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Chicken Little Comes to Roost in Bankruptcy

Why §362(b)(28) Doesn't Mean the Sky Is Falling

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The Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 (BAPCPA)[1] made several health care business amendments to the Bankruptcy Code. Among those amendments was an addition to the exemptions to the automatic stay contained in §362(b).[2] Congress created §362(b)(28), which provides that the automatic stay does not stay acts by the Secretary of U.S. Department of Health and Human Services (HHS) to exclude debtors from participation in the Medicare program or any other federal health care program.[3]


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The response of commentators to this addition has been reminiscent of Chicken Little's hysterical conclusion that the sky was falling.[4] For example, one law firm's blog opines that this addition "is of potentially massive import to health care businesses as it provides the Center for Medicare and Medicaid Services (CMS) huge amounts of leverage over health care business debtors."

Attorneys well known for their experience in health care insolvency issues suggested that this provision alters the existing case law that governs whether Medicare's right to adjust ongoing post-petition payments to recover pre-petition obligations is an act of setoff or an act of recoupment, that it is "intended to make it harder for Medicare providers to avoid penalties," and go so far as to prognosticate that this amendment may "affect the structure of health care financing." Finally, it has been stated that this amendment "effectively removes the bankruptcy court 'as a limitation on the administrative powers of HHS, which will grant HHS a significant role in the outcome'" of health care business bankruptcy cases. Fortunately, neither the plain language of §362(b)(28) nor the existing case law support such conclusions. To the contrary, a review of the statute and cases decided prior to passage of the Act suggest that this amendment will make little, if any, change in how health care restructuring cases are resolved.

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What the Statute Says

Section 362(b)(28) makes explicit that exclusions from the Medicare program are not subject to the automatic stay; it states that "the filing of a petition...does not operate as a stay...of the exclusion by the Secretary of Health and Human Services of the debtor from participation in the Medicare program or any other federal health care program."[5] Exclusion is a specific term under the Medicare program; a person or facility or supplier of goods or services who is "excluded" from participation in the Medicare program "is no longer permitted to provide items or services to Medicare patients and receive any payment for them."[6] Exclusion from the Medicare program can also trigger exclusion from other federal and state programs, even if they are unrelated to the provision of health care.


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Since Medicare is the single largest payor for health care services in the health care industry,[7] being "excluded" from participation can often be the "kiss of death" for a health care provider. There are two types of exclusion—mandatory and permissive—and while some exclusions have been imposed for relatively short periods of time, others have been lengthy or even indefinite.

Intensive Care

1 Pub. L. 109-8, enacted Apr. 19, 2005; signed into law on Apr. 20, 2005. Most provisions, including this one, went into effect on Oct. 17, 2005.

2 All references to "sections" herein are to sections of the Bankruptcy Code, 11 U.S.C. §§101-1330, as amended.

3 11 U.S.C. §362(b)(28).

4 "The Sky is Falling," also known as "Chicken Little," "Chicken Licken" or "Henny Penny," is an old fable about a chicken who believes the sky is falling. The phrase has also become used to indicate a hysterical or mistaken belief that disaster is imminent. According to Wikipedia.org (last visited on June 16, 2006), the story may have its origins in the Jataka, a body of folklore and mythic literature, associated with Theravada Buddhist tradition as written in the Pali language.

5 11 U.S.C. §362(b)(28).

6 McKessy, Ana-Marie, "Exclusion from the Medicare Program: What Does It Mean for O&P and How Likely Is It?," www.ppsv.com/issues/medicare.htm (Power Pyles Sutter & Verville PC 1999).

7 The Medicare program covers 42.5 million beneficiaries and spent approximately $330 billion in 2005.

Mandatory Exclusion

The Office of Inspector General (OIG) for HHS (who is statutorily responsible for such determinations) is required by law to exclude a provider under four circumstances: (1) conviction for a crime related to the delivery of an item or service related to Medicare or state health care program; (2) conviction for a crime relating to patient neglect or abuse; (3) a felony conviction relating to health care fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct; and (4) a felony conviction relating to the manufacture, distribution, prescription or dispensing of a controlled substance.[8] All the mandatory exclusions must be based on a conviction for an offense related to criminal acts directly affecting the health care business and patient care. Statistically, individuals are more likely to be convicted of such offenses, so that these mandatory exclusions are more frequently imposed against individuals rather than health care businesses.

