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Treatment of Medicare and Medicaid Provider Agreements in Bankruptcy—Recent Developments May Increase Bargaining Power for Distressed Health Care Providers

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Health care providers in recent years have faced a number of challenges that do not appear to be abating, especially as we confront the possibility of a general economic slowdown. The COVID-19 pandemic has had a severe impact on providers and continues to present significant operational and financial challenges for the health care industry at large. In addition, health care providers are wrestling with labor shortages, increased operating costs, increased liability, and other litigation risks (particularly but not exclusively for skilled nursing facilities), and reduced revenues (due to reductions in Medicare and Medicaid reimbursements, elective surgeries, and outpatient visits, among other factors). These mounting challenges will likely be exacerbated by the effects of the No Surprises Act enacted as part of the 2021 Consolidated Appropriations Act[1] (which became effective on January 1, 2022) and the deadlines for payment of

employer payroll taxes deferred under the Coronavirus, Aid, Relief and Economic Security Act (CARES Act)[2] (half of which were due on January 3, 2022 and the remaining half of which will come due on January 3, 2023). Moreover, the health care sector has seen increased leverage at higher multiples in recent years, leaving the sector more vulnerable to economic downturns. Recent administration pronouncements and regulatory focus on private equity's role in this sector may lead to restrictions on and/or decreased appetite for future investments by these firms, which, in turn, may limit the options available for incremental liquidity or buyers for distressed providers.

As providers contemplate potential restructuring options, there are specific difficulties unique to the health care industry. One such challenge is the ability to deal with actual and potential government liabilities. Medicare and Medicaid provider agreements—a necessary prerequisite for receiving government reimbursement—are often among the more-valuable assets of health care providers. This article examines the developing bankruptcy case law surrounding two key provider agreement-related issues, successor liabilities under transferred provider agreements and suspension/withholding of Medicare or Medicaid reimbursements by the government, and highlights how recent developments may increase health care providers' leverage in negotiations with the government and provide for greater ability to restructure providers' businesses or sell them without the burden of government liabilities linked to provider agreements.

Successor Liabilities Under Transferred Provider Agreements

One of the key issues for the proposed sale of a distressed health care provider's business is the transfer of Medicare and Medicaid provider agreements and the provider number that corresponds to these agreements. Because health care providers' revenue tends to be heavily dependent on reimbursements from Medicare and/or Medicaid, the ability to immediately bill these programs under provider agreements is critical to preventing disruptions to the providers' business. In certain jurisdictions, it can take purchasers six to nine months to obtain a new agreement, depriving them of the right to reimbursement from the government during that period. Purchasers of providers' assets will therefore generally seek to acquire sellers' provider agreements rather than risk being unable to obtain Medicare and Medicaid reimbursements. The question then becomes what successor liabilities come along with the agreements.

Typically, the U.S. Department of Health and Human Services (HHS), acting through the Centers for Medicare & Medicaid Services (CMS), as well as their state counterparts, generally require assignees of provider agreements to assume all successor liabilities thereunder,[3] which can include not only liabilities for overpayments, but also liabilities under the False Claims Act[4] and anti-kickback laws.[5] These liabilities can be significant and/or undetermined at the time of the sale, and, as a result, providers may be forced to either look to the limited pool of prospective

purchasers with their own existing provider numbers or account for successor liability risks by accepting a substantially reduced purchase price, creating a reserve under the sale documents, or coming up with some other resolution acceptable to the purchaser. Under any of these scenarios, successor liability issues limit the distressed seller's options and negatively impact the return to the seller's stakeholders.

As discussed below, recent developments in bankruptcy case law regarding transfers of Medicare and Medicaid provider agreements suggest that the government's ability to compel transferees to assume all successor liability under such agreements in bankruptcy may not be as unassailable as the government has asserted, and, consequently, health care provider debtors may have more leverage than once believed in the treatment of successor liabilities.

Ability to Sell Provider Agreements Free and Clear of Successor Liabilities

In bankruptcy cases, HHS and CMS routinely take the position that Medicare and Medicaid provider agreements constitute "executory contracts" as a means of conditioning the transfer of such agreements upon the purchaser's assumption of any and all associated successor liabilities.

Executory contracts (judicially defined as contracts "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 performance of the other"[6]) may only be transferred through assumption and assignment in accordance with section 365 of the Bankruptcy Code. Section 365 provides, among other things, that the debtor must "assume" the executory contract (accepting all burdens and benefits thereunder) in order to assign it to a third party,[7] and that the debtor "cure[], or provide[] adequate assurance that the [debtor] will promptly cure, such default" (subject to limited exceptions relating to nonmonetary defaults) at the time of assumption.[8] Governmental entities assert that in order to participate in Medicare or Medicaid, any transferee of a provider agreement in bankruptcy must assume liability for all amounts due under the provider agreement as would be required outside of bankruptcy, and must cure or provide adequate assurance of prompt cure of all defaults under the provider agreement. One reason that this position is particularly difficult for providers is the government's insistence that the "cure" includes assumption subject to CMS' right at any time to review reimbursements made in the prior five years. Accordingly, the assignee is taking on not just known liabilities, but also any potential liabilities related to the pre-closing period that CMS may identify years after the closing.

