HEALTHCARE INDUSTRY WHITE PAPER

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CROSSROADS, LLC

McGUIREWOODS
Relationships That Drive Results

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1. The States' Budget Crises and the Impact on the Healthcare Industry

The states' budget crises appear likely to persist into fiscal year (FY) 2005 at a minimum. Nearly every state is facing revenue shortfalls that exceed earlier projections. At the Federal level, the government faces worsening deficits, due at least in part to a sluggish economic recovery and expenses related to the war in Iraq. Many states are constitutionally required to balance their budgets. If the federal government is not able or willing to step in next year, very difficult resource allocation decisions will have to be made. It is anticipated that there will be a few winners but more losers in the battle for scarce healthcare dollars.

As the fiscal crisis in the states enters its fourth year, the 6.4% national unemployment rate appears to be near its peak for this economic cycle. Resultant losses in both income and private insurance coverage have forced more workers and their families onto the Medicaid rolls. At the same time, according to a study by the Kaiser Commission on Medicaid and the Uninsured (KCMU) released September 22, 2003, state tax revenues have fallen 7.4% from their pre-recession levels. This is more than twice the severity of state revenue declines experienced in the two prior recessions of 1990-91 and 1980-82. A collapse in capital gains tax revenues in the wake of the late '90's stock market boom (off 50% in 2001 alone), weakness in manufacturing, and reduced consumption leading to lower sales tax revenues all are playing a part. The net result of these and other factors was a collective $61.8 billion state-level revenue shortfall in FY 2002, versus a $6.9 billion growth in Medicaid spending for the year.

Medicaid is second only to education as a percent of states' general fund expenditures. After expanding benefits in the boom years, state Medicaid programs have been on the chopping block now for several years. According to the KCMU survey, "…all 50 states and the District of Columbia have planned or implemented Medicaid cost containment actions for FY 2004." These measures go beyond cuts made in FY 2002 and 2003. Only the $20 billion in emergency Federal fiscal relief granted to the states by Congress in June 2003 prevented planned FY 2004 state Medicaid spending cuts from going even deeper.

Medicaid Feels the Knife

State budget pressure on Medicaid is having an impact on all sectors of the healthcare industry to varying degrees. According to the KCMU survey, in FY 2004 alone provider payments have been frozen or reduced in 49 states – particularly payments earmarked for physicians and inpatient hospital care. This is increasing pressure on physician groups and hospitals to cut costs.

Industry analysts are also noting a decline in the growth rate of hospital admissions in 2003 as rising costs, the influence of managed care, and slow-moving personal income growth have apparently deterred some patients from seeking treatment. It is anticipated that admission declines will put pressure on hospital bottom lines already impacted by government payer freezes and reductions:

- KCMU reports 44 states are acting to control prescription drug costs, either through expanding preferred drug lists (PDLs) or by seeking supplemental rebates from the drug industry.
- Twenty states are reducing benefits for services such as dental care, vision, home care, and physician visits.
- Eighteen states are reducing or restricting Medicaid eligibility, including decreasing income eligibility limits to nearer the Federal poverty line.

- Twenty-one states plan to increase beneficiary co-payments in FY 2004.

Interestingly, skilled nursing facilities (SNFs) as a group did relatively well compared to other healthcare sectors in the contest for FY 2004 state Medicaid dollars. According to KCMU, 29 states actually *increased* provider rates for nursing homes, while 13 states froze them. Only six states acted to decrease nursing home Medicaid reimbursement rates.

With growth in Medicaid enrollment finally easing as eligibility tightens, average Medicaid spending growth slowed to 9.3% in FY 2003 – the first growth rate decline in seven years. Growth in Medicaid spending is expected to slow still further – to 4.6% in FY 2004. However, despite cost containment measures already implemented, thirty-two state governments surveyed by KCMU foresee a Medicaid budget shortfall this fiscal year. Many state officials are concerned that FY 2005 will not be any better, since state revenue levels are not expected to rebound strongly in the foreseeable future. Additional Federal emergency funding may be tougher to obtain – especially considering the $87 billion estimated price tag for Iraq.

2. Medicare, Medicaid and the SNFs

In recent years the SNFs have faced the challenges of government payer policy shifts – from cost-based reimbursement to the prospective payment system, or PPS. The SNFs have also been buffeted by escalating cost trends in other respects (see medical malpractice discussion below). Inpatient hospital services were the first to transition to PPS back in October 1984, but the nursing home industry escaped until July 1998. Since then, most other healthcare service sectors have been subjected to the PPS process: outpatient services, August 2000; home health services, October 2000; inpatient rehabilitation, January 2002; and other long-term care services, in October 2002.

The transition to PPS was a rough one for the SNFs. At one time in the late 1990s, five of eight major for-profit nursing facility companies were in bankruptcy. While a period of recovery ensued in which four of five former bankrupt companies emerged from Chapter 11, a new round of financial distress took shape following the imposition of the Medicare add-on payment provision sunset on October 1, 2002. Since that time, Centennial Healthcare and two regional nursing facility chains have filed for bankruptcy.

However, the potential for further bankruptcies has apparently been somewhat blunted by Federal and state reimbursement rate increases during 2003. As already mentioned, increases in Medicaid reimbursement rates have been instituted in many states during 2003, despite earlier fears of cuts stemming from state budget problems. Even budget-strapped California upped its Medicaid payment rates for SNFs by 3.8% in August. Meanwhile, several of the larger chains have successfully instituted higher per diem rates for private pay patients, while continuing to “fine tune” their portfolio of properties to improve their quality mix (proportion of revenues from Medicare and private pay patients) and maintaining improving occupancy trends. Other strategies aimed at rebuilding margins include increasing the mix of Alzheimer’s disease (AD) units, further boosting the private pay component of revenues.

While still not enough to fully offset the negative impact of prior reimbursement reductions, this has been a step in the right direction.

Medicare SNF Payments Increased in October 2003

More good news came in August 2003, when the Centers for Medicare & Medicaid Services (CMS, the successor agency to the Health Care Financing Administration or HCFA) announced it would increase reimbursement rates for SNF services commencing October 1 – the reverse of what happened in 2002. There are two parts to the increase: (1) a 3.3% rate hike to correct past forecasting errors, and; (2) a 3% annual update in Medicare reimbursement rates for FY 2004. The resultant 6.3% rate increase makes up better than half the sunset cuts imposed last year.

3. Medicare Reform and Drug Reimbursement Bill Progress

Aside from potential fallout of the pending Medicare reform legislation mainly related to drug reimbursement, no major Medicare reimbursement cutbacks are on the horizon. The major remaining reimbursement uncertainty involves progress on this year's Medicare reform bill and the impact of the recent implementation of caps on reimbursement for therapy services (mostly at nursing homes).

Sharply different versions of the Medicare reform bill were passed by the United States Senate and the House of Representatives in June. As we went to press, the legislation was tied up in a joint House-Senate conference committee, while lawmakers attempt to iron out major differences between the House and Senate versions.

