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Medicare Issues in Bankruptcies



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Hospitals and health care facilities continue to struggle in the current economic climate. By necessity, certain of those health care providers will turn to bankruptcy to effectuate a reorganization of their obligations under the protections of title 11 of the Bankruptcy Code. During the course of a health care provider bankruptcy, issues will arise related to its participation in the federal Medicare program, especially if the debtor seeks to assume and assign, or sell, its Medicare provider agreement to a third party. Inevitably, questions arise in health care bankruptcies with respect to (1) whether a debtor may assume and assign its Medicare provider agreement to a third party, (2) the extent of the assignee's successor liability, if any, for amounts due and owing to the government under the provider agreement and (3) whether the government may assert its right of recoupment with respect to Medicare overpayments received by the debtor pre-petition.

An Introduction to Medicare

The Medicare program was established under title XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395ccc (the "Medicare Act"), and is overseen by the Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services (HHS). In its simplest terms, Medicare is a federal program that provides health insurance for certain disabled persons, as well as persons over the age of 65. Health care providers, such as hospitals, can participate in the Medicare program by entering into a provider agreement with the Secretary of HHS. Pursuant to the provider agreement, health care entities agree to comply with all aspects of the Medicare statute, including the requirement that the entity charge Medicare patients only those fees that are authorized by the Medicare Act for the services that it provides to such patients. In return, the government agrees to reimburse the health care provider for its services to Medicare patients.

The Medicare program operates on a prospective-payment system.¹ This means that a health care provider receives payments from HHS on a periodic basis, which are estimates or "prospective payments" of the health care provider's actual expenditures for its participation in the Medicare program. The health care provider's actual expenditures are then audited by a fiscal intermediary, such as Blue Cross and Blue Shield, in order to determine whether the health care provider was overpaid or underpaid by HHS for the Medicare services that it actually rendered during that audited period. The prospective payments made are then subject, under the Medicare statute, to "necessary adjustments on account of previously made overpayments or underpayments."²

Medicare Agreements as Executory Contracts and Successor Liability

Pursuant to Medicare regulations, when a health care provider undergoes a change of ownership outside of bankruptcy, whether as a result of a merger or sale, its Medicare provider agreement is automatically assigned to the new owner unless the new owner declines to accept the assignment of the provider agreement.³ Upon assignment, all of the assets *and liabilities* of the debtor under the provider agreement are transferred to the new owner. This means that the new owner assumes the obligation to repay HHS for any of the assignor's accrued Medicare overpayments, regardless of who owned the provider agreement at the time that the overpayments were made or discovered.⁴ In a bankruptcy context, the question that arises when a health care debtor looks to assume and assign its provider agreement to a third party is whether or not the provider agreement is considered to be an executory contract.

¹ 42 C.F.R. § 413.60.

² 42 U.S.C. § 1395g(a).

³ 42 C.F.R. § 489.18(c).

⁴ *United States v. Vernon Home Health Inc.*, 21 F.3d 693 (5th Cir. 1994) (purchaser liable for Medicare overpayments that had been incurred by seller).

Although not defined in the Bankruptcy Code, the term “executory contract” has often been described by bankruptcy courts as “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.”⁵ In accordance with § 365 of the Bankruptcy Code and subject to bankruptcy court approval, executory contracts may be assumed, rejected or assumed and assigned by the debtor, but only if the debtor cures, or provides adequate assurance that it will promptly cure, any defaults under the contract. If provider agreements are deemed to be executory contracts, then an assignee of a provider agreement may be responsible for all of the liabilities relating to that provider agreement, including any overpayments made to the debtor under the provider agreement.⁶ If provider agreements are not executory contracts, however, then a debtor could theoretically cut off any successor liability by selling the provider agreement to a purchaser as an asset “free and clear” of liabilities under § 363(f) of the Bankruptcy Code.

A majority of bankruptcy courts have determined that provider agreements are executory contracts.⁷ Generally, courts arrive at this conclusion because provider agreements require performance and create obligations on both sides. Because the provider agreement incorporates the Medicare statute by implication, the health care entity is obligated to provide services to Medicare patients and the government is obligated to reimburse the health care entity for those expenditures.⁸

There are, however, some courts that do not recognize Medicare provider agreements as executory contracts.⁹ Rather, such courts have determined that Medicare provider agreements are not like typical contracts because they do not involve negotiations of any kind. In addition, such courts opine that Medicare provider agreements are simply form documents that, rather than imposing new obligations on a health care entity, merely recite already-existing Medicare regulations. Regardless of this fact, courts have generally been wary of finding that Medicare provider agreements can be sold free and clear of interests under § 363. As discussed briefly above, the government has a right to recoup any overpayments made to the health care provider. The right of recoupment, being an equitable defense, is not an “interest” in property and is therefore not affected by a bankruptcy court’s order authorizing the sale “free and clear” of all liens and interests.¹⁰ As a result, it would seem that successor liability will attach to the transfer of a provider agreement

regardless of whether such transfer occurred as a result of the assumption and assignment of the provider agreement or the sale of the provider agreement.