In contrast to executory contracts, a debtor's other assets can generally be sold "free and clear" of any "interest" of another party under section 363(f) of the Bankruptcy Code where one of several alternative requirements is met (including, among others, where "such interest is in bona fide dispute" or "such entity could be compelled, in a legal or equitable proceeding, to accept a money satisfaction of such interest").[9] "Interest" as

used in section 363(f) has been broadly construed by courts to include not only traditional claims and liens, but also "monetary obligations arising from the ownership of property, even when those obligations are imposed by statute."[10]

Courts have historically reached differing conclusions regarding whether provider agreements are executory contracts,[11] and given the uncertainty on this issue under the case law, debtors in many health care provider bankruptcy cases have acquiesced to governmental demands to have provider agreements treated as executory contracts and attempted to negotiate favorable resolutions regarding cure amounts or have otherwise provided for them in transactional documents. However, in two recent cases where the issue was not resolved consensually before the sale hearing, *Center City Healthcare* and *Verity*, the bankruptcy courts rejected the government's long-standing position and held that the provider agreements at issue were "statutory entitlements" that could be sold free and clear of successor liability under section 363(f) of the Bankruptcy Code, rather than executory contracts subject to section 365.

The debtors in *Center City Healthcare* operated two major hospitals in Philadelphia. One of the hospitals hosted a resident physician training program under which the debtor-operator was entitled to receive Medicare reimbursements for each of the roughly 500 participating resident physicians pursuant to a provider agreement. In bankruptcy, the debtors sought authority to sell the residency program (along with the associated Medicare provider agreement) to a third-party purchaser pursuant to section 363(f) of the Bankruptcy Code. CMS opposed the sale, insisting that the provider agreement was an executory contract and that the purchaser should be required to assume all successor liability under the provider agreement.

The *Center City Healthcare* court held that the debtors were entitled to sell the Medicare provider agreement pursuant to section 363(f) because the agreement was "a statutory entitlement and not a contract," and that the purchaser would "not take with successor liability."[12] The court found that the conditions for a sale free and clear of CMS' claims under section 363(f) of the Bankruptcy Code were satisfied because the claims were the subject of a bona fide dispute and CMS could be compelled in a legal or equitable proceeding to accept a money satisfaction of such claims.[13] However, due to Third Circuit precedent holding that the equitable right of recoupment (as a defense to payment rather than claim) is not an "interest" for purposes of section 363(f),[14] the purchaser required further clarity regarding its liability for post-closing recoupment of overpayments by CMS. Absent the requested clarity, CMS likely could have still pursued the buyer for prepetition overpayments. The *Center City Healthcare* court's sale order therefore expressly capped the purchaser's liability for any pre-closing claims of CMS under the provider agreement at $3 million (the amount deposited by the purchaser into an escrow account to fund payments to CMS, among other items, pursuant to its asset purchase agreement with the debtors).[15]

Three weeks after the *Center City Healthcare* ruling, a different bankruptcy court in *Verity* similarly overruled a sale objection by the California Department of Health Care Services (DHCS) and held that the debtors' Medi-Cal (California's state Medicaid program) provider agreements were statutory entitlements rather than executory contracts, that successor liabilities to DHCS under the provider agreements constituted an "interest" in property under section 363(f), and that the provider agreements could be sold free and clear of such interest because DHCS could be compelled to accept a money satisfaction of its interest in a legal or equitable proceeding.[16] "In fact," the court noted, "receiving a money satisfaction is and has been DHCS' objective all along."[17] However, the *Verity* court specifically declined to rule on the issue of DHCS' post-closing recoupment rights, finding that the issue had not been sufficiently briefed.[18]

The rulings in both *Center City Healthcare* and *Verity* were appealed by the government and vacated by agreement of the parties prior to a ruling on appeal,[19] but may still serve as persuasive authority. Indeed, another court has since followed *Center City Healthcare* and *Verity* in approving a sale of Medicare provider agreements as "statutory entitlements" free and clear under section 363(f).[20] As the cases illustrate, obtaining a finding that a Medicare or Medicaid provider agreement can be sold free and clear under section 363(f) does not entirely resolve all successor liability issues but does provide distressed providers and parties interested in acquiring providers' businesses greater potential flexibility dealing with such claims.