The bill's estimated $400 billion price tag over ten years, much of it earmarked to fund a new prescription drug benefit, is daunting. Other provisions of the bill allocate approximately $25 billion in payment assistance to rural healthcare providers. The House version of the bill also calls for a hospital Medicare payment update at a rate of 0.4 % below inflation in 2004 and 2005. The Senate version includes restrictions on physician referrals to specialty hospitals – a recently growing healthcare sector. With time running short, it is anticipated that a more limited version of the legislation – one that provides some senior drug benefits, for example – may be enacted in place of the broader measure currently under discussion.

Momentum Building to Reform Payment for Drugs

Depending on which version (and how much) of the Medicare reform bill is enacted, the legislation could either eliminate or substantially alter the existing average wholesale price (AWP) methodology used to calculate drug reimbursement amounts paid to doctors and healthcare facilities. Because the bill could eliminate what amounts to a cross-subsidization of pharmacy services and other hospital costs via current Medicare pharmacy reimbursements, there is a high probability that this legislation will trigger a budget crunch in the acute care segment of the hospital industry.

As things stand now, hospitals and other healthcare providers are reimbursed at AWP rates that are frequently in excess of prices that are privately negotiated with pharmaceutical suppliers. Healthcare providers use these savings to support other services. Eliminating the effective subsidy through retooling the AWP formula would effectively reduce reimbursement paid to healthcare providers through Medicare. Drug wholesalers also stand to be adversely impacted depending upon which version of the proposed law is eventually enacted.

Recent press reports suggest that the crux of the Medicare reform bill negotiation turns upon the issues of:

- Whether to eliminate AWP altogether in favor of a competitive bidding process orchestrated by the drug wholesalers, while also providing the option of reimbursement directly to doctors based on an average *selling* price methodology (the House version), or;
- Whether to grant the CMS wide latitude determining the AWP methodology and formula (the Senate version). The methodology would likely set reimbursement rates as much as 15% below current levels.
- The degree to which Medicare might be made to compete with the private health insurance sector in the future.

As already noted, negotiations between proponents of the bill's House and Senate versions were ongoing at press time. No compromise had yet been reached, making passage this year of broad legislation increasingly doubtful with each passing day. With a presidential election year on tap in 2004, it seems doubtful that any further progress on this matter will occur until 2005 – at the earliest. Meanwhile, CMS is proposing rule changes of its own concerning Medicare drug reimbursement, which will only take effect if the legislative effort fails. Suffice to say the eventual outcome of this imbroglio is difficult to gauge.

Drug reimbursement reform appears unlikely to take a major toll on SNFs in the same manner as the add-on provisions sunset of 2002. Elimination of the favorable cross-subsidy characteristics of the old drug reimbursement system is a negative development. However, provision of pharmacy *services* (apart from the drugs themselves) looks likely to be given added weight in reimbursement calculations under the new legislative guidelines. This could ease the sting of the Medicare reform bill for SNFs and acute care hospital facilities alike.

Medicare Part B Caps Finally Implemented

Of greater importance to the rehabilitation sector, CMS has proposed new rules involving annual "caps" on physical, speech, and occupational therapy. The Balanced Budget Act of 1997 created SNF therapy caps for Part B outpatient rehabilitation services – that is, for patients in a nursing home who are not on Medicare Part A. The caps were repeatedly delayed, and some observers thought they would never go into effect, as they severely restrict the amount of therapy a beneficiary can receive. AARP and other organizations have lobbied for another delay, but in September 2003 the caps became the law. The caps are an annual $1,590 per beneficiary limit for occupational therapy and a separate $1,590 for physical and speech therapy combined. There are no reliable estimates on the potential impact of the caps on SNFs (the caps do not apply to other providers of therapy).

4. The Growing Cost of Medical Malpractice Insurance

The Medical Malpractice (also referred to as Patient or Professional Liability) crisis is considered a significant threat to the healthcare system in the United States. Every provider organization is at risk for sudden losses resulting from litigation that could put many healthcare organizations out of business. All stakeholders need to reconfigure their risk analysis and monitoring protocols of the healthcare businesses under their review. No longer are simple financial ratios and other traditional performance evaluation tools sufficient. New, more operationally focused tools are needed to properly evaluate investment risk and protect healthcare providers from this type of litigation.

Medical litigation has forced U.S. healthcare costs higher, while distorting healthcare services in the United States through so-called "defensive medicine." As of mid-2003, the American Medical Association had identified twelve U.S. states – Florida, Georgia, Mississippi, Nevada, New Jersey, New York, Ohio, Oregon, Pennsylvania, Texas, Washington, and West Virginia – as crisis states for medical malpractice lawsuits. California nursing facilities are feeling the sting of increased patient liability costs – this despite legislation enacted in 1975 which set limits on liability awards impacting other healthcare segments in the state.

Federal and state lawmakers are gradually responding to the costly up-tick in these cases. The Office of Disability, Aging and Long-Term Care Policy within the U.S. Department of Health and Human Services issued a white paper addressing this topic in March 2003. This white paper detailed the Bush Administration's quality of care concerns, quantified costs arising from the medical litigation system and proposed several needed reforms – notably federal tort reform legislation. The Administration argues that the current medical litigation system is threatening access to care, jeopardizing quality of care, and forcing healthcare costs higher. Huge, non-economic damages awarded by juries and the ballooning settlement costs these awards engender are *prima facie* evidence in the Administration's case of the root source of healthcare cost escalation. Doctors fearing medical malpractice claims practice "defensive medicine" – ordering medically unnecessary tests and procedures for patients out of concern over potential lawsuits. This drives up medical costs, in turn affecting private insurers and state and Federal government agencies.

The government white paper goes on to describe how doctors, hospitals, and nursing homes in many states are encountering difficulty obtaining insurance. Meanwhile, insurance premiums (when coverage is still available) have been skyrocketing at double-digit annual rates. Premiums charged to specialists in 18 states without effective caps on non-economic damages rose 39% from 2000 to 2001. These punishing cost increases are forcing more doctors and hospitals to curtail or exit certain specialty practices and nursing homes to flee some state jurisdictions such as Florida. Obstetrics-gynecology (OB-GYN) is the worst affected specialty, although internal medicine, orthopedics, neurosurgery, radiology, and trauma physicians and practices are also experiencing rapid run-ups in "med mal" insurance costs.

Imposing caps on non-economic damages has the potential to save taxpayers billions of dollars annually, according to government estimates. To further this objective, the Administration supports federal reforms in medical liability law including a cap on recoveries for non-economic damages of $250,000 and a cap on punitive damages of $500,000. The Administration also wants to tighten statutes of limitation and allow for

payments of judgments over time, rather than as “lump sums.” Beyond this, the Administration foresees intangible benefits of tort reform. Better collection of incident reports (similar to the process in New York State) would foster an environment where best practices and quality of care would take precedence over a tendency to “sweep mistakes under the rug” to avoid legal liability.