Permissive Exclusion

The OIG also has the discretion to exclude providers, but this discretion is neither unguided nor unlimited.[9] The Medicare statutes provide 15 grounds for the imposition of a permissive exclusion:

1. conviction for a misdemeanor crime relating to fraud, such as theft, embezzlement or breach of fiduciary responsibility that did not fall within the mandatory exclusion provisions.[10]
2. conviction relating to obstruction of a criminal investigation relating to the issues mentioned above.[11]
3. misdemeanor conviction for an offense relating to manufacture, distribution, prescription or dispensing of a controlled substance.[12]
4. revocation or suspension of a provider's license to provide health care by a state authority or the surrender of a license while a formal disciplinary proceeding is pending.[13]
5. exclusion or suspension under federal or state health care program. The term "suspension" here should not be confused with the situation where Medicare adjusts ongoing payments to a provider to recover a prior overpayment. This provision applies to other federal and state health programs, such as CHAMPUS and health programs run through the Department of Veterans Affairs.[14]
6. claims for excessive charges or unnecessary services and failure of certain organizations to furnish medically necessary services.[15] This intends to restrain price discrimination (*i.e.*, when the provider charges substantially higher rates to the government than to the public. However, this provision is infrequently invoked because of how billing is actually conducted in the health care industry).[16] Health care entities have their regular rates for goods and services, but Medicare has set its own rates that it will pay for all goods and services, and those rates may be significantly lower than a health care business's "regular" rates. Health care providers will also enter into contracts with health plans or other large purchasers of health care goods or services, setting rates for each of those entities. Thus, the "regular" rate may only apply to those without health insurance (including Medicaid and Medicare) or the infrequent visitor to the facility who is there on an emergency basis. Because of this complicated billing system, the federal government rarely, if ever, invokes this basis for a permissive exclusion.[17]
7. providers that have (a) submitted or caused to be submitted false or fraudulent claims to Medicare or other state or federal health care programs, or (b) offered, paid, solicited or received kickbacks in return for the referral of Medicare or Medicaid patients.[18]
8. a provider that is controlled by an individual, for example the CEO or owner of a health care business, who has been sanctioned under the Medicare Act.[19]
9. failure to disclose required information. This allows exclusion of a provider if that provider refuses to cooperate with a government request for information, for example, about ownership or control of the business, the billing practices, or the provision of health care services.[20]
10. failure to supply requested information on subcontractors and suppliers. This allows exclusion of a provider if (1) the government requests information, for example, about ownership or control of the business, the billing practices, or the provision of health care services related to a subcontractor or supplier of goods or services to the Medicare provider, and (2) the provider refuses to cooperate.[21]
11. failure to supply payment information. This is intended to make payment records available to the government in order to confirm payment amount and determine when payments are due.[22]
12. failure to grant immediate access. This provides for exclusion where the government has sought to inspect or visit a facility and access is denied.[23]
13. failure to take corrective action. After an inspection of a facility that finds deficiencies, the facility is required to follow certain administrative procedures and create a corrective plan. If this corrective action does not occur, then the health care business may be excluded.[24]
14. default on health education loan or scholarship obligations by individuals who have received government educational loans and failed to pay those loans when they came due.[25]
15. individuals controlling a sanctioned entity. Just as an entity can be excluded if controlled by a sanctioned individual, an individual can be excluded if he or she is in control of a health care business that itself is sanctioned by Medicare.[26]

In addition to these grounds for which exclusion may be imposed, the OIG has published four guidelines that are used to guide its discretion in imposing a permissive exclusion against providers under §1128(b)(7) of the Medicare Act (the provision dealing with fraud against the Medicare or Medicaid programs or conduct related to kickbacks): (a) the degree of misconduct, (b) the provider's response to the alleged fraud, (c) the provider's willingness to accept