Recoupment and Setoff by HHS

As discussed, Medicare operates on a prospective-payment system, which often results in a health care provider receiving overpayments for the services that it rendered during a specific timeframe. Outside of bankruptcy, when an audit reveals the existence of overpayments, the Secretary has broad powers to offset, recoup or suspend Medicare reimbursements as a result of such overpayments.¹¹

A key question that often arises at the inception of a health care bankruptcy proceeding is whether the government’s adjustment to a debtor’s reimbursement claims for pre-petition overpayments constitutes an invalid setoff that violates the automatic stay under § 362(a)(7) of the Bankruptcy Code, or whether such action constitutes a permissible recoupment that would not be in violation of established bankruptcy principles. In many health care bankruptcies, the debtor relies on Medicare payments to fund ongoing operations in the absence of traditional receivables financing.

As courts continue to look to balance the rights of health care debtors and the government in bankruptcy proceedings, distressed health care entities seeking bankruptcy protection should...formulate a strategic plan prior to filing to deal with potential Medicare issues.

The automatic stay provides a type of temporary injunction against virtually all creditor activity against the debtor.¹² Among other things, the automatic stay prohibits creditors from collecting on any pre-petition claims they may hold against a debtor. Section 362(a)(7) specifically operates as a stay, applicable to all entities, of the setoff of any debt owing to the debtor that arose before the commencement of the debtor’s case under chapter 11 against any claim against the debtor.¹³ The definition of “entity” in § 101(15) of the Bankruptcy Code includes governmental units, and as a result, HHS is generally prohibited from using any of its rights of setoff in a health care provider’s bankruptcy proceeding with respect to such provider’s prepetition receipt of Medicare overpayments.

The right of setoff, discussed in § 553(a) of the Bankruptcy Code, provides that a creditor may exercise its right to setoff if there is a mutual debt between the creditor and the debtor that arose before the commencement of the case.¹⁴ The debts held by the creditor and the debtor do not

5 Countryman, “Executory Contracts in Bankruptcy, Part 1,” 57 *Minn. L. Rev.* 439, 460 (1973). See, e.g., *Sharon Steel Corp. v. Nat’l Fuel Gas Distribution Corp.*, 872 F.2d 36, 39 (3d Cir. 1989).

6 *United States v. Vernon Home Health Inc.*, 21 F.3d 693, 696 (5th Cir. 1994).

7 See, e.g., *In re Univ. Med. Ctr.*, 973 F.2d 1065, 1076 (3d Cir. 1992); *In re Consumer Health Servs. of Am. Inc.*, 171 B.R. 917, 920 (Bankr. D.D.C. 1994), *rev’d on other grounds*, 108 F.3d 390 (Bankr. D.D.C. 1997); *In re Heffernan Mem’l Hosp. District*, 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 provider agreement is an executory contract.”).

8 *In re Monsour Medical Ctr.*, 11 B.R. 1014 (W.D. Pa. 1981).

9 *Maximum Care Home Health Agency v. HCFA*, No. 3-97-CV-1451-R, 1998 WL 901642, at *5 (N.D. Tex. April 14, 1998) (“[A] Medicare service provider agreement is not a contract in the traditional sense. It is a statutory entitlement created by the Medicare Act.”); *Hollander v. Brezenoff*, 787 F.2d 834, 838 (2d Cir. 1986) (“[Provider] agreements merely obligate the providers to keep necessary records and furnish the state agency with that information upon request. They contain no substantive reimbursement provisions.”).

10 See, e.g., *In re Vital Signs Homecare Inc.*, 396 B.R. 232, 241 (Bankr. D. Mass. 2008); but see *In re BDK Health Management Inc.*, 1998 Bankr. LEXIS 2031 (Bankr. M.D. Fla. Nov. 16, 1998) (holding that debtor could sell its Medicare provider agreement free and clear of liens pursuant to § 363(f) without curing any defaults under agreement because agreement was not executory contract).

11 42 C.F.R. § 405.370, defining “offset” as “the recovery by Medicare of a non-Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness,” and “recoupment” as “the recovery by Medicare of any outstanding Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness.”

12 11 U.S.C. § 362(a).

13 11 U.S.C. § 362(a)(7).

14 11 U.S.C. § 553(a).

need to arise from the same transaction; however, they must both arise pre-petition.