Anti-Discrimination Protections Under Section 525(a)

Regardless of whether a provider agreement is deemed an executory contract or a statutory entitlement, section 525(a) of the Bankruptcy Code may provide another useful means of preventing governmental authorities from thwarting the proposed transfer of a provider agreement based on claims for alleged pre-closing overpayments. Section 525(a) 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, [or] discriminate with respect to such a grant against, . . . a person that is or has been a debtor under this title . . . , 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 . . . , has been insolvent before the commencement of the case under this title, or during the case but before the debtor is granted or denied a discharge, or has not paid a debt that is dischargeable in the case under this title . . . .[21]

Although section 525(a) does not expressly refer to "contracts," courts have held that the enumerated categories in the statute are not exclusive and that section 525(a) applies with equal force to contracts.[22] Further, courts have demonstrated a willingness to scrutinize and reject attempts by government entities to disguise

bankruptcy- or insolvency-based discrimination as driven by other purported regulatory concerns in order to evade the restrictions of section 525(a).[23]

Notably, one court held that section 525(a) effectively eliminates the requirement that a debtor permit a governmental authority to exercise recoupment rights as part of a cure of defaults under section 365 of the Bankruptcy Code.[24] Thus, if a provider agreement is deemed an executory contract subject to the cure requirements of section 365, the debtor may nevertheless be able to argue that section 525(a) prohibits the government from blocking the proposed assumption and assignment of the agreement based solely on the failure to satisfy successor liabilities. Similarly, if the government argues that a provider agreement cannot be sold under section 363(f) without satisfaction of all successor liabilities (for example, based on other statutes generally requiring debtors to comply with applicable non-bankruptcy law while in bankruptcy[25]), the debtor may likewise be able to use section 525(a) to counter such arguments.[26] However, to the extent that section 525(a) only prohibits discrimination based on the failure to pay "dischargeable" debts, it may be less helpful with respect to successor liabilities that are potentially non-dischargeable.[27]

Health care provider debtors have included language asserting rights under section 525(a) in sale orders involving provider agreements[28] and governmental entities have occasionally raised objections to such language,[29] but these disputes have not resulted in clear guidance as to whether and under what circumstances section 525(a) bars the government from conditioning its approval of the transfer of a provider agreement upon preservation of the government's ability to pursue successor liability claims for pre-closing overpayments against the transferee.[30] This issue can be relevant not only in the context of section 363 sales, but also in the context of chapter 11 plans of reorganization (which may, for example, provide for the assumption of provider agreements by the reorganized debtors, the assignment of such agreements to third parties, and/or the treatment of the government's claims under assumed or assigned provider agreements[31]).

While the full impact of the section 525(a) line of cases and the *Verity* and *Center City Healthcare* decisions—including, among other things, on the key issue of post-closing recoupment rights—remains to be determined in future case law, they may enable providers to exert greater leverage in pre-closing negotiations with governmental entities by bolstering potential challenges to those entities' asserted cure rights in connection with a sale or a plan of reorganization.

Suspension of Medicare and Medicaid Payments

Outside of bankruptcy, CMS may institute Medicare and/or Medicaid reimbursement suspensions for various reasons, including credible allegations of fraud/pending investigations thereof.[32] Because reimbursements can comprise a significant portion if not substantially all of a health care provider's revenue stream, suspension of these

payments can have disastrous consequences for providers. Moreover, because the Medicare Act contains provisions effectively barring federal courts from exercising jurisdiction over disputes arising thereunder prior to the exhaustion of administrative remedies, it can be difficult for providers to obtain timely resolution of disputes regarding suspensions or alleged overpayments via traditional litigation avenues.

After a health care provider files for bankruptcy, issues can arise regarding the extent of the bankruptcy court's jurisdiction over Medicare and Medicaid-related disputes and the government's ability to withhold reimbursements for post-petition services in light of the automatic stay triggered by the bankruptcy filing pursuant to section 362(a) of the Bankruptcy Code.[33] The automatic stay generally bars "any act to obtain possession of property of the estate . . . or to exercise control over property of the estate" and "any act to collect, assess, or recover a claim against the debtor that arose before the commencement of the case,"[34] with "property of the estate" broadly defined as including "all legal or equitable interests of the debtor in property as of the commencement of the case."[35]

Some early decisions had found that the government's withholding of post-petition Medicare payments violated the automatic stay,[36] but until the *True Health* case in 2019, there was little in the way of recent published case law on the issue. In *True Health*, the court provided another win for health care provider debtors, holding that the automatic stay barred the government from withholding Medicare reimbursements to a health care provider for post-petition services based on alleged prepetition overpayments.

Ability to Enjoin Post-Petition Withholding of Reimbursements Under Provider Agreements

The *True Health* case illustrates both the difficulties associated with Medicare reimbursement suspensions for health care providers and how bankruptcy can be not only a result of, but also a potential solution to, those difficulties.