8 42 U.S.C. §1320a-7(a).
9 42 U.S.C. §1320a-7(b).
10 42 U.S.C. §1320a-7(b)(1).
11 42 U.S.C. §1320a-7(b)(2).
12 42 U.S.C. §1320a-7(b)(3).
13 42 U.S.C. §1320a-7(b)(4).
14 42 U.S.C. §1320a-7(b)(5).
15 42 U.S.C. §1320a-7(b)(6).
16 There are continuing discussions about how to amend this provision in order to define "excessive charges" and make the provision more effective. *See* 68 Fed. Reg. 53939-45 (Sept. 15, 2003).
17 Telephonic interview with Patric Hooper, health law attorney, Hooper Lundy & Bookman, Los Angeles, on June 16, 2006.
18 42 U.S.C. §1320a-7(b)(7).
19 42 U.S.C. §1320a-7(b)(8).
20 42 U.S.C. §1320a-7(b)(9).
21 42 U.S.C. §1320a-7(b)(10).
22 42 U.S.C. §1320a-7(b)(11).
23 42 U.S.C. §1320a-7(b)(12).
24 42 U.S.C. §1320a-7(b)(13).
25 42 U.S.C. §1320a-7(b)(14).
26 42 U.S.C. §1320a-7(b)(15).

imposition of a compliance program to avoid future problems and (d) the financial stability of the provider.[27]

Thus, §362(b)(28) exempts from the automatic stay OIG's mandatory and permissive exclusion determinations. After a determination to exclude is made, however, the provider is entitled to 30 days' notice,[28] the right to a hearing and judicial review.[29] While the appeal is pending, the exclusion is effective, and the appeal is usually limited to whether the underlying acts actually occurred and whether the length of the exclusion is reasonable. If the underlying acts are proven, the OIG's decision to exclude is not subject to appeal.

Amendment Makes Virtually No Change to Existing Status

The addition of §362(b)(28) makes exclusions exempt from the automatic stay. However, despite the dire predictions of commentators, this merely makes express what was probably the common perception before passage of the Act. Previously, most practitioners and judges had thought that exclusions from the Medicare program were already exempt from the automatic stay pursuant to §362(b)(4), which exempts police or regulatory acts by governmental entities from operations of the automatic stay.[30] For example, the bankruptcy court in *Psychotherapy and Counseling Ctr.* commented that the government's right to exclude a health care business from participation in the Medicare program "would clearly represent an exercise of police or regulatory power."[31]

That the OIG's determination to exclude a provider could be exempt from the automatic stay under §362(b)(4) is sensible. To determine whether §362 (b)(4) is applicable, bankruptcy courts employ two tests: the "public policy test" and the "pecuniary purpose test."[32] These tests were developed based on statements of two of the sponsors of the bill, who stated that the statute was intended to be read narrowly to avoid governmental actions seeking to assert pecuniary interests rather than enforcing substantive policy.[33] Under the public-policy test, the bankruptcy court has to determine whether the governmental unit is attempting to enforce its policy or regulatory power or rather is merely adjudicating private pecuniary interests. Under the pecuniary-purpose test, a bankruptcy court has to determine whether the government action relates primarily to the protection of the governmental unit's pecuniary interest in the debtor's estate. Government proceedings intended to safeguard what is merely a pecuniary interest in the debtor's estate are subject to the stay. For example, in *In re Rusnak*,[34] the bankruptcy court held that a Medicare exclusion based solely on a debtor's failure to pay an educational loan and not based on any fraud was not exempt from the automatic stay under §362(b)(4) because its purpose was to protect the government's pecuniary interest, rather than to promote a public purpose. In other cases, the federal government has conceded that if the proposed Medicare exclusion were based on a "desire to protect its pecuniary advantage," §362(b)(4) would not apply.[35] Even though pecuniary interests are implicated by choosing to exclude a health care business in bankruptcy, if the purpose of the exclusion is the substantive protection of patients or prevention of fraud, the exclusion will likely be considered exempt from the automatic stay. On the other hand, if the exclusion is based solely on failure to meet financial obligations, like educational loans, the bankruptcy court will be more likely to find that the exclusion is intended to protect a pecuniary purpose.