While Federal tort reform action this year is not now expected, many state legislatures have pressed forward with a variety of tort reform bills aimed to stem further cost increases and deterioration in healthcare availability.

Treatment of Post-Bankruptcy Malpractice Claims

While there is little case law involving the treatment of post-bankruptcy medical malpractice claims, these claims clearly fall into the same class as all other unliquidated, contingent or disputed administrative claims. A healthcare provider may be required to estimate these malpractice claims in its plan of reorganization for the purpose of establishing plan feasibility or other confirmation requirements. Because ultimate loss experience will be challenging to estimate, these patient liability issues may assume central importance in future long-term care bankruptcies. The nearer to the mark these estimates are, the more likely a reorganization plan will succeed in putting the long-term care enterprise back on its feet as a viable “going concern.” (Please refer to **Appendix A,** “Treatment of Post-Petition Medical Malpractice Claims in Chapter 11 Plans of Reorganization” for a more detailed legal exposition of the issues at hand.)

5. Patient Care Liability Issues and the SNFs

A study undertaken by Aon Risk Consultants, Inc. for the American Health Care Association (July 2003) examined the patient liability crisis from the standpoint of the long-term care industry. The study encompassed SNFs, independent living, assisted living, home healthcare, and rehabilitation facilities representing 480,000 beds – about 26% of U.S. long-term care beds.

Since 1995, general liability/professional liability (GL/PL) losses at the SNFs have accelerated at rates that offset an ever growing proportion of Medicaid reimbursement increases. Patient rights laws enacted during the past fifteen years are primarily responsible, according to Aon’s authors.

On a per diem basis, where the overall cost per exposure, or “loss cost,” absorbed about 2% of Medicaid reimbursement in 1995, by 2002, fully 7% of Medicaid reimbursement dollars went to stoke the GL/PL furnace. Double-digit annual increases in both the number of claims and the average claim size (frequency and severity) have plagued six states in particular – Florida and Texas (the worst affected), followed by Arkansas, California, Mississippi and Alabama. Unfortunately, this represents a national trend, since the loss cost per occupied bed in the long-term care industry has mushroomed nearly ten-fold in a dozen years – from $290 in 1991 to $2,880 in 2002 – according to the Aon study. That said, the Florida loss cost was $11,810 per occupied bed in 2002, while Texas rang the register at $6,310. Correspondingly, in Florida higher insurance costs have absorbed 69% of Medicaid reimbursement rate increases since 1995; in Texas, the percentage for the same period was 53%.

Despite Medicaid's countrywide average reimbursement rates that were $30.69 (40.6%) per diem higher in 2002 than in 1995, the Aon study finds that insurance costs have absorbed $6.38 of this amount – about 21% of total increases. Aon analysts express concern that even with tort reform caps of $250,000 on non-economic damages, rising *frequency* rates represent a worrisome trend that tort reform by itself is insufficient to staunch.

Before 1995, insurance companies considered the nursing home industry a relatively good insurable risk. Now, they are exiting the business altogether in some states, while sharply increasing rates elsewhere. According to the Aon survey, annual commercial insurance premium levels jumped 143% between 2001 and 2002, even as coverage was reduced. This followed a 130% premium hike in the prior year. Clearly, these increases range far above cost increases in other categories and are biting into already thin operating profit margins across the long-term care sector.

To no surprise, major long-term care providers – and nursing facility chains in particular – are scrambling to limit their patient care liability exposure by divesting facilities located in states with an unfavorable liability settlement track record. As already noted, some insurers have stopped writing patient liability coverage policies in certain states altogether, further contributing to upward cost pressures.

6. Progress on Tort Reform in the United States

Even if the U.S. cavalry is not on the way in 2003, the state militia is. Tort reform is gradually making inroads at the state level. Texas and Florida – historically two of the most difficult patient care liability jurisdictions – recently enacted tort reform. In August 2003, Florida Governor Jeb Bush signed into law a bill capping non-economic damages against individual physicians at $500,000, and against physician groups at $1 million. In September, Texans ratified a constitutional amendment capping medical malpractice damages. Earlier, the Texas legislature passed and the governor signed a new law capping non-economic damages for physicians at $250,000. Although it was ratified by a narrow margin, the new constitutional amendment should help fend off serious legal challenges to the new law.

Despite progress in these two important states, patient care liability costs remain a significant challenge to SNFs in the Gulf states region in particular (except for Louisiana, which already has non-economic damage caps in place) and in many other states as well. Even though passage of preemptive tort reform in states such as Ohio is encouraging, new liability "hot spots" could flare up before tort reform is complete.

7. Financing Considerations

Progress on tort reform, recent CMS reimbursement actions, and neutral-to-positive FY 2004 Medicaid moves by the states have resulted in a more sanguine view of the SNFs on Wall Street than earlier this year. While access to debt markets is running about even with 2002, equity financing is making a slower recovery. Until the long-term care industry generally (and SNFs in particular) begins to show a sustained turn-around in profit margins, attracting additional equity capital will be difficult.

To some degree, government loan programs help stabilize funding for the SNFs and the long-term care industry more generally. Bond offerings and bank loan renewals are augmented by government-sponsored funding sources such as Fannie Mae, Freddie Mac,

The Department of Housing and Urban Development, and the Federal Housing Administration (HUD/FHA). FHA insured $1.2 billion in nursing facility loans in FY 2002, in addition to $0.6 billion for other assisted living facilities during the period.

Another important source of financing for nursing facility operators is real estate investment trusts (REITS). Unlike tenant nursing home operators, who shoulder the increasing cost of patient care liability risk, property owners and landlords at the REITS are not responsible for these costs. New nursing home operators can generally be found to replace those who fall into financial difficulty, leaving the income stream underlying the REITS unscathed.

8. Treatment of Nursing Home Leases in a Bankruptcy

It is increasingly apparent that SNFs that lease rather than own their facilities operate can benefit from a careful review of their lease costs, which may be considerably higher than market comparables. Particularly for companies nearing a cash-flow "crunch," renegotiating and reducing lease costs may provide significant relief.

Likewise, rejecting leases during the bankruptcy process can provide relief. When pursuing this tactic, it is important to understand how nursing home leases are treated during a bankruptcy. The status of a nursing home lease in a Chapter 11 process hinges upon the court's determination of whether a given facility constitutes residential or non-residential real property. As for any executory contract, the bankruptcy process provides the debtor an opportunity to assume or reject leases as economic or non-economic. However, the time period in which such a determination must be made varies depending on whether the leased real property in question is primarily of a residential or non-residential character. If the property is deemed by the court to be non-residential, the decision to assume or reject must be made within 60 days of filing or within such additional extension of time as may be granted by the bankruptcy court. If residential, the debtor may assume or reject the lease at any time before the confirmation of the plan of reorganization. (Please see **Appendix B**, "Is a Nursing Home Lease a Lease of Residential or of Non-Residential Real Property…" for a more detailed discussion of these related legal issues.)