In 2017, CMS informed True Health Diagnostics, LLC (True Health), a "laboratory provider of diagnostic and disease management solutions," that CMS was suspending 100% of its Medicare payments to that entity on the basis of credible allegations of fraud.[37] In 2019, True Health received a notice imposing another 100% suspension of Medicare payments, again based on credible allegations of fraud.[38] True Health initially sought injunctive relief in federal district court, but after issuing a temporary restraining order, the district court determined that it lacked subject matter jurisdiction to adjudicate the dispute under 42 U.S.C. § 405(h) (a Social Security Act provision that, as made applicable to Medicare,[39] generally prohibits federal courts from exercising jurisdiction over actions against the government "to recover on any claim arising under [the Medicare Act]") and dismissed the litigation.[40] In the meantime, CMS issued two overpayment determinations to True Health identifying nearly $30 million in alleged overpayments relating to periods spanning from late 2015 to mid-2017.[41]

Forced to file for bankruptcy, True Health obtained emergency debtor-in-possession financing conditioned upon True Health obtaining full Medicare reimbursements without deduction, offset, or withholding within 22 days of the petition date. On the petition date, True Health filed an adversary proceeding against HHS and CMS and sought a temporary injunction barring the defendants from withholding Medicare payments for post-petition services based on alleged prepetition overpayments, arguing that such withholding violated the automatic stay. HHS and CMS raised several arguments in opposition, all of which the bankruptcy court rejected.

First, HHS and CMS argued that the bankruptcy court lacked jurisdiction to issue the requested injunction under 42 U.S.C. § 405(h) because True Health had not exhausted its administrative remedies.[42] Citing Third Circuit precedent holding that "where there is an independent basis for bankruptcy court jurisdiction, exhaustion of administrative remedies pursuant to other jurisdictional statutes is not required,"[43] the bankruptcy court reasoned that because it was only addressing "the narrow question of whether the Defendants are in violation of the automatic stay by continuing to withhold Medicare payments post-petition for medical tests performed by True Health post-petition based upon alleged pre-petition overpayments," the automatic stay issues were not, as HHS and CMS contended, "inextricably intertwined with" the defendants' prepetition reimbursement determinations under the Medicare Act, and the bankruptcy court had jurisdiction to issue the requested injunction.[44]

Second, HHS and CMS argued that the Medicare reimbursements withheld from True Health were not property of True Health's estate (and thus not subject to the automatic stay), relying on two decisions out of the Fifth Circuit holding, in non-bankruptcy contexts, that health care providers lacked property interests in Medicare reimbursements.[45] The bankruptcy court rejected the government's cited authority as unpersuasive and found that the withheld post-petition Medicare reimbursements were "indisputably" property of the estate.[46]

Third, HHS and CMS argued that their withholding activities were exempt from the automatic stay under section 362(b)(4) of the Bankruptcy Code, which provides that the stay does not apply to actions by a governmental unit "to enforce such governmental unit's police and regulatory powers."[47] The bankruptcy court found that there was no indication in the record that the withholding of post-petition Medicare payments was for any purpose other than protecting the government's pecuniary interest in property of the debtor's estate, or that the withholding constituted an effort to enforce public policy.[48] The bankruptcy court noted that HHS and CMS had offered "no evidence" that True Health had engaged in fraud post-petition or that there had been any overpayments post-petition,[49] and found that "[t]he only reasonable conclusion is that the Defendants are withholding post-petition payments on account of pre-petition overpayment determinations—the exact conduct that the pecuniary interest test was designed to prohibit."[50]

The *True Health* bankruptcy court further found that the debtors were not required to satisfy the traditional requirements for issuance of a preliminary injunction because the automatic stay applied to bar the disputed withholding activity, and that even if such traditional requirements were applicable, they were satisfied under the facts presented.[51] The bankruptcy court therefore granted the debtors' motion to enforce the automatic stay and issued a preliminary injunction compelling CMS to make post-petition Medicare payments owed to True Health. The debtors were then able to use the much-needed liquidity provided by reimbursements under the injunction to consummate multiple asset sales and confirm a chapter 11 plan of liquidation (which did not provide any reserve or other special treatment for the government's disputed claim).[52] HHS and CMS appealed the injunction order, but the bankruptcy court and district court denied CMS' motions for stay pending appeal, and the district court later dismissed the appeal as interlocutory.[53]

After the order confirming the debtors' plan was affirmed by the district court in another appeal by HHS and CMS,[54] the liquidating trust formed pursuant to the debtors' plan and HHS and CMS entered into a settlement resolving their dispute over the Medicare payments, pursuant to which the parties agreed to move for the vacatur of the related orders and/or opinions of the bankruptcy court and the district court (including the preliminary injunction decision).[55]

It remains to be seen whether and to what extent other courts will be willing to restrict the government's ability to suspend post-petition Medicare and Medicaid payments to health care providers in bankruptcy, particularly where the government is alleging ongoing (rather than strictly prepetition) fraudulent activities by the debtor. That said, the injunction ruling in *True Health* should increase health care providers' bargaining power in their negotiations with the government by offering a potential means of obtaining prompt, lasting relief from otherwise-devastating payment suspensions. The success of the debtors' strategy in *True Health* may also generate increased willingness among lenders to fund similar efforts by other distressed health care providers to preserve value through post-petition financing conditioned upon the providers' ability to timely obtain an injunction against any suspensions of reimbursement payments by the government, which, in turn, may enable the debtors to pursue value-maximizing transactions in bankruptcy.