Very few of the grounds for exclusion relate to pecuniary interest at all. Moreover, given the government's interest in protecting the integrity of the Medicare program and Medicare's patients, the courts have no difficulty in concluding that acts to exclude providers are based on issues relating to the public interest, rather than on adjudication of private rights.[36] Thus, as a practical matter, §362(b)(28) simply makes explicit what most courts and practitioners thought was already the state of the law under §362(b)(4). To the extent it changes the rules for debtors who had failed to repay educational loans, like in *Rusnak*, those will only affect individual cases.

In any event, this issue rarely arises in bankruptcy cases. Although thousands of Medicare providers may be excluded at any time, there are very few reported bankruptcy decisions on exclusions. The majority of the case law regarding Medicare issues in bankruptcy cases deals with reimbursement of Medicare funds, including suspensions of payments, rather than an exclusion of Medicare providers.[37] Thus, as a practical matter, entities facing exclusion have only infrequently tried to contest that exclusion in bankruptcy court and §362(b)(28) will, at best, be used sparingly.

What the Law Does Not Do

Some commentators have interpreted §362(b)(28) as changing the way that HHS can exclude health care businesses from participation in Medicare. One law firm blog said that "CMS may now exclude any health care business from federally funded programs." Of course, the government can exclude providers, but the blog entry suggests that this is a new power derived from the Act. As explained above, most practitioners and courts already thought exclusions were exempt from the automatic stay. Moreover, the blog entry suggests that the OIG[38] can exclude without regard for the bankruptcy court. This is untrue for at least two reasons. First, exclusion decisions are subject to administrative appeals and appellate review.[39] While that review is limited,[40] it suggests that an exclusion decision could be reviewed by a bankruptcy court for at least the same statutory grounds available to other review authorities.[41] Second, debtors facing exclusion can still seek to have the bankruptcy court impose a temporary injunction under §105, even if the automatic stay does not apply.[42] Third, exclusion solely on the basis that a debtor has failed to repay a dischargeable debt

27 "Criteria for Implementing Permissive Exclusion Authority under §1128(b)(7) of the Social Security Act," *Federal Register,* Vol. 62, No. 247, at 67392 (Dec. 24, 1997).

28 42 U.S.C.S. 1320a-7(c)(2).

29 42 U.S.C.S. 1320a-7(f).

30 *See, e.g., In re Orthotic Ctr. Inc.*, 193 B.R. 832 (N.D. Ohio 1996); *In re Univ. Nursing Care Ctr. Inc.*, No. 92-00199 (Bankr. N.D. Fla. Jan. 16, 1996); *see, generally, In re Moss*, 270 B.R. 333 (Bankr. W.D.N.Y. 2001) (court in chapter 13 case held debtor's pre-petition exclusion from Medicare program that continued post-petition did not violate the automatic stay.).

31 *In re Psychotherapy and Counseling Ctr.*, 195 B.R. 522, 529-30 (Bankr. D. D.C. 1996) (court enforced a pre-petition settlement agreement between HHS and debtor that barred HHS from excluding the debtor from participation in the Medicare program).

32 *Psychotherapy and Counseling Ctr.*, 195 B.R. at 527-28.

33 *Id.* at 528 (*quoting* 124 Cong. Rec. H. 11092, H 11093 (Sept. 28, 1978); S17409 (Oct. 6, 1978) (remarks of Rep. Edwards and Sen. DeConcini)).

34 184 B.R. 459 (Bankr. E.D. Pa. 1995).

35 *See Psychotherapy and Counseling Ctr.*, 195 B.R. at 525; *accord, Medicar Ambulance Co. Inc. v. Shalala* (*In re Medicar Ambulance Co. Inc.*), 166 B.R. 918, 926-27 (Bankr. N.D. Cal. 1994) (discussing pecuniary purpose test in context of a Medicare suspension of payments to provider).