9. Recent Instances of Fraud in the Healthcare Industry – Foreshadowing the Future?

Two substantial healthcare frauds have been unveiled within the past year. The first involved National Century Financial Enterprises, a purchaser, and financial re-packager of healthcare receivables. The second was HealthSouth Corporation, the largest provider of services in the rehabilitation sector.

While fraud in the healthcare sector is not new, it is natural to wonder whether the problems of these two important healthcare companies might be a harbinger of broader industry distress. Even if they prove to be relatively isolated instances, might the same "negative halo" effect in terms of access to financial markets come to dominate various segments of the healthcare industry as it has the energy sector? There, even industry leaders have been tainted by allegations that energy trading volumes were falsified in order to artificially inflate revenues derived from the supposedly fast-growing energy marketing and trading business.

National Century Financial Enterprises

National Century Financial Enterprises bought medical receivables from healthcare providers and packaged structured transactions which were supported by medical insurance reimbursements. The company filed for Chapter 11 in November 2002, after it became evident that receivables were about half a billion dollars less than reported.

According to prosecutors, National Century had evolved into a huge Ponzi scheme. In August 2003, the former Executive Vice President – Compliance of National Century pleaded guilty to conspiracy to commit securities fraud. Separately, on September 15, 2003, the company presented the bankruptcy judge a joint plan of liquidation for the resolution of outstanding claims and equity interests. (Please refer to **Appendix C**, "Criminal Penalties for Making False Representations in Any Claim for Medicare Payments" for a further discussion of criminal liability.)

More difficult collections of healthcare receivables are driven by such trends as increased unemployment, higher co-pays, and tightened Medicaid eligibility standards. Lengthening collection cycles are providing a growing market niche for companies similar to National Century that finance healthcare accounts receivable. It has been estimated that between 10 and 20% of total healthcare accounts receivable are now financed in this manner. The National Century debacle has not had a significant negative impact on the remaining lenders participating in this market; however, it has resulted in an expansion opportunity for the smaller lenders in this fragmented business.

HealthSouth Corporation

HealthSouth Corporation was the largest provider of inpatient and outpatient rehabilitation services in the United States. The corporation's growth prior to 1998 was largely a product of acquisitions and geographic expansion.

HealthSouth thrived under the old cost-based reimbursement system. With the transition to a prospective payment system (PPS) in 1998, revenue growth stalled while pressure on profit margins accelerated sharply.

The government alleged earlier this year that, starting in 1999, HealthSouth's former management conspired to overstate earnings and assets by $1.4 billion and $0.8 billion, respectively. In March 2003 the company announced that "…historical financial information should not be relied upon." Following this announcement, the company's banks declared HealthSouth in default of its revolving credit agreement, blocked interest payments on the corporation's senior subordinated notes, and blocked payment of principal and interest on HealthSouth's convertible securities. Subsequently, two former CFOs and an Assistant Controller pleaded guilty to Federal fraud charges (the first of what proved to be several more guilty pleas), and the company's CEO, CFO, and auditor were replaced. On November 4, 2003, Richard Scrushy, former CEO of HealthSouth, was indicted on Federal fraud charges.

The company continues to operate outside of bankruptcy, amidst widening legal investigations of the company's operations and former officers. Congressional hearings into HealthSouth began on November 5, 2003.

It appears that the problems that have been unveiled so far involving National Century and HealthSouth are particular to those companies and their individual circumstances, rather than evidence of a systemic problem, such as what afflicted the energy business in recent months. In the energy, power, and utilities sector, many of the allegations of corporate malfeasance centered upon the sudden and unregulated development of the energy, marketing, and trading businesses as within the industry and the widespread reporting of false information regarding trading volumes and revenues. By contrast, the healthcare companies in question were already regulated and operating under scrutiny for fraud. Also, National Century and HealthSouth operate in a number of different sectors within a highly fragmented industry; therefore no unified pattern of malfeasance characterizes them. As a result, unlike the situation that developed in the energy sector, the financial markets have not painted all the companies in healthcare industry with the same brush. The industry's problems, for example in the SNF sector, will continue to be driven by underlying weaknesses in the business, not by the specter or possibility of fraud.

10. Post-Petition Recoupment of Pre-Petition Medicare Overpayments

The issue of post-petition recoupment of pre-petition Medicare overpayments will assume importance for any provider of healthcare services that files bankruptcy. Basically, a provider must evaluate to what extent CMS (or various state Medicaid agencies) might reduce future payments to recover prior overpayments. (See **Appendix D**, "Post-Petition Recoupment of Pre-Petition Medicare Overpayments" for a more detailed legal discussion of this issue.) Because adjustments are made to correct past payment inaccuracies in the normal course of administering Medicare payments, courts have generally found that CMS may in fact reduce current payments to bankrupt providers to recover pre-petition overpayments, unless to do so would be inequitable to other parties in the bankruptcy process. Courts have generally applied this approach in instances involving Medicaid, although it is important to realize that future distinctions may be made based on differences between the administration of Medicare and Medicaid claims.

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11. Appendices

Appendix A: Treatment of Post-Petition Medical Malpractice Claims in Chapter 11 Plans of Reorganization

Medical malpractice claims arising after the petition date may become an important concern for a healthcare provider reorganizing under the Bankruptcy Code (the "Code"). In many jurisdictions, medical malpractice awards are skyrocketing and insurance premiums are following suit. Generally, these claims are uncertain and may take several years to litigate. Nonetheless, the expansive definition of a "claim" under the the Code clearly includes these unliquidated, contingent, and disputed personal injury claims. 11 U.S.C. § 101(5); 28 U.S.C. § 157(b)(2)(B) (implicitly assuming that "unliquidated personal injury tort" claims constitute "claims" under the Code). In fact, medical malpractice claims arising after the petition date are administrative expenses under 11 U.S.C. § 503(b)(1)(A), Reading Co. v. Brown, 391 U.S. 471 (1968), and receive the highest statutory priority. 11 U.S.C. § 507(a)(1). Therefore, the healthcare provider must account for these malpractice claims in its plan of reorganization.

A Chapter 11 plan will only be approved by a bankruptcy court if it is feasible, meaning that it is not likely to result in the provider's liquidation or require additional reorganization unless contemplated by the plan. 11 U.S.C. § 1129(a)(11). A plan cannot be approved without providing for payment in full of administrative claims. In re Pizza of Hawaii, Inc., 761 F.2d 1374, 1382 (9th Cir. 1985); 11 U.S.C. § 1129(a)(9)(A). Placing too high a value on any one medical malpractice claim in a plan would work to the detriment of the other creditors by reducing the amount of money available for the satisfaction of their claims, while placing too low a value on any one medical malpractice claim can result in the creation of a plan that the healthcare provider cannot satisfy. Therefore, ascribing a value to each known malpractice claim and an aggregate for unknown but incurred malpractice claims may be necessary for a healthcare provider to successfully reorganize under Chapter 11.