Conclusion

The recent developments regarding successor liabilities under transferred Medicare or Medicaid provider agreements and suspension/withholding of reimbursements under such agreements in bankruptcy are unlikely to result in any immediate change in the government's official position on these issues but are nevertheless noteworthy. As evidenced by the government's persistent litigation of the issues and its insistence on vacatur of adverse rulings as part of any negotiated resolution, any health care provider-friendly rulings are significant insofar as they open the door to future challenges by

other debtors and prospective purchasers seeking to address liabilities under provider agreements in bankruptcy. To date, such parties have mostly opted for consensual resolutions over litigation, and only time will tell if the above-described rulings will embolden them to change course and contribute to the evolving case law. Absent clear and consistent precedent, treatment of provider agreements in bankruptcy remains an area to watch.

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[1] Pub. L. No. 116-260, 134 Stat. 1182, Div. BB, tit. I (2020).

[2] Pub. L. No. 116-136, 134 Stat. 281, Div. A § 2302 (2020).

[3] A provider agreement may only be assigned upon CMS' determination that there is a valid "change of ownership," at which time the agreement is automatically assigned to the new owner. *See* 42 C.F.R. § 489.18(a), (c). The assigned provider agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued, including, among other things, adjustment of payments to account for prior overpayments. *See, e.g.*, *United States v. Vernon Home Health, Inc.*, 21 F.3d 693, 696 (5th Cir. 1994) (citing 42 C.F.R. § 489.18(d); 42 U.S.C. § 1395g(a)), *cert. denied*, 513 U.S. 1015 (1994).

[4] 31 U.S.C. §§ 3729 *et seq.*

[5] *See, e.g.*, 42 U.S.C. §§ 1320a-7b(b) (Anti-Kickback Statute), 1395nn (Stark Law).

[6] *See, e.g.*, *Sharon Steel Corp. v. Nat'l Fuel Gas Distrib. Corp.*, 872 F.2d 36, 39 (3d Cir. 1989) (internal quotations omitted).

[7] *See* 11 U.S.C. § 365(f)(2)(A); *see also Univ. Med. Ctr. v. Sullivan (In re Univ. Med. Ctr.)*, 973 F.2d 1065, 1075 (3d Cir. 1992) ("Assumption of the executory contract requires the debtor to accept its burdens as well as permitting the debtor to profit from its benefits.").

[8] *See* 11 U.S.C. § 365(b)(1)(A); *see also id.* § 365(f)(2)(b) (requiring adequate assurance of future performance of assignee in case of assignment).

[9] *See* 11 U.S.C. § 363(f).

[10] *In re Gardens Reg'l Hosp. & Med. Ctr., Inc.*, 567 B.R. 820, 825 (Bankr. C.D. Cal. 2017), *appeal dismissed*, Case No. 2:17-cv-03708 JLS, 2018 WL 1229989 (C.D. Cal. Jan. 19, 2018); *see also, e.g.*, *United Mine Workers of Am. 1992 Benefit Fund v. Leckie Smokeless Coal Co. (In re Leckie Smokeless Coal Co.)*, 99 F.3d 573, 582 (4th Cir. 1996)).

[11] *Compare, e.g.*, *In re Univ. Med. Ctr.*, 973 F.2d at 1075 n.13 ("A Medicare provider agreement easily fits within th[e] definition [of executory contract]."); *In re VitalSigns Homecare, Inc.*, 396 B.R. 232, 239 (Bankr. D. Mass. 2008) ("[A] majority of bankruptcy court[s] considering the Medicare-provider relationship conclude that the Medicare provider agreement, with its attendant benefits and burdens, is an executory contract.") *with In re BDK Health Mgmt., Inc.*, No. 98-00609-6B1, 1998 WL 34188241, at *6-7 (Bankr. M.D. Fla. Nov. 16, 1998) (holding that Medicare provider numbers were "statutory entitlements, not contracts," and could be sold free and clear under section 363(f)).

[12] *See* Tr. of Hr'g, *In re Ctr. City Healthcare, LLC*, Case No. 19-11466 (KG) (Bankr. D. Del. Sept. 6, 2019) [ECF No. 664] at 16:2-16:8.

[13] *See* Order under 11 U.S.C. §§ 105, 106, 363, 365, 503, 507, and 525 (A) Approving Asset Purchase Agreement with Thomas Jefferson University Hospitals, Inc., (B) Authorizing Sale of Certain of Debtor's Assets Free and Clear of Interests, (C) Authorizing Assumption and Assignment of Certain of the Debtor's Executory Contracts, and (D) Granting Related Relief, *In re Ctr. City Healthcare, LLC*, Case No. 19-11466 (KG) (Bankr. D. Del. Sept. 12, 2019) [ECF No. 681] (Center City Sale Order) ¶ T(v).

