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## Intensive Care

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### Navigating the Choppy Waters of Health Care Insolvency Cases

In many respects, health care insolvency cases are unique creatures. Health care cases involve unique statutes and entail pronounced pressures for both clients and professionals, as well as inherent unpredictability. The only certainty in a health care case is that there will be uncertainty.

Recognizing the uncertainty of these cases, it is prudent to try to manage the unpredictability from the inception of a case so that the case can be administered as efficiently as possible in order to maximize value for all creditors and parties-in-interest. This article focuses on how to manage risk in three discrete areas: (1) health care receivables and how they are affected by Medicare and Medicaid setoff and recoupment issues; (2) the role of governmental approval in effectuating a sale of a nonprofit health care institution and how to avoid pitfalls that could delay or impede the closing of a possible transaction; and (3) issues that arise in health care cases in connection with valuation of health care receivables.

#### Health Care Receivables and Setoff/Recoupment

Medicare and Medicaid accounts receivable are the lifeblood of many struggling health care institutions. A significant disruption in the revenue cycle of these entities can often mean the difference between a successful restructuring or sale and the closure of the facility.

Under the government's periodic interim-payment system, health care providers receive Medicare and Medicaid interim-reimbursement payments under their provider agreements based on projections before the Centers for Medicare and Medicaid Services (CMS) finally determines the actual reimbursement amount that the provider is

entitled to receive in a given year. Section 1395g(a) of the Social Security Act provides that "[t]he Secretary shall periodically determine the amount [that] should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate ... the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments."

Providers must file annual cost reports, which are subsequently audited by CMS. Reimbursement payments are made based on projections subject to reconciliation following the submission of the annual cost reports. Due to a backlog, it is not unusual for CMS audits to lag cost reports by several years. However, once a determination is made, the provider is legally obligated to return any overpayments, which is typically implemented through the withholding (*i.e.*, setoff or recoupment) of the overpayment amount from current or future periodic payments by CMS.

The bankruptcy filing of a health care provider that has received overpayments presents a number of issues concerning CMS's ability to recover those overpayments, including through setoff and recoupment, two of the most powerful tools for government payors. Section 553 of the Bankruptcy Code specifically preserves a creditor's right to set off mutual obligations against the debtor arising from separate transactions, provided that both obligations arose prior to the bankruptcy petition date.

Recoupment is similar to setoff but differs in several key respects. It is not expressly provided for in the Bankruptcy Code. Instead, it is recognized through case law as an equitable remedy applicable in bankruptcy cases where mutual obligations arise from the same transaction, regardless of whether the obligations are both pre-petition obligations.



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While both setoff and recoupment are available to CMS, recoupment is CMS's preferred tool. Pre-petition obligations cannot be set off against post-petition obligations, and the enforcement of a right to setoff is subject to the automatic stay of § 362 of the Bankruptcy Code. Therefore, a creditor seeking to perform a setoff must first seek relief from the automatic stay. On the other hand, recoupment is neither affected by the petition date nor generally subject to the automatic stay. As a result, recoupment, to the greatest extent applicable, allows CMS to apply a pre-petition overpayment owed by a health care provider to the post-petition stream of periodic interim amounts payable to such health care provider.

The key issue in most recoupment disputes is whether both the creditor's claim and the amount owed to the debtor arise from a single contract or transaction. What constitutes a single contract or transaction typically depends on the specific facts of the case. Courts have developed two primary tests in analyzing whether mutual obligations arise from the same contract or transaction: the "logical relationship" and "integrated transaction."

The integrated-transaction test is a much more stringent inquiry, and courts adopting this test are less likely to find recoupment as being applicable. In health care provider bankruptcy cases, the issue becomes whether reimbursement payments made in one cost report year arise from transactions wholly distinct from reimbursement payments made in any other cost report years.