Recoupment, on the other hand, is a common law doctrine that allows a creditor to reduce its pre-petition claim against a debtor by recouping from a post-petition amount owed by the creditor to the debtor. Although recoupment is “not limited to pre-petition claims and thus may be employed to recover across the petition date,” in order for the doctrine of recoupment, to apply the debts held by the creditor and the debtor must arise from a single contract or transaction.¹⁵ The differences between setoff and recoupment are slight but infinitely important because they will determine whether the government will be able to adjust a debtor’s reimbursement claims for prior overpayments. As explained by the court in *In re Slater Health Center Inc.*, the difference between setoff and recoupment is that “[a] setoff is C’s deduction from C’s debt to B of an amount based on B’s unrelated debt to C; a recoupment is C’s deduction from C’s debt to B based on B’s debt to C arising out of the same transaction.”¹⁶

Courts have developed two tests in order to determine whether the debts held by a creditor and debtor arise from a single contract or transaction: the logical-relationship test and the integrated-transaction test. Under the logical-relationship test, “a transaction may include a series of many occurrences, depending not so much upon the immediateness of their connection as upon their logical relationship.”¹⁷ The integrated-transaction test, on the other hand, contemplates that “both debts must arise out of a single integrated transaction so that it would be inequitable for the debtor to enjoy the benefits of that transaction without also meeting its obligations.”¹⁸ The application of the tests influences the outcome of whether the withholding of a debtor’s post-petition reimbursement and the application of such reimbursements to pre-petition overpayments by the government constitute a permissible recoupment.

Generally, the First, Seventh, Ninth and District of Columbia Circuits follow the logical-relationship test and have found that pre-petition Medicare overpayments to a health care entity and the subsequent post-petition adjustments to such amounts are all part of the same transaction, even though such payments may not have been made in the same year.¹⁹ For example, in *In re TLC Hospitals*, the court noted in its analysis:

The fact that the overpayments and underpayments relate to different fiscal years does not destroy their logical relationship or indicate that they pertain to separate transactions. The Medicare statute creates a sufficient relationship between different cost years to permit recoupment.... [T]he fiscal intermediary generally will not begin an audit until after the provider has supplied its cost report. This cost report is not due until five months after the conclusion of the reporting period. 42 C.F.R. § 413.24(f)(2). Consequently, a reality of the complex Medicare system is that any overpayments will not be discovered, and accordingly

the ‘retroactive adjustment’ will not occur, until after the end of the cost year in which the overpayments were made. The timing of the audit is not material to the logical relationship between the overpayments and underpayments.²⁰

As a result, the court found that Medicare’s post-petition adjustments to overpayments received by the debtor pre-petition constituted a permissible recoupment and not a setoff.

The Third Circuit, on the other hand, adopted the more stringent “integrated-transaction test” in *University Medical Center v. Sullivan*. The U.S. Court of Appeals for the Third Circuit focused on the annual account-reconciliation process used by the government when reviewing a provider’s services and transactions. As a result, the Third Circuit held that the overpayment debts owed by the debtor were “distinct from and [bore] no direct relation to the particular claims for reimbursement for services performed post-petition.”²¹ As a result, the court found that the government’s withholding of the debtor’s post-petition reimbursements and application of such reimbursements to prepetition overpayments was an impermissible setoff in violation of the automatic stay.

The issue of whether the withholding of a debtor’s post-petition reimbursement and the application of such reimbursements to pre-petition overpayments by the government constitutes a permissible recoupment is not settled. Courts are still split in their analysis of whether such transactions arise out of a single contract or transaction, and future health care debtors should be mindful of the relevant authority in their particular jurisdictions.

Conclusion

Health care entities that are contemplating a bankruptcy filing should carefully consider the effects that the filing will have on their Medicare arrangements. In addition, health care debtors should be aware that the automatic stay will likely not prevent the government from enforcing its right to recoupment after the commencement of the bankruptcy. To the extent that a health care debtor intends to assume and assign or sell its Medicare provider to a third party, consideration should be given to the possibility of successor liability and the cost of implementing such a transaction. As courts continue to look to balance the rights of health care debtors and the government in bankruptcy proceedings, distressed health care entities seeking bankruptcy protection should endeavor to formulate a strategic plan prior to filing to deal with potential Medicare issues. **abi**

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²⁰ *In re TLC Hospitals*, 224 F.3d at 1013.
²¹ *In re Univ. Med. Ctr.*, 973 F.2d at 1081.

¹⁵ *Sims v. United States Dep’t. of Health & Human Serv. (In re TLC Hospitals Inc.)*, 224 F.3d 1008, 1011 (9th Cir. 2000).

¹⁶ *In re Slater Health Inc.*, 398 F.3d 98, 103 (1st Cir. 2005).

¹⁷ *Powell v. FELRA and UFCW Health and Welfare Fund (In re Powell)*, 284 B.R. 573, 576-577 (Bankr. D. Md. 2002).

¹⁸ *In re Univ. Med. Ctr.*, 973 at 1081.

¹⁹ See, e.g., *Slater Health Ctr. Inc. v. United States (In re Slater Health Ctr. Inc.)*, 398 F.3d 98 (1st Cir. 2005); *In re TLC Hospitals*, 224 F.3d at 1013; *United States v. Consumer Health Servs. of America Inc.*, 323 U.S. App. D.C. 336, 108 F.3d 390 (D.C. Cir. 1997).