[14] *See Folger Adam Sec., Inc. v. DeMatteis/MacGregor JV*, 209 F.3d 252, 261 (3d Cir. 2000).

[15] *See* Center City Sale Order ¶¶ M, Q, T(v), 12.

[16] *In re Verity Health Sys. of Cal., Inc.*, 606 B.R. at 853.

[17] *Id*.

[18] *Id.* at 854.

[19] In *Center City Healthcare*, the parties stipulated to vacatur of the sale order and dismissal of the government's then-pending appeal from that order as moot after the purchaser backed out of the transaction. *See* Stipulation Dismissing Appeal as Moot and United States' Request for Vacatur of Bankruptcy Court's Sale Order, *United States v. Ctr. City Healthcare, LLC (In re Ctr. City Healthcare, LLC)*, Case No. 1:19-cv-01711-RGA (D. Del. Mar. 17, 2020) [ECF No. 44]. In *Verity*, the parties stipulated to vacatur of the decision and order approving the sale of the provider agreement as part of a broader settlement (pursuant to which the debtors agreed to transfer the provider agreements pursuant to section 365 of the Bankruptcy Code rather than section 363) while DHCS' appeal was pending. *See In re Verity Health Sys. of Cal., Inc.*, 2019 WL 7288754, at *1; Order Approving Stipulation Re: Assumption and Assignment of Medi-Cal Provider Agreements to Strategic Global Management, Inc., *In re Verity Health Sys. of Cal., Inc.*, Lead Case No. 18-bk-20151-ER (Bankr. C.D. Cal. Dec. 9, 2019) [ECF No. 3787].

[20] *See* Order (I) Approving the Sale of Certain of the Debtors' Assets Free and Clear of All Liens, Claims, Encumbrances, and Interests, (II) Authorizing the Assumption and Assignment of Certain Executory Contracts and Unexpired Leases; and (III) Granting Related Relief, *In re MBH Highland, LLC*, Case No. 3:20-bk-01940 (Bankr. M.D. Tenn. June 19, 2020) [ECF No. 158] ¶ II ("[T]he Court finds that the Medicare Provider Agreements are statutory entitlements and thus shall be sold to [the purchaser] free and clear of all Encumbrances, pursuant to section 363(f) of the Bankruptcy Code, including, without limitation, any regulatory and pecuniary interests CMS may have against the Sellers as of the Closing Date.").

[21] 11 U.S.C. § 525(a).

[22] *See, e.g.*, *Exquisito Servs., Inc. v. United States (In re Exquisito Servs., Inc.)*, 823 F.2d 151, 154-155 (5th Cir. 1987) (holding that government's refusal to renew contract based solely on debtor's bankruptcy filing violated section 525(a)); *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) (noting 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," and finding that government's refusal to reinstate debtor's participation in Medicare and Medicaid program due to outstanding prepetition overpayments and civil penalties violated section 525(a)).

[23] *See, e.g.*, *In re Psychotherapy & Counseling Ctr., Inc.*, 195 B.R. 522, 534 (D.D.C. 1996) (rejecting HHS' contention that it was seeking to exclude the debtor from participation in the Medicare program "for being untrustworthy" as "a red herring" where HHS had based its "conclusion of 'untrustworthiness'" solely on the debtor's default under a prepetition settlement agreement with HHS); *NextWave Pers. Commc'ns Inc. v. FCC*, 254 F.3d 130, 152 (D.C. Cir. 2001) (finding that section 525(a) was violated despite FCC's contention that it sought "only to revoke [the debtor's] licenses, not to collect on the debt, and insofar as timely payment is a condition to license retention, it is a regulatory requirement, not a dischargeable debt").

[24] *See Hiser v. Blue Cross of Greater Phila. (In re St. Mary Hosp.)*, 89 B.R. 503, 512 (Bankr. E.D. Pa. 1988). The *St. Mary Hospital* court explained: "Although other creditors may be entitled to payment of pre-petition debts in exchange for a debtor's assumption of an executory contract, we believe that § 525(a) changes this as to a governmental unit. . . . . [W]e conclude that, although § 365(b)(1) would otherwise appear to require the Debtor to allow HHS its recoupment rights as a condition for utilization of its Medicare provider contract in the future, § 525(a) eliminates that condition." *Id*. at 512. *See also Kings Terrace Nursing Home & Health Related Facility v. N.Y. State Dep't of Soc. Servs. (In re Kings Terrace Nursing Home & Health Related Facility)*, No. 91 B 11478 (FGC), 1995 WL 65531, at *14-15 (Bankr. S.D.N.Y. Jan. 27, 1995) (noting that "Congress explicitly urged courts to stretch the contours of section 525(a) beyond its traditional application," and following *St. Mary Hospital* in holding that state agency's attempt to collect on claims for prepetition overpayments via recoupment violated not only discharge injunction under debtor's confirmed plan, but also section 525(a)), *aff'd*, 184 B.R. 200 (S.D.N.Y. 1995); *but see In re Univ. Med. Ctr.*, 973 F.2d at 1071 n.6 (describing *St. Mary Hospital* as having been vacated pursuant to a settlement).