Bankruptcy courts are not authorized to liquidate or estimate personal injury claims for the purpose of determining plaintiffs' distributions under a reorganization plan. 28 U.S.C. § 157(b)(2)(B). This determination is reserved for the Federal district courts. 28 U.S.C. § 157(b)(5).[1]

Bankruptcy courts have jurisdiction to enter final orders concerning the "allowance or disallowance of claims … and [the] estimation of claims … for the purposes of confirming" a Chapter 11 plan. 28 U.S.C. § 157(b)(2)(B). Courts disagree as to whether bankruptcy courts may allow or disallow personal injury tort claims all together. In re Schepps Food Stores, Inc., 169 B.R. 374 (Bankr. S.D. Tex. 1994); In re Dow Corning Corp., 215 B.R. 346 (Bankr. E.D. Mich. 1997). This issue typically arises when the legal sufficiency of a plaintiff's claim is challenged (i.e. whether a claim is barred by a statute of limitations or is subject to final resolution on a motion for summary judgment). However, when the allowance or disallowance of these claims is not at issue, bankruptcy courts will estimate these claims for the limited purpose of determining whether a chapter 11 plan is feasible.

Neither the Code nor the Federal Rules of Bankruptcy Procedure provides a procedure for estimating unliquidated, contingent, or disputed administrative claims. Therefore, many courts have applied the statutory provision permitting bankruptcy courts to estimate pre-petition claims contained in 11 U.S.C. § 502(c) to estimate administrative claims to confirm a plan of reorganization. In re MacDonald, 128 B.R. 161 (Bankr. W.D.Tex. 1991); In re Dennis Ponte, Inc., 61 B.R. 296 (Bankr. 9th Cir. 1986); Bittner v. Borne Chemical Co., 691 F.2d 134 (3rd Cir. 1982).

However, bankruptcy courts will only estimate unliquidated claims when the normal allowance process of 11 U.S.C. § 503(b) would unduly delay the administration of the bankruptcy case. In re MacDonald, 128 B.R. at 165. Section 503(b) requires the court conduct a hearing before allowing an administrative expense. This process is not typically onerous when addressing the majority of administrative claims. However, a § 503(b) hearing would likely be very burdensome and cause undue delay when considering an unliquidated medical malpractice claim or a group of unknown but incurred medical malpractice claims, which may require a trial.

Section 502(c) does not dictate the procedure bankruptcy courts must use to estimate claims. Provided the relevant substantive law is applied in the estimation process, the courts are free to use "whatever method is best suited for the circumstances." Bittner, 691 F.2d at 135. Conceivably, bankruptcy courts can follow any number of procedures ranging from an abbreviated hearing to arbitration or even a trial. Id. Bankruptcy courts are given

[1] A district court may abstain from hearing a medical malpractice claim in order to allow it to proceed before the proper state court. 28 U.S.C. § 1334(c).

wide latitude in deciding the proper method for estimating a claim subject only to an abuse of discretion standard on appeal.

The estimated value determined by the bankruptcy court is given even greater deference on review. The estimate will only be overturned if the appellate court determines that the conclusion was clearly erroneous. Appellate courts have even affirmed bankruptcy court decisions setting the estimated value of the claim at $0.00. Bittner, 691 at 139; Colorado Mountain Express, 193 B.R. at 339. However, the bankruptcy court must perform an estimate before confirming a plan of reorganization or the plan will be open to challenge on the basis of feasibility. In re Pizza of Hawaii, Inc., 761 F.2d at 1382 (holding that the bankruptcy erroneously confirmed a Chapter 11 plan without first estimating the amount of an unliquidated claim which could have a significant effect on the plan's future success if the creditor received a favorable judgment on the claim).

It is important to note that the bankruptcy court estimates unliquidated, contingent, or disputed claims for the limited purpose of confirming a reorganization plan in a Chapter 11 case when an adjudication would eliminate undue delay of the bankruptcy proceeding. Therefore, the bankruptcy court's valuation of a claim may not prohibit the creditor from reducing his or her malpractice claim to an enforceable judgment. The court in In re MacDonald specifically stated that the better rule was that an estimation of a post-petition claim under 11 U.S.C. § 502(c) does not "set the 'outer limits of a claimants' right to recover.'" Id. (distinguishing and quoting Matter of Baldwin-United Corp., 55 B.R. 885 (Bankr. S.D. Ohio 1985), which held that a § 502(c) estimation limits the creditor's right to recover a pre-petition claim). Essentially, a court applying § 502(c) may also borrow 11 U.S.C. § 502(j) (allowing reconsideration of a ruling on allowing a pre-petition claim for cause) and Rule 3008 (allowing for a hearing on the reconsideration of a claim) to narrow the healthcare provider's discharge under 11 U.S.C. § 1141(d). Therefore, a malpractice plaintiff will probably be able to reset the amount of any previously estimated administrative claim, which must be paid in full under 11 U.S.C. § 1129(a)(9).

The extent to which a bankruptcy court's estimation of a post-petition claim bars a greater recovery is still not absolutely clear. In re MacDonald was decided by the Bankruptcy Court for the Western District of Texas and, therefore, only offers persuasive authority on the issue. If the provider is successful in limiting the estimation of a malpractice claim to a low amount, the bankruptcy court will be more likely to confirm the plan. However, if the plaintiff later obtains a large uninsured judgment, the healthcare provider may not be able to limit its expense to the earlier estimate.

A healthcare provider may consider the purchase of a medical malpractice insurance policy to cover post-petition malpractice claims. Such a policy would provide an independent source of funds to pay successful plaintiffs' claims and aid a bankruptcy court in determining whether a Chapter 11 plan is feasible. The confirming court will be able to compare its malpractice claim estimations with the limits of the insurance policy and determine whether there are sufficient funds between the policy and the reorganization plan to pay all likely administrative medical malpractice claims, whether known or unknown.

Appendix B: Is a Nursing Home Lease a Lease of Residential or of Non-Residential Real Property and What is the Effect of that Determination on a Healthcare Provider in Bankruptcy?

A financially-stressed healthcare provider should consider the impact a bankruptcy filing might have upon his/her rights and obligations under leases of the real property on which its nursing or convalescent homes are situated. As a general matter, once a petition for bankruptcy has been filed, a debtor (the "Debtor") may, subject to approval of the bankruptcy court, assume (and thereby reaffirm) the unexpired leases considered favorable and reject those unexpired leases considered unfavorable.[2] 11 U.S.C. § 365(a). The time within which a Debtor must exercise his/her right to assume or reject an unexpired lease, however, and his/her ability to delay complying fully with lease obligations while reorganizing, depend in part upon whether the lease in question is a lease of *residential* real property or of *nonresidential* real property.

