order. The hospital was initially sold under section 363 of the Bankruptcy Code in a very successful auction (the purchase price went from $8.5 million to $19.5 million). The California Attorney General approved the sale, but imposed such onerous economic conditions on the buyer that the sale failed, which led to the hospital's closure. The hospital sold again, now as a closed hospital, for approximately $7 million, over the objection of the Attorney General. When the Attorney General appealed the sale order, the firm successfully obtained a dismissal of the appeal. The case resulted in three published opinions, all on cutting edge issues of bankruptcy law, and a distribution to unsecured creditors.
- **Puerto Rico:** Represented the Fiscal Agency and Financial Advisory Authority and the Government Development Bank for the Commonwealth of Puerto Rico regarding its restructuring and revitalization efforts prior to commencement of proceedings under the Puerto Rico Oversight, Management, and Economic Stability Act (PROMESA).
- **ICPW Liquidation Corp., a Nevada corp., (formerly In re Ironclad Performance Wear Corp.), et al.:** Represented the Official Committee of Equity Holders (and currently the Trustee and the Trustee Board) in chapter 11 jointly-administered cases. The Debtors' assets were sold at auction for $25.25 million, which is 60 percent more than the stalking-horse bid. Thereafter, the Equity Committee and the Debtors confirmed a joint plan of liquidation that pays unsecured creditors in full and results in significant distributions to equity.
- **Domum Locis, LLC:** Represented a real estate debtor in successfully restructuring its obligations with its secured lender and emerging from Chapter 11.
- **Radio personality:** Represented non-debtor spouse and well-known radio personality in contentious litigation instituted by secured lender.
- **Heller Erhman, LLP:** Represented the Official Committee of Unsecured Creditors in the administration of estate and claims litigation.
- **South Bay Expressway L.P.:** Represented the California Department of Transportation in the Chapter 11 proceedings of the state's largest public-private partnership, which built a toll road in Southern California.
- **Consolidated Freightways Corp., et al.:** Represented a Chapter 11 liquidating trustee in Consolidated Freightways Corp. and certain affiliates (the former operator of one of the largest less-than-truckload long-haul freight transportation companies in the United States, which generated more than US$2 billion in revenues annually) in connection with the administration of the estates, complex insurance litigation and other matters.

- **Rachel Ashwell Designs, Inc. dba Shabby Chic:** Represented a Chapter 11 debtor (a retailer, manufacturer, licensor and wholesaler of home furnishings, bedding and accessories) in connection with the liquidation of certain retail stores and a structured dismissal.

Recognition

- Recognized, *Best Lawyers in America*, Bankruptcy and Creditor Debtor Rights / Insolvency and Reorganization Law, 2023
- Listed, Recognized Lawyer, *The Legal 500*, 2022
- Recognized as "Up & Coming" in California by *Chambers USA*, Bankruptcy/Restructuring,2022; Ranked 2021
- Named by The Minority Corporate Counsel Association as a “Rising Star”
- Received individual acclaim as one of five finalists for *The Los Angeles Business Journal’s* 2020 Leaders in Law Award
- Recipient of Dentons’ WomenLEAD Award, 2019
- Recognized as a "Rising Star" by *Southern California Super Lawyers*, 2013–2015

In the Media

- "**How I Made Practice Group Chair: 'As a Latina With a Bicultural Background, Diversity and Inclusion Are at My Core,' Says Tania Moyron**,” Law.com, November 15, 2022
- "Pimco-Backed Mortgage Originator Files Ch. 11," *The Deal*, July 2, 2022
- "First Guaranty Mortgage Gets Court OK To Tap $11M," *Law360*, July 1, 2022
- "**The coronavirus pandemic impact on a hospital bankruptcy**," *The Bond Buyer*, April 30, 2020
- "AHMC Healthcare to Buy Two San Francisco-Area Hospitals for $40 Million" *The Wallstreet Journal,* April 23, 2020
- "Verity Cleared to Sell Two Hospitals," *The Deal*, April 13, 2020
- "Verity Collects Approval to Sell Remaining Hospitals," *The Deal*, April 18, 2019
- "Altavita Village Latest Retirement Community Casualty," *The Deal*, March 12, 2019
- "$610M Stalking Horse Bid For 4 Verity Hospitals Approved," *Law 360*, February 20, 2019
- "Verity Reveals Sale of Remaining Hospitals," *The Deal,* January 18, 2019
- "Verity Health Collects Bid Procedures Approval," *The Deal*, October 25, 2018
- "Verity to Seek Sale of Hospitals in Chapter 11," *The Deal*, September 1, 2018