[25] *See* 28 U.S.C. § 959(b) (requiring debtors to manage and operate their property "according to the requirements of the valid laws of the State in which such property is situated"); 11 U.S.C. § 363(d)(1) (providing that nonprofit debtors may use, sell or lease property "only in accordance with nonbankruptcy law applicable to the transfer of property by a debtor that is such a [non-profit]").

[26] *See Berkelhammer v. Novella (In re Berkelhammer)*, 279 B.R. 660, 668 (Bankr. S.D.N.Y. 2002) (rejecting HHS' argument that section 525(a) did not prohibit HHS from conditioning debtor's reinstatement as Medicaid-eligible on payment of amounts owed under debtor's prepetition reinstatement agreement because such payment was required under 28 U.S.C. § 959(b), and reasoning that "[s]ection 959's operating mandate does not require the chapter 7 trustee to pay the Debtor's prepetition debts, such as the Debtor's obligation under the Reinstatement Agreement").

[27] *See, e.g.*, *Yates v. D.C. (In re Yates)*, Adv. No. 06-1305-TJC, 2006 WL 4481987, at *6-7 (Bankr. D. Md. Nov. 3, 2006) (noting that "[s]ection 525 does not bar discrimination based upon nonpayment of a debt that is not dischargeable," and finding that

governmental agency did not violate section 525(a) in enforcing surety bond requirement against individual debtor because surety bond requirement was not a dischargeable debt). Notably, some courts have held that False Claims Act claims are non-dischargeable under 11 U.S.C. § 1141(d)(6) (which prohibits the discharge of certain fraud-based claims by corporate chapter 11 debtors). *See, e.g.*, *United States ex rel. Minge v. Hawker Beechcraft, Inc. (In re Hawker Beechcraft, Inc.)*, 515 B.R. 416, 419-420 (S.D.N.Y. 2014).

[28] *See, e.g.*, Order (I) Approving the Sale of Certain of the Debtors' Assets Free and Clear of All Liens, Claims, Encumbrances, and Interests, (II) Authorizing the Assumption and Assignment of Certain Executory Contracts and Unexpired Leases; and (III) Granting Related Relief, *In re MBH Highland, LLC*, Case No. 3:20-bk-01940 (Bankr. M.D. Tenn. June 19, 2020) [ECF No. 158] ("To the extent provided by section 525 of the Bankruptcy Code, no governmental unit may revoke or suspend any grant, permit, or license relating to the operation of the Assets sold, transferred or conveyed to the Successful Bidder on account of the filing or pendency of these Chapter 11 Cases or the consummation of the Sale."); Order (I) Approving the Sale of Substantially All of the Debtors' Assets Free and Clear of Liens, (II) Approving the Assumption and Assignment of Executory Contracts and Unexpired Leases, and (III) Granting Related Relief, *In re Watsonville Hosp. Corp.*, Case No. 21-51477 (Bankr. N.D. Cal. Feb. 23, 2022) [ECF No. 347] ¶¶ 2 n.6, 18 (including similar protective section 525(a) language regarding grants relating to operation of "Acquired Assets," but noting that provider agreements would not be considered "Acquired Assets" until pending objections of HHS and DHCS were resolved).

[29] *See* Obj. of the State of New Hampshire to Sale of the Debtor's Assets, *In re LRG Healthcare*, Case No. 20-10892-MAF (Bankr. D.N.H. Dec. 11, 2020) [ECF No. 332] ¶ 65 (objecting to proposed sale order on grounds that it improperly predetermined that any conditioning of entry into provider agreement on purchaser's payment or assumption of successor liabilities under such agreement would violate section 525(a), and arguing that court should address such issues "if or when they arise in the future"); Obj. and Non-Consent of the United States to Final Order Approving Sale of Alleged Hahnemann University Hospital Residency Program Assets to Jefferson to the Extent the Court Exceeds Its Constitutional Authority and Jurisdiction by Enjoining or Otherwise Constraining the Rights of the United States Against Non-Debtor Parties, *In re Ctr. City Healthcare, LLC*, Case No. 19-11466 (KG) (Bankr. D. Del. Sept. 5, 2019) [ECF No. 654] at 2-3 (objecting to section 525 provisions of proposed sale order on grounds that bankruptcy court lacked "authority under the United States Constitution and jurisdiction to grant such relief").