Unless the court sets a shorter time period, a Debtor reorganizing under Chapter 11 has the broad right to assume or reject an unexpired lease of *residential* real property "*at any time before the confirmation of a plan.*" 11 U.S.C. § 365(d)(2) (emphasis added). The Debtor's options are more limited, however, where the Debtor is the lessee of *nonresidential* real property. Absent a court-ordered extension of time, the Debtor must assume or reject an unexpired lease of nonresidential real property within just *60 days* after filing for bankruptcy; if the Debtor fails to do so, the lease is treated conclusively as rejected, and the Debtor must "immediately surrender" the property to the lessor.[3] 11 U.S.C. § 365(d)(4).

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2 This general proposition is subject to various conditions, exceptions and restrictions. For example, if the Debtor has defaulted on his/her lease obligations, he/she must, at the time of assumption, cure the existing defaults, compensate the other party for actual losses and provide adequate assurances that he/she will perform his/her obligations in the future. 11 U.S.C. § 365(b).

3 Note that in Chapter 7 cases, even a lease of *residential* real property is deemed rejected if the trustee has not assumed it within 60 days after entry of the order for relief. 11 U.S.C. § 365(d)(1).

In addition, until the Debtor assumes or rejects a lease of nonresidential real property, he/she must remain current on all lease obligations from the time he/she receives bankruptcy court protection. 11 U.S.C. § 365(d)(3). From the perspective of a Debtor-lessee, therefore, if a nursing home lease is deemed nonresidential, the Debtor must promptly commence performing obligations hereunder, continue to perform them on an administrative basis, and assume or reject the lease within the compressed, 60-day period.[4]

Discussion of the Relevant Case Authorities

There is a split of authority in the bankruptcy courts on the issue of whether a nursing or convalescent home lease is a lease of residential or of nonresidential property. The trend, though admittedly based on a very small number of cases directly addressing the issue, appears to be toward categorizing nursing home leases as unexpired leases of *residential* real property.

The determinative factor appears to be whether the court focuses upon the nature of the lease and the relationship between the debtor and the landlord or on the nature of the real property.[5] Courts that focus on the nature of the lease conclude that the legislative intent was to afford special treatment to "commercial leases, e.g. shopping center leases" and that the term "nonresidential" does not refer to the character of the property at all, "which is not really of any consequence." *In re Condominium Administrative Services, Inc.*, 55 B.R. 792, 795 (Bankr. M.D. Fla. 1985) (finding a lease of a mobile home park to be "clearly a commercial lease" that the debtor had failed to assume within the required 60-day deadline.).

This approach was followed by a California bankruptcy court in a 1986 case. *Wilson v. Sonora Convalescent Hospital, Inc. (In re Sonora Convalescent Hospital, Inc.)*, 69 B.R. 134 (Bankr. E.D. Cal., 1986) ("*Sonora")*. In *Sonora*, the court determined that a lease of a convalescent hospital was "nonresidential" because the parties had entered into the lease for *commercial* purposes. While patients were expected to, and did, reside at the hospital, the *Sonora* court did not believe this made the lease residential, because the patients paid to reside there and thus did so on a commercial basis. *Id.*, 69 B.R. at 136. Because the debtor had failed to assume the lease within the required 60 day period, the *Sonora* court

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4 The 60-day period may be extended for cause, but continued post-petition performance is required throughout the extension. 11 U.S.C. §§ 365d(1) and (d)(3).

5 *See* William Norton, 39 Bankruptcy Law and Practice 2d § 39.37 (2003) ("The focus of the inquiry is not on the relationship of the debtor to the landlord but on the type of property or building leased. … That the debtor as lessee does not actually use the leased real property as its own residence is irrelevant.").

held it had been rejected as a matter of law. *Id.*, 69 B.R. at 137. *See also*, *In re Emory Properties, Ltd.*, 106 B.R. 318 (Bankr. N.D. Ga. 1989) (holding that a hotel is "nonresidential" within the meaning of § 365, notwithstanding that several employees resided there year-round).

Several courts, including the most recent to address the issue, have reached the opposite conclusion, by focusing on the residential use of the real property. In each case, these courts ruled that leases of nursing homes are leases of "residential" real property. *E.g., In re Texas Health Enterprises, Inc.*, 255 B.R. 181 (Bankr. E.D. Texas 2000) ("*Texas Health Enterprises*") (holding the 60 day deadline of 11 U.S.C. § 365(d)(4) inapplicable to debtors' nursing home leases); *In re Care Givers, Inc.*, 113 B.R. 263 (Bankr. N.D. Texas 1989) (same principle and finding the 60-day assumption deadline inapplicable to property with mixed residential and nonresidential uses); *In re Independence Village, Inc.*, 52 B.R. 715 (Bankr. E.D. Mich. 1985) ("*Independence Village*") (holding the 60-day deadline of § 365(d)(4) inapplicable to a lease of a "life-care" facility operated by the debtor).[6]

The courts' focus in these cases was based on their view that a fair statutory construction required consideration of the property use. The *Independence Village* court reasoned that, because the 60-day deadline for the assumption of a lease of "nonresidential" real property is an exception to the usual rule (imposing no such deadline), the provision must be construed narrowly. *Independence Village*, 52 B.R. at 722. The court rejected the lessor's contention that the term "nonresidential" is intended to protect all real estate leases made to any commercial enterprise, finding instead that it "describes the type of property and not the type of lease which the debtor may have entered into with another."[7] *Id.*, 52 B.R. at 721-22.

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6 Several other jurisdictions appear to apply the same analysis in determining which leases are of "residential" and which are of "nonresidential" property, although they have not addressed the issue in the context of a nursing home lease. *See, e.g., In re Historical Locust Street Development Assocs.*, 246 B.R. 218 (Bankr. E.D. Pa. 2000) (relying upon *In re Care Givers, Inc.* and holding that a lease of a tenant parking lot adjacent to their residence was not a lease of "nonresidential real property"); *Bankers Trust Co. of California, N.A. v. Fankhanel*, 1998 WL 405024 (Minn. App. 1998) (holding that a lease of a mobile home park had not been rejected during a prior bankruptcy because it was not a leasing of nonresidential real property); *In re Roy Lippman*, 122 B.R. 206 (Bankr. S.D. N.Y. 1990) (holding that three co-op apartments leased by the debtor were "residential," even though debtor's motive for leases the spaces was, at least in part, commercial).

7 The legislative history, discussed at length in *Independence Village*, makes clear that Congress' intent was to afford relief to shopping center lessors, who faced the prospect of long-term vacancies when tenants went into bankruptcy. *See Independence Village*, 52 B.R. at 721 (reciting portions of the legislative history).