36 That said, it should be recognized that there are serious questions about the validity of the "public interests/private rights" test. *See* Cordy, Karen, "Public Interest and Private Rights—A Simpler Theory of Regulatory Action," Am. Bankr. Instit. J. (June 2003).

37 *HHS v. James*, 256 B.R. 479,481 (W.D. Ky. 2000).

38 OIG is the actual agency, not CMS, with authority to exclude providers.

39 42 U.S.C.S. 1320a-7 (c)(2) and (f).

40 *See, e.g., In re Durrell A. Chappell*, HHS Departmental Appeals Board, Civil Remedies Division, CR108 (Nov. 8, 1990), available at www.hhs.gov/dab/decisions/cr108.html (administrative law judge finds that exclusion for conviction for Medicaid related fraud is a "police or regulatory act" to "prevent or stop a present or immediate danger to the public" of fraud against the Medicaid program, and therefore exempt from the automatic stay under §362(b)(4)).

41 Whether debtors in bankruptcy must exhaust administrative remedies prior to the bankruptcy court taking jurisdiction is controversial. Maizel, Samuel R., "Anatomy of a Health Care Insolvency Case: Issues and Recent Amendments," prepared for Commercial L. and Bankr. Section of Am. Bar Ass'n. of San Francisco (June 13, 2006).

would likely violate §525(a).[43] Thus, the OIG cannot act without any regard for the bankruptcy court, despite the new exception to the automatic stay.

At least one commentator has suggested that §362(b)(28) affects the existing controversy over whether Medicare's efforts to adjust post-petition payments to recover prior overpayments is an act of setoff (and, therefore, subject to the automatic stay) or a recoupment (and, therefore, not subject to the automatic stay). This is not the case. The statute itself has no language addressing the issues that courts consider when deciding whether Medicare's adjustments constitute a recoupment or setoff. Conceptually, payments subject to recoupment are post-petition payments that arise out of the same transaction as some pre-petition obligation. Recoupment is not subject to the stay because it would be inequitable to allow the debtor to take the benefits of the transaction without the burdens. Setoff, on the other hand, occurs where payments arise out of different transactions. A creditor's right to setoff is subject to the automatic stay. Thus, the issue bankruptcy courts grapple with is whether the Medicare payments arise under a single transaction or, because of how those payments are structured, arise annually out of different transactions. Because of Medicare's position as the largest single payor for medical services in the nation, this issue can frequently be the deciding factor in a Medicare provider's ability to reorganize.[44]

Making clear that the Secretary's exclusionary powers are exempt from the stay offers no guidance regarding the recoupment versus setoff issue. None of the grounds discussed in the Medicare statutes for exclusion relate to a failure by a health care provider to repay prior overpayments, and they certainly do not discuss any issues related to how a bankruptcy court would evaluate whether the Medicare payment procedures create a single transaction for recoupment purposes. The implicit question is whether the amendment provides some indirect leverage to the government so that it will be able to compel debtors to allow the adjustments by threatening to exclude them from participating in Medicare, thereby jeopardizing their reorganization efforts. This amendment does not seem to aid this type of coercion.

Moreover, to the extent that the government began to stray from its statutory grounds to exclude a provider and sought to do so based on a failure to voluntarily repay prior overpayments, presumably bankruptcy courts could react by applying the same tests that have been used in evaluating conduct under §362(b)(4)—*i.e.,* is the exclusion an effort by the government merely to protect its own pecuniary interest?

In courts that had held Medicare exclusions exempt from the automatic stay under §362(b)(4), some debtors had been able to obtain injunctions under §105 to stay the exclusion.[45] The legislative history suggests, and cases have held, that debtors can obtain discretionary stays to enjoin acts exempted from the automatic stay.[46] An example of this is *Richmond Paramedical Services Inc.*,[47] where the bankruptcy court, in an effort to preserve the going-concern value of the debtor's assets, granted a temporary injunction under §105 against a valid exclusion pending the sale of the debtor's assets. However, one commentator has suggested that "[u]nder the amendment, injunctions [against exclusions by the government] are less likely."