Insights

- Co-author, “Medicare, Medicaid Provider Agreements May Transfer Free and Clear in Bankruptcy,” *Journal of Corporate Renewal*, September 2020
- Co-author, "The Effect of the Global Pandemic on Hospitals in America: The Rich Get Richer, But for the Rest …" in *Norton Journal of Bankruptcy Law and Practice*, Vol. 29, No. 4 (August 2020)

Community Involvement and Pro Bono

- Cycle for Survival, Team Lead
- LA Beats Cancer, Board Member

Presentations

- Moderator, Roundtable panel on Healthcare Industry Issues at The Deal Economy: Predictions and Perspectives Conference, September 21, 2021
- Panelist, “Lessons on Distressed Healthcare Sales From the Verity Bankruptcy Case,” Expert Webcast
- Panelist, "Cutting-Edge Commercial Law/Regulatory Issues in Health Care Insolvencies," ABI Annual Spring Meeting 2021
- Panelist, “How to Effectuate Distressed Hospital Sales Where Prior Efforts have Failed,” Distressed Investing Conference
- Panelist, "Nonprofits in Distress Never Say Never," Western Conference on Tax Exempt Organizations
- Speaker, "Appellate Ethics and Frivolous Appeals," 4th Annual Bankruptcy Ethics Symposium, Federal Bar Association
- Speaker, "What's up with Attorney Civility?," 5th Annual Bankruptcy Ethics Symposium, Federal Bar Association
- Producer, "Back to the Minefield: (Even More) Ethical Dilemmas Facing Young Insolvency Professionals," California Bankruptcy Forum, Rancho Mirage, California

Memberships

- Member, American Bankruptcy Institute
- Member, American Bar Association
- Member, International Women’s Insolvency and Restructuring Confederation (IWIRC)
- Member, Los Angeles County Bar Association
- Member, Latina Lawyers Bar Association
- Member, Turnaround Management Association

Areas of Focus

Practices

- Restructuring, Insolvency and Bankruptcy
- Creditor and Equity Committee Representation
- Cross-Border Restructuring Matters
- Debtor Representation
- Insolvency Litigation and Enforcement

- Out-of-Court Restructurings and Work-outs

Industry Sectors

- Distressed Health Care
- Health Care
- Life Sciences and Health Care

Education

- University of the Pacific, McGeorge School of Law, 2004, Juris Doctor
- University of California, San Diego, 1999, BA

Admissions and Qualifications

- California
- US Bankruptcy Court for the Central District of California
- US Bankruptcy Court for the Eastern District of California
- US Bankruptcy Court for the Northern District of California
- US Bankruptcy Court of the Southern District of California
- US Court of Appeals for the Ninth Circuit
- US District Court for the Central District of California
- US District Court for the Northern District of Texas

Languages

- English
- Spanish

Nicholas Rubin

Nicholas is a co-founder of Force 10 Partners. Prior, he was a Senior Managing Director with GlassRatner Advisory & Capital Group. Nicholas has over 20 years of combined leadership experience in capital markets, financial planning, commercial real estate, and corporate finance. He began his career at a leading international public accounting and auditing firm, where he worked with clients providing accounting, management accounting, and auditing services. In addition to his experience in accounting, he has served in many executive interim leadership roles as well as team leader in many business consulting assignments with a specialization in dispute resolution.

Nicholas has experience developing and leading teams that implement solutions designed to ensure optimal performance through financial planning, budgeting, profitability, and needs analysis. Nicholas's experience includes restructuring and corporate finance, including roles as a financial advisor and investment banker.

Nicholas works closely with clients to build comprehensive and strategic plans incorporating financial planning, consolidation, infrastructure, management reporting, and business intelligence to support growth. He has managed clients and businesses in the U.S., China, Hong Kong, Israel, and South Africa. His clients include corporations, banks, lenders and other secured and unsecured creditors, buyers, sellers, bankruptcy counsel, and litigators.

Nicholas holds a bachelor of commerce degree in financial and management accounting, auditing, business management, marketing, and finance from the University of Port Elizabeth, South Africa.

Nicholas Rubin

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