The majority of courts that have addressed the issue of whether CMS may recoup pre-petition overpayments against post-petition reimbursement payments across the petition date line without the need to obtain relief from the automatic stay have applied the logical-relationship test. Under this test, a transaction might include a series of many occurrences, depending not so much upon the immediateness or closeness in time of their connection as upon their logical relationship. The U.S. Courts of Appeals for the First, Seventh, Ninth and D.C. Circuits have adopted this test and have ruled that post-petition reimbursement payments and pre-petition overpayments are part of the same transaction, which allows the government to recoup these payments without violating the automatic stay.

On the other hand, in *In re University Medical Center*,<sup>2</sup> the Third Circuit (applying the more limited integrated-transaction test) held that the doctrine of recoupment should be narrowly construed. The Third Circuit reasoned that the ongoing relationship between Medicare and the debtor did not meet the integrated-transaction test because the debtor's current and future reimbursements were "independently determinable" and "completely distinct" from the overpayments made by Medicare in the past. The court concluded that a mere logical relationship is not enough; the fact that the same two parties are involved, and that a simi-

lar subject matter gave rise to both claims, does not mean that the two arose from the same transaction.

Given the critical importance of maintaining stable liquidity and uninterrupted flow of reimbursements to health care providers entering chapter 11, the issues concerning any actual or potential setoff or recoupment by CMS should be thoroughly analyzed prior to the petition filing and, if possible, addressed at the outset of the bankruptcy case. The debtor can attempt to address these issues through cash collateral and/or debtor-in-possession financing orders by seeking approval of the provisions that prohibit CMS and applicable state Medicaid agencies from exercising setoff or recoupment rights without prior notice and an order of the bankruptcy court.

While government payors might object to the inclusion of such language, this allows a debtor to at least flush out potential reimbursement disputes and bring them to the court's attention early in the case. This might also provide an avenue to open a dialogue with the appropriate decision-makers representing the government payors in order to establish a framework under which the government reserves all of its rights but agrees to forbear from exercising setoff or recoupment for a period of time, thus allowing the debtor a reasonable opportunity to implement its reorganization or sell its assets in an orderly fashion to maximize value.

## The Governmental Approval Process

Health care institutions have faced significant consolidation in recent years, and although consolidation may have temporarily abated, the trend will likely continue based on regulatory changes, market forces and financial pressures. Those forces often lead a number of health care institutions to either seek the protections of the Bankruptcy Code in order to reorganize their affairs or use the bankruptcy process to effectuate a sale transaction. In the context of a sale transaction, there is generally some type of state government oversight in which the state will seek to determine how a sale transaction affects the community and how the delivery of health care is aligned with needs assessments and regional health planning.

In certain instances, the state government oversight works co-extensively with the chapter 11 process and the state oversight does not affect the rights and interests of creditors and parties-in-interest. However, there are times when the state-oversight process impedes the process and detrimentally affects the rights of creditors and parties-in-interest. However, there are tools in the chapter 11 toolbox that can be utilized to address a conflict between state oversight and the interests of creditors. For example, § 1221(e) states, as a rule of construction:

Nothing in this section shall be construed to require the court in which a case under chapter 11 ... is pending to remand or refer any proceeding, issue, or controversy to any

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2 973 F.2d 1065 (3d Cir. 1992).

other court or to require the approval of any other court for the transfer of property.<sup>3</sup>

This section was interpreted by the U.S. Bankruptcy Court for the Southern District of New York in *HHH Choices Health Plan LLC, et al.*,<sup>4</sup> in the context of a sale of the assets of a continuing care retirement community and the determination of which bidder should be authorized to acquire the assets. In connection with the court's determination of the highest and best bidder, the court determined whether ordinary state court procedures must be followed for the approval of the sale that the court found proper. The court stated:

My interpretation of the statute is that substantive state law requirements are applicable, but that I am the one who is supposed to apply them, not the New York State Court. Not that that has turned out to be such an easy or welcome task in this particular case; nevertheless, it is my obligation. Similarly, my judgments on these issues are subject to appeal to the district court and higher courts, but I do not believe they are subject to review or to reconsideration or challenge or veto by a state court.