Similarly, the court in *In re Care Givers, Inc.*, 113 B.R. 263, 266 (Bankr. N.D. Texas 1989), focused on the nature of the real property. It rejected the lessor's argument that nursing home leases were "nonresidential," holding that the statutory phrase "'lease of nonresidential real property,' is not synonymous with the phrase 'commercial lease of real property.'" *Id.*, 113 B.R. at 266. It found the debtor's six nursing home leases not to be leases of "nonresidential" real property. *Id.* Most recently, the Bankruptcy Court for the Eastern District of Tennessee echoed the same reasoning applied by the *Independence Village* and *Care Givers* courts. *Texas Health Enterprises.* 255 B.R. at 184. That court held a nursing home lease to be a lease of residential real property to which the 60-day deadline of § 365(d)(4) did not apply.[8] 255 B.R. at 184. It thus appears that the majority of courts that have addressed the issue directly have found nursing home leases to be leases of "residential" real property and not of "nonresidential" real property for purposes of § 365.

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8 Interestingly, although the *Texas Health Enterprises* court concluded that the lessor had properly moved to have the lease deemed rejected for other reasons (because the debtor was unable to cure its defaults hereunder), the court declined to permit lessor to "precipitously terminate" the lease to the prejudice of the residents in the nursing home and refused to allow lessor to take possession until it could assure "continuity of care for the patients." *Id.*, 255 B.R. at 184-85.

Appendix C: Criminal Penalties for Making False Representations in Any Claim for Medicare Payments

Skilled nursing facilities, hospitals, and many other health care providers rely heavily upon Medicare reimbursement, and, thus, the implications of the Medicare regulations relating to cost reporting are significant to these providers. Of particular importance to such providers in a financially stressed condition are those rules and regulations relating to the payment of accrued but unpaid expenditures, which are reflected in cost reports. Providers should be aware that failure to comply with these regulations, may give rise to liabilities under a broad array of federal statutes both civil and criminal.

42 C.F.R. § 413.24 of the Medicare and Medicaid regulations requires Medicare providers to submit cost reports containing various disclosures and certifications to their intermediaries on or before the last day of the fifth month following the close of the period covered by the report. Although SNFs have been reimbursed under the Prospective Payment System since 1998, rather than on the basis of reasonable costs, they are required to submit cost reporting forms annually to aid reimbursement determinations. Section 2320 of Part I of the Provider Reimbursement Manual (the "Manual") and 42 C.F.R. § 405.453 require such cost reports to be based on the accrual basis of accounting. Sections 2305 and 2305.1 of the Manual instruct that short term liabilities must be liquidated within one year after the end of the cost reporting period in which the liability is incurred unless the intermediary grants an exception, for up to three years for good cause, including insufficient cash flow or accounting error. After nearly two decades of challenges to the meaning of liquidation and grounds for a good cause delay in liquidation, 42 C.F.R. § 413.100 was enacted to codify the general one-year rule for liquidation and to clarify specific instances in which the one-year rule will not apply.

Section 413.100 requires "timely" liquidation of costs claimed on a cost report. Generally, short term liabilities must be liquidated within one year after the end of the cost reporting period in which the liability is incurred. If, within that one-year time frame, the provider furnishes to the intermediary sufficient written justification for nonpayment of the liability, the intermediary may grant an extension of up to three years beyond the end of the cost reporting year in which the liability was incurred. However, the regulation clarifies exceptions to this general rule for liabilities such as vacation pay, sick pay, FICA, and other payroll taxes. Notably, accrued liability related to compensation to owners other than sole proprietors, partners and contributions to a self-insurance program for various types of coverage must be liquidated within 75 days after the close of the cost reporting period in which such liabilities arose.

In the case of a financially distressed provider, care should be taken in circumstances in which the provider knows certain liabilities will not be liquidated within the required frames. Liability under the Federal Civil False Claims Act occurs when a person or entity knowingly presents a false or fraudulent claim for payment, or documentation or other statements supporting such claim, to the United States government for the purpose of receiving payment. 31 U.S.C. § 3729(a). Federal courts have held that submission of a cost report for reimbursement under Medicare can lead to False Claims Act liability when the submitting provider either knew that the information contained in the cost report was false or when the provider failed to amend a cost report when required to do so. In *U.S. v. Century Health Services*, *Inc.,* 289 F.3d 409 (6th Cir. 2002), the Court of Appeals for the Sixth Circuit held that providers have a duty to "file an amended cost report if they fail to liquidate their liability in a timely manner or the provider determines that an expense for which they requested reimbursement was non-allowable." According to the *Century Health Services* court, providers impliedly certify that the information contained in a cost report is true and that they will continue to update such cost reports as the truthfulness of the original submission changes. *Id.* In that case, the defendants had submitted anticipated contributions to an employee stock ownership plan as a component of employee expenses on its cost report, but when they received payment, they first used the money to contribute to the plan and then promptly withdrew the funds for their own corporate use. *Id.* The officers and the company were found liable for knowingly submitting false cost reports due to their failure to amend the cost reports when they knew the funds were no longer being used for a Medicare reimbursable expense. *Id.* Therefore, according to at least the Sixth Circuit, providers and their officers or managers can violate the False Claims Act by failing to file an amended cost report when a liability is not timely liquidated (and the cost consequently becomes non-reimbursable), even if the claim was not expressly false when filed. The holding in *Century Health Services* is consistent with other Federal court decisions and with Provider Reimbursement Review Board decisions. *See, e.g., Ab-Tech Construction, Inc. v. U.S.*, 31 Fed. Cl. 429 (1994).

In addition to civil false claims liability, officers and providers may be vulnerable to criminal liability for violations of 42 U.S.C § 1320a-7(a), which provides criminal penalties for knowingly and willfully making any false statements or representations in any claim or application for Medicare payments. See, e.g., US ex rel. *Thompson v. Columbia-HCA*, 20F.Supp.2d 1017 (S.D. Tex. 1998). Federal courts have found that because certification is required for the submission of cost reports, criminal liability may arise for failure to comply with Medicare requirements upon submission of cost reports made with willful knowledge of their falsehood. See, e.g., id.

In addition to the duty to amend a cost report when liabilities are not timely liquidated, providers should also be aware that the government may be concerned with knowing submissions of items on cost reports that the provider never intends to pay. Because the cost report could be construed as representing that the provider has accrued such liabilities for payment, the provider would knowingly be submitting for reimbursement information that he/she knows is not then accurate. The 1984 HCFA Deputy Administrator Decision in *Home Medical Services, Inc. v. Office of Direct Reimbursement*, PRRB Dec. No. 84-D14 (CCH ¶ 33,906 discussed provider intent in a cost report submission in the False Claims Act context, noting that "[a]ccrued liabilities . . . can be used to exaggerate costs when there is no real intent to make definite payment until some future profitable time" and that the one-year liquidation rule was introduced to assure that only accruals of actual liabilities would be reimbursed.