[30] In *LRGHealthcare*, the court ultimately approved scaled-back language that reserved the debtor's and purchasers' right to assert that section 525(a) applied to the New Hampshire Department of Health and Human Services (DHHS) without an express finding as to whether or how section 525(a) would impact DHHS' recoupment

rights. *See* Order (A) (I) Approving the Sale of Substantially All of the Debtor's Estate Free and Clear of All Interests, (II) Approving the Assumption and Assignment of Certain Executory Contracts and Unexpired Leases, and (III) Granting Related Relief, *In re LRGHealthcare*, Case No. 20-10892-MAF (Bankr. D.N.H. Dec. 4, 2020) [ECF No. 405] ¶ 59. In *Center City Healthcare*, the court's (subsequently vacated) sale order included the debtors' proposed section 525 language notwithstanding the government's constitutional authority and jurisdictional arguments. *See* Center City Sale Order ¶ 20.

[31] *See* 11 U.S.C. § 1123 (describing required and permitted contents for chapter 11 plans).

[32] *See* 42 C.F.R. §§ 405.371(a)(2), 455.23(a)(1).

[33] 11 U.S.C. § 362(a).

[34] 11 U.S.C. § 362(a)(3), (6)

[35] 11 U.S.C. § 541(a).

[36] *See, e.g.*, *In re Univ. Med. Ctr.*, 973 F.2d at 1069, 1074-1075, 1083-1085; *Medicar Ambulance Co. v. Shalala (In re Medicar Ambulance Co., Inc.)*, 166 B.R. 918, 923-27 (B.A.P. 9th Cir. 1994); *Tidewater Mem. Hosp., Inc. v. Bowen (In re Tidewater Mem. Hosp., Inc.)*, 106 B.R. 876, 880, 881-882 (Bankr. E.D. Va. 1989).

[37] *True Health Diagnostics LLC v. Azar (In re THG Holdings, LLC)*, 604 B.R. 154, 157-158 (Bankr. D. Del. 2019), *appeal dismissed*, 2020 WL 1493622 (D. Del. 2020).

[38] *In re THG Holdings, LLC*, 604 B.R. at 158.

[39] *See* 42 U.S.C. § 1359ii.

[40] *In re THG Holdings, LLC*, 604 B.R. at 158.

[41] *Id*.

[42] *Id*. at 158-159.

[43] *Id.* at 159 (quoting *In re Univ. Med. Ctr.*, 973 F.2d at 1073-74).

[44] *Id*. at 159-160.

[45] *Id*. at 161.

[46] *Id*. at 160.

[47] 11 U.S.C. § 362(b)(4).

[48] *In re THG Holdings, LLC*, 604 B.R. at 161. As explained by the bankruptcy court, courts apply two overlapping tests to determine whether a governmental unit's actions fall within the exception to the automatic stay under section 362(b)(4) of the Bankruptcy Code: (i) the "pecuniary interest test," which "asks whether the government 'primarily seeks to protect a pecuniary governmental interest in the debtor's property,'" and (ii) the "public policy test," which "asks whether the government is enforcing public policy as opposed to private rights." *Id*.

[49] At the hearing on the debtors' motion for preliminary injunction, HHS and CMS had attempted to introduce evidence that there were post-petition fraud allegations being investigated, but the court sustained the debtors' objection to the introduction of such evidence on the basis that HHS and CMS had previously agreed not to introduce it. *See THDL Liquidating LLC v. Azar (In re THDL Liquidating LLC)*, Adv. Proc. No. 19-50280 (JTD), 2020 WL 6818442, at *2 (Bankr. D. Del. Jul. 7, 2020). The court later denied the debtors' motion to dismiss the adversary proceeding, finding that the defendants should have an opportunity to develop the factual record regarding whether the withholding was for the purpose of preventing fraud. *See id.* at *3-4.

[50] *Id*.

[51] *Id*. at 159, 162-163.

[52] *See Azar v. True Health Diagnostics, LLC (In re THG Holdings LLC)*, Civ. No. 19-1714 (RGA), 2020 U.S. Dist. LEXIS 53588, at *6 (D. Del. Mar. 27, 2020).

[53] *See Azar v. THGH Liquidating LLC (In re THGH Liquidating LLC)*, Civ. No. 19-2215-RGA, 2020 U.S. Dist. LEXIS 164740, at *4-5 (D. Del. Sept. 9, 2020) (describing procedural history).

[54] *See id.* at *25.

[55] *See* Order Approving Mot. of the Debtors Pursuant to Bankruptcy Rule 9019, Local Rule 9013-1 and 11 U.S.C. §§ 105(a) and 363(b), for Entry of an Order Authorizing Settlement with the Government, *True Health Diagnostics, LLC v. Azar (In re THGH Liquidating LLC)*, Adv. Proc. No. 19-50280 (JTD) (Bankr. D. Del. Apr. 16, 2021) [ECF No. 102], Ex. 1 (settlement agreement).