How passage of §362(b)(28) would affect a bankruptcy court's determination as to imposing an injunction under §105 is hard to discern in the language of the amendment. Exemption from the automatic stay does not mean that a creditor's acts can not be stayed—it only means that the stay must be imposed, if at all, upon motion by the debtor and consideration of the facts by the bankruptcy court. In order for the bankruptcy court to grant a §105 injunction, the debtor must satisfy the traditional elements for a preliminary injunction, which are usually (1) irreparable harm to the debtor, (2) likelihood of success on the merits (in this case, with regard to reorganization), (3) balance of harm to the creditor and debtor and (4) public interest.[48] Bankruptcy courts that have imposed injunctions under §105, presumably, have reached the conclusion compelled by the amendment: The automatic stay does not apply to exclusions. If the automatic stay applied, an injunction under §105 would not be necessary. If a debtor is able to convince the bankruptcy court to impose a discretionary injunction when the exclusion was exempt from the stay under §362(b)(4), it suggests that the debtor could also convince the bankruptcy court when the exclusion is exempt under §362(b)(28). The further evidence of Congress' specific concern and intention to allow these exclusions to take place is likely to inform the court's analysis of how to use its discretion when deciding a §105 motion. That being said, there is simply nothing in the language of §362(b)(28) to alter or affect a bankruptcy court's analysis of the four-part test traditionally used to decide whether to impose an injunction under §105.

Conclusion

Section 362(b)(28) does little to alter the status of exclusions before the amendment. Moreover, it neither expands the rights of the OIG to exclude providers, nor eliminates the bankruptcy court's power to address an exclusion. Despite all the dire predictions of doom occasioned by the enactment of §362(b)(28), it is far from clear that it will have any significant impact on health care restructuring practice. So calm down, Chicken Little: The sky is not falling. ■

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42 *But see, e.g., In re 1820-1838 Amsterdam Equities, Inc.*, 191 B.R. 18, 21-22 (S.D.N.Y. 1996); *In re First Alliance Mortgage Co.*, 264 B.R. 634, 651-56 (C.D. Cal. 2001) (noting that, while use of §105(a) was possible under the case law, the appropriate circumstances for its use were highly circumscribed and it should not be used merely to avoid an unfavorable result in litigation).

43 Section 525(a) prohibits governmental entities from discriminating against debtors on the basis of discharged debts. 11 U.S.C. §525(a) ("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...a person that is or has been a debtor under [the Bankruptcy Code] or...has not paid a debt that is dischargeable in the case under [the Bankruptcy Code] or that was discharged under the Bankruptcy Act").

44 For more on the issue of whether Medicare's rights are properly characterized as setoff or recoupment, *see* Maizel, Samuel R., "An Issue that Just Won't Go Away," *ABI Journal*, Vol. XXIII, No. 6, at 34 (Jul./Aug. 2004); Maizel, Samuel R., "Medicare's Recoupment Rights Get More Confusing," *ABI Journal*, Vol. XVI, No. 7 (Sep. 1997).

45 *See, e.g., In re Hosp. Staffing Servs., Inc.*, No. 98-21899-BKC-RBR, Adv. Pro. No. 98-2151-BKC-RBR A (Bankr. S.D. Fla. May 15, 1998); *In re Community Hospice Inc.*, No. 93-11993-PHX-SSC, Adv. Pro. No. 93-1158 (Bankr. D. Ariz. Dec. 6, 1993); *Richmond Paramedical Serv. Inc. v. United States.*, 94 B.R. 881 (Bankr. E.D. Va. 1988), *aff'd. in part,* 1989 WL 149150 (E.D. Va. May 17, 1989), but remanded for consideration of sovereign immunity issues.

46 *In re King Mem'l Hosp.*, 4 B.R. 704, 719 (Bankr. S.D. Fla. 1980). For more on obtaining injunctive relief in health care businesses cases, *see* Maizel, Samuel R. and Waltz, Judith, "Injunctive Relief In Health Care Insolvencies," 24 Cal. Bankr. J. No. 3 (1998).

47 *Richmond Paramedical Serv.*, *supra*, fn. 27.

48 *Doran v. Salem Inn Inc.*, 422 U.S. 922, 931 (1975).