Medicare and Medicaid Developments in Health Care Bankruptcies

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In 2019, the increased wave of distressed health care companies continued, and with downward pressure on reimbursement rates, regulatory changes, decreased occupancy rates and technological advances, this trend is unlikely to subside in 2020.

Health care providers often are heavily dependent on revenues from government programs such as Medicare and Medicaid, accounting for nearly 40% of national health care spending in 2018. Therefore, a Medicare payment suspension could cripple a health care provider.

In Chapter 11 cases, the government, through the Centers for Medicare and Medicaid (CMS), often seeks to enhance its ability to collect on claims, including by arguing it is exempt from application of the automatic stay, and that the bankruptcy court does not have subject matter jurisdiction to affect Medicare or Medicaid claims, allowing for unfettered recoupment/setoff of overpayments to providers. In numerous cases, the government has pointed to a debtor's so-called provider agreements, arguing that they are executory contracts that must be assumed subject to an uncapped cure and cannot be sold free and clear of any claims.

Recently, courts have rejected the government's arguments, giving companies increased leverage in these disputes. Thus, health care companies planning for bankruptcy and their potential purchasers must be aware of recent case developments to ensure a successful reorganization or bankruptcy sale.

Suspension of payments: True Health Diagnostics, LLC filed for Chapter 11 after CMS suspended and withheld Medicare payments. CMS continued withholding, forcing True Health to file suit to enforce the stay.

The bankruptcy court found that the Medicare payments were property of the bankruptcy estate, CMS had violated the stay by withholding postpetition payments without alleging any postpetition misconduct related to such withholding and the police powers exception did not apply. The bankruptcy court therefore ordered the government to remit all Medicare payments withheld postpetition and continue to make such payments.

After the bankruptcy court denied CMS' motion to stay the order pending appeal, True Health closed the sale of certain of its operating assets as a going concern, as well as most of its remaining physical assets, and discontinued providing laboratory testing services to Medicare beneficiaries and submitting claims to CMS for Medicare reimbursement. Thus, according to True Health, CMS paid virtually all claims as required under the order enforcing the stay.

For that reason, True Health filed a motion to voluntarily dismiss the adversary proceeding. But CMS pushed forward with its appeal, asserting that it already delivered millions of dollars to True Health under the order and claiming that if the order were reversed the funds should be returned to CMS subject to a completed investigation.

On appeal, the government argued that the bankruptcy court did not have subject matter jurisdiction, given that administrative processes were not exhausted, as allegedly required under the Social Security Act (42 U.S.C. § 405(h)). Third Circuit precedent, however, holds that no administrative exhaustion is required where a bankruptcy court is interpreting the extent of the automatic stay under the Bankruptcy Code. Ultimately, the district court granted True Health's motion to dismiss the appeal finding, among other things, that the order was interlocutory.

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Thus, all that remains is a pending adversary proceeding that True Health is willing to dismiss and any CMS arguments to keep it alive to preserve its chance at clawback. But the debtor received its money and emerged from bankruptcy. For now, the Third Circuit can remain a refuge for debtors against governmental efforts to collect on their claims at the expense of a debtor's reorganization. But the government is not going quietly.

Treatment of provider agreements: Another area of contention in health care cases relates to the treatment of Medicare and Medicaid provider agreements. If provider agreements are treated as executory contracts, any defaults must be cured to assume and/or assign them. If the agreements are statutory entitlements, they may be sold free and clear of successor liability under Section 363 of the bankruptcy code without any requirement to cure defaults.

Outside of bankruptcy, CMS takes the position that provider agreements are not contracts at all, let alone executory contracts. Once a provider files for bankruptcy, however, CMS typically takes the opposite position, because the Bankruptcy Code requires a debtor to cure existing defaults, allowing CMS to assert uncapped cure amounts (which might even include substantial claims for treble damages under the False Claims Act) and otherwise permits CMS to elevate its claim because debtors in bankruptcy almost invariably do not want to lose access to Medicare revenues. Notably, unlike other contract counterparties, CMS argues that it need not step forward to meet its burden to establish a sum certain cure amount.

In *Center City Healthcare, LLC*, a Delaware bankruptcy court held that the Medicare provider agreements were statutory entitlements that could be sold free and clear of liabilities, including successor liability, and not executory contracts. After the sale order was stayed pending appeal, the proposed purchaser backed out of the transaction. The parties thus dismissed the appeal as moot and vacated the bankruptcy court's decision.

In *In re Verity Health System of California, Inc*., the California bankruptcy court held that the provider agreements at issue were statutory entitlements and not executory contracts and thus, cut off any successor liability. Ultimately, the parties settled, agreeing to vacate the bankruptcy court's judgment, as the bankruptcy court's favorable ruling provided the debtors with leverage to establish limits on the government's ability to recoup.

As more health care providers turn to Chapter 11, parties should pay close attention to the evolving case law.