The court further stated that there might be other relevant regulatory requirements and licensing issues, and that other approvals might be necessary, but the court had the power to determine the disposition of estate assets. This precedent has broad ramifications when state regulators attempt to make the call on how health care assets are sold and creates potential turf wars between the federal bankruptcy courts and state courts across the nation.

Another tool that might help to reconcile conflicts between state regulators and bankruptcy law and policy is § 363(f) of the Bankruptcy Code, which provides for the sale of property free and clear of any interest in that property, provided that certain requirements have been met. Specifically, the term "interests" in § 363(f) has been broadly interpreted to impede the efforts of regulators to condition or otherwise limit the sale of health care assets upon the payment of monetary obligations. In *Gardens Regional Medical Center*,<sup>5</sup> the debtor sought to sell the assets of a closed hospital, and the California attorney general attempted to block that sale unless and until the purchaser agreed to a specified amount of charity care and continuing charitable care obligations. The U.S. Bankruptcy Court for the Central District of California rejected this effort and determined that the conditions the attorney general sought to impose on the sale were "interests in property" and that the sale could be effectuated free and clear of those interests.

## Valuation of Health Care Receivables

Medicare and Medicaid accounts receivable frequently comprise a significant portion of collateral securing a health care provider's obligations to its lenders. Unlike regular commercial receivables, government receivables are subject to anti-assignment rules. This prohibits a health care provider from assigning its right to payment for services to any person other than the provider, which prevents the provider's creditors secured by government receivables from demanding direct payment from the government.<sup>6</sup>

A violation of the anti-assignment rules can result in termination of the health care provider's participation in Medicare or other government programs. As a result, a lender could hold a validly granted and properly perfected security interest in the government accounts receivable under the Uniform Commercial Code (UCC), but the lender might face significant hurdles in realizing the value of its collateral if the debtor defaults, because the lender cannot compel direct payment from the government.

Valuation of a lender's collateral consisting of government accounts receivable in order to determine the amount of such creditor's secured claim pursuant to § 506 of the Bankruptcy Code can often be one of the most significant factors in creating a possibility of meaningful, or any, recovery to general unsecured creditors in a health care provider's bankruptcy case. Section 506 provides that "such value shall be determined in light of the purpose of the valuation and of the proposed disposition or use of such property, and in conjunction with any hearing on such disposition or use or on a plan affecting such creditor's interest." Thus, bankruptcy courts have broad discretion in determining what valuation methodology is appropriate at various junctures of the case.

In general, health care receivables are inherently difficult to value because of the large variations between billed charges and the lesser contract rates negotiated with insurance companies, managed-care organizations and other payors. In some instances, providers do not (1) establish adequate reserves in their financial statements to accurately reflect the estimated net realizable value of the receivables, nor (2) update such reserves on a regular basis. The valuation of government health care receivables is even more complicated due to the uncertainty created by the possibility of recoupments by government payors based on audits of annual cost reports (which are often backlogged for years) and the limitation on the secured creditor's ability to realize on its collateral through direct collection of accounts receivable as a result of the anti-assignment rules.

The uncertainties and limitations associated with the ability of secured creditors to realize on health care accounts receivable provide unsecured creditors' committees with an important tool to challenge the secured creditor's valuations of health care receivables in the context of allowance of the amount of the creditor's secured claim pursuant to § 506. These factors create an opportunity for the unsecured creditors' committees to argue that the ultimate amount of the allowed secured claim should reflect appropriate discounts accounting for collectability risks given the special characteristics of health care receivables. This process should result in a secured creditor's allowed secured claim that is consistent with the fair value of its collateral while general unsecured creditors have an opportunity to maximize their recovery. **abi**

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3 Pub. L. No. 109-8, § 1221(e) (2005).

4 554 B.R. 697 (Bankr. S.D.N.Y. 2016).

5 Case No. 2:16-bk-17463-ER (Bankr. C.D. Cal.).

6 See 42 U.S.C. § 1395g(c)(1).