Appendix D: Post-Petition Recoupment of Pre-Petition Medicare Overpayments

When contemplating a reorganization of its business, a healthcare provider participating in Medicare must accurately evaluate the amount of the payments he/she will receive from the Department of Health and Human Services ("HHS")[9]. These payments may be critical to meeting the provider's financing requirements. In order to accurately perform this analysis, the provider must consider whether and to what extent HHS will be able to reduce payments to the provider in order to recover prior overpayments. This analysis requires an understanding of the system by which healthcare providers receive payments from HHS and the common law doctrine of recoupment as it is applied in the context of the Bankruptcy Code (the "Code").

HHS makes payments to providers based upon services rendered. These payments are subject to an audit at the end of the "reporting year" to determine whether these payments have resulted in an overpayment or an underpayment. 42 U.S.C. § 1395g(a); 42 C.F.R. § 405.1803(a). In the event of an overpayment, HHS may decrease the amount of subsequent payments to recover the difference. Id.; 42 C.F.R. §§ 413.64(f), 405.371(a). Therefore, as an inevitable result of this payment system, adjustments are routinely made to current reimbursements to correct past inaccuracies. This system often results in debts owed by the provider to HHS for past overpayments.

When a provider files a petition for relief under the Code, this payment system may be upset by the intersection of the Medicare statute and the Code. Once a provider has filed a petition for relief, the automatic stay generally prevents creditors from taking any action to collect pre-petition debts from the provider. 11 U.S.C. § 362. However, the automatic stay has been found not to bar HHS from reducing its current payments to recover pre-petition overpayments to the provider.

A. The Doctrine of Recoupment

Recoupment is a common law, equitable doctrine that is not expressly recognized by the Code but is preserved by judicial decisions. Recoupment permits a creditor to deduct amounts owed by a debtor from a debt owed to the debtor provided that both debts arise from the same transaction or agreement. *Conoco, Inc. v. Styler (In re Peterson Distributing, Inc.)*, 82 F.3d 956, 958 (10th Cir. 1996). This doctrine is not subject to the automatic stay and permits the creditor to withhold post-petition payments based on pre-petition debts. This doctrine differs from the concept of setoff under the Code, 11 U.S.C. §

9 HHS generally funnels Medicare payments to healthcare providers through private intermediaries. However, for the sake of simplicity, this article will simply refer to HHS.

553, which allows adjustments based on mutual debts from separate transactions or agreements, but which is subject to the automatic stay.

The critical aspect in applying the doctrine of recoupment is in determining whether the debts arise from the same transaction. The Medicare payment system involves an on-going relationship between HHS and the provider consisting of multiple reimbursements over an extended period of time. Therefore, the ability of HHS to reduce post-petition payments to a provider to recoup pre-petition overpayments rests on the determination of whether or not the post-petition payments are part of the same transaction that created the pre-petition overpayments. Three circuit courts have addressed this issue, but reached conflicting decisions. This split between the circuits has created two distinct views on the application of recoupment to the Medicare payment system.

B. The Minority View: *University Medical Center v. Sullivan (In re University Medical Center)*.

The Third Circuit Court of Appeals was the first circuit court to apply the doctrine of recoupment in this context. *University Medical Center v. Sullivan (In re University Medical Center)*, 973 F.2d 1065 (3rd Cir. 1992). That case involved an attempt by HHS to reduce post-petition payments in 1988 to recover overpayments made in 1985. Id.

The Third Circuit held that the debts must "arise out of a single integrated transaction" for recoupment to be applicable. Id. at 1081. The court determined that although the relationship between the provider and HHS lasts over an extended period and includes multiple payments, the post-petition payments were "independently determinable" and "due for services completely distinct from those" paid for in 1985. Id. Based on the fact that the entire Medicare payment system operates on an annual basis (with audits taking place at the end of a reporting year, followed by any adjustments to current payments), the court determined that the recovery of the 1985 overpayment in 1988 was the "final act" of the transactions that began in 1985. Id. at 1082. Based on this conclusion, the court ruled that HHS had violated the automatic stay and could not reduce its post-petition payments to the provider. Id. at 1084-1085.

This approach has been considered in cases arising under both Medicare and Medicaid in the lower courts. However, the Third Circuit's restrictive approach is the minority view, and a provider considering reorganizing under the Code cannot be certain that this approach will be applied outside of the Third Circuit.

C. The Majority View: *U.S. v. Consumer Health Services of America, Inc. and Sims v. H.H.S. (In re TLC Hospitals, Inc.).*

The Courts of Appeals for the District of Columbia and the Ninth Circuit applied a more expansive view of a transaction and reached the opposite result.

In *U.S. v. Consumer Health Services of America, Inc.,* 108 F.3d 390 (D.C.Cir. 1997), the court stated that the Third Circuit failed to properly apply the Medicare statute. The court looked to the provisions of the Medicare statute and held that the continuous stream of payments and services that exists between a provider and HHS constitutes a single transaction in the application of recoupment. Id. at 395. Specifically, the court determined that the Third Circuit incorrectly based its holding on the timing of audits and looked to statutory formula for calculating Medicare payments. Because the amount actually due under Medicare includes "necessary adjustments on account of previously made overpayments …," post-petition payments include adjustments for pre-petition inaccuracies. Id. at 394 (quoting 42 U.S.C. § 1395g(a)). Therefore, the court held the reduction of post-petition payments to providers does not violate the automatic stay.

The Ninth Circuit echoed this approach in *Sims v. H.H.S. (In re TLC Hospitals, Inc.)*. 224 F.3d 1008 (9th Cir. 2000). Rejecting the Third Circuit's "single integrated transaction" test, the Sims court applied a "logical relationship" test, under which a transaction may include a number of events "depending not so much upon the immediateness of their connection as upon their logical relationship." Id. at 1012. Adopting the rationale applied in Consumer Health Services, the court held that HHS could recover past overpayments by adjusting current reimbursements regardless of the automatic stay under the doctrine of recoupment.

Although this approach is expansive, it is not without limits. Recoupment is an equitable doctrine. Therefore, the court must also balance the respective harms to the parties before reaching its decision. Recently, the Bankruptcy Court for the District of Rhode Island applied the majority view but did not allow HHS to recoup prior overpayments that were incurred for services provided by outside professionals, when they would not ultimately be paid by HHS. *Slater Health Center, Inc., v. HHS*, 294 B.R. 423, 431 (Bankr. D.R.I. 2003). The court reasoned that the harm to the debtor, the therapists and other creditors if HHS removed this money from the estate exceeded the harm suffered by the government and refused to permit recoupment. Id. at 431-432.

The Consumer Health Services/Sims approach has been adopted by the majority of lower courts in other jurisdictions in both the Medicare and Medicaid contexts. However, providers should be aware that this approach relies heavily on the statutory construction of the Medicare payment system and may be distinguishable on that basis. Although many courts have applied this analysis in the Medicaid context, the Medicaid statutory reimbursement process differs greatly from that under Medicare. The courts applying the majority view in Medicaid cases have at this point generally concluded that the statutory differences are irrelevant; however, important distinctions may develop. Therefore, providers should be aware of the applicable Medicaid provisions, which may limit the majority approach.

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