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UNITED STATES BANKRUPTCY COURT

CENTRAL DISTRICT OF CALIFORNIA - LOS ANGELES DIVISION

In re VERITY HEALTH SYSTEM OF CALIFORNIA, INC., *et al.*, Debtors and Debtors In Possession. ☒ Affects All Debtors ☐ Affects Verity Health System of California, Inc. ☐ Affects O'Connor Hospital ☐ Affects Saint Louise Regional Hospital ☐ Affects St. Francis Medical Center ☐ Affects St. Vincent Medical Center ☐ Affects Seton Medical Center ☐ Affects O'Connor Hospital Foundation ☐ Affects Saint Louise Regional Hospital Foundation ☐ Affects St. Francis Medical Center of Lynwood Foundation ☐ Affects St. Vincent Foundation ☐ Affects St. Vincent Dialysis Center, Inc. ☐ Affects Seton Medical Center Foundation ☐ Affects Verity Business Services	Lead Case No. 2:18-bk-20151-ER Jointly administered with: Case No. 2:18-bk-20162-ER Case No. 2:18-bk-20163-ER Case No. 2:18-bk-20164-ER Case No. 2:18-bk-20165-ER Case No. 2:18-bk-20166-ER Case No. 2:18-bk-20167-ER Case No. 2:18-bk-20168-ER Case No. 2:18-bk-20169-ER Case No. 2:18-bk-20170-ER Case No. 2:18-bk-20171-ER Case No. 2:18-bk-20172-ER Case No. 2:18-bk-20173-ER Case No. 2:18-bk-20175-ER Case No. 2:18-bk-20176-ER Case No. 2:18-bk-20178-ER Case No. 2:18-bk-20179-ER Case No. 2:18-bk-20180-ER Case No. 2:18-bk-20181-ER Chapter 11 Cases Honorable Ernest M. Robles **SUPPLEMENTAL OBJECTION OF THE UNITED STATES, ON BEHALF OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN**

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☐ Affects Verity Medical Foundation
☐ Affects Verity Holdings, LLC
☐ Affects De Paul Ventures, LLC
☐ Affects De Paul Ventures - San Jose Dialysis, LLC,

Debtors and Debtors In Possession.

SERVICES AND CENTERS FOR MEDICARE AND MEDICAID SERVICES TO DEBTORS' MOTION FOR THE ENTRY OF AN ORDER AUTHORIZING THE SALE OF PROPERTY FREE AND CLEAR OF ALL CLAIMS, LIENS, AND ENCUMBRANCES; AND MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT THEREOF

Date: October 23, 2019
Time: 10:00 a.m.
Place: Courtroom 1568
255 E. Temple Street, Los Angeles, CA

TO THE HONORABLE ERNEST M. ROBLES, UNITED STATES BANKRUPTCY JUDGE, DEBTORS, OFFICIAL COMMITTEE OF UNSECURED CREDITORS, OFFICE OF THE UNITED STATES TRUSTEE, AND ALL INTERESTED PARTIES:

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The United States, on behalf of the U.S. Department of Health and Human Services ("HHS") and the Centers for Medicare and Medicaid Services ("CMS") (collectively, "HHS"), hereby files its Supplemental Objection to the *Debtors' Motion for the Entry of an Order (A) Authorizing the Sale of Property Free and Clear of All Claims, Liens and Encumbrances* [Docket No. 1279] ("Motion").[1]

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION AND PROCEDURAL BACKGROUND

HHS files this Supplemental Objection[2] because the Debtors impermissibly seek to sell their Medicare provider agreements under 11 U.S.C. § 363, free and clear of regulatory requirements and successor liability under the Medicare Statute (defined below). Over the last several decades, the vast majority of debtors and bankruptcy courts have treated Medicare provider agreements, including numbers and related lockbox accounts (collectively, the "Medicare Provider Agreements") as executory contracts, subject to the requirements of 11 U.S.C. § 365. This practice has been acceptable to the United States because (and to the extent that) the requirements of section 365 are consistent with those of the Medicare Statute. For instance, section 365 requires debtors to cure all defaults and requires the assignee to assume liability for all amounts due under the Medicare Provider Agreements, as required by the Medicare Statute, specifically 42 U.S.C. § 1395(g)(A). While this Court recently expressed in dicta that Medicare provider agreements are not executory contracts under section 365 and can be sold free and clear of successor liabilities under subject 363(f) in a memorandum decision issued on September 26, 2019, *In re Verity Health System of Cal., Inc.*, No. 2:18-bk-20151-ER, 2019 WL 4729457, at *6 (Bankr. C.D. Cal. Sept. 26, 2019), the issue

[1] The parties are in the midst of settlement negotiations. This Supplemental Objection is filed as a precautionary measure in the event the parties do not reach a settlement.

[2] By order entered October 10, 2019 approving a stipulation between the Debtor and HHS ("Stipulated Order") (Docket No. 3326), both parties were authorized to file additional briefing on the issues raised in HHS's previously filed *Limited Objection and Reservation of Rights* to the Motion ("HHS Limited Objection") (Docket No. 1346) and the Debtor's *Reply* to the HHS Limited Objection (Docket No. 1438) ("Debtor's Reply"). Additionally, by no later than October 15, 2019, either the Debtors will file a notice of a resolution of the issues regarding the transfer and/or proposed assumption and assignment or rejection of the Medicare Provider Agreements or HHS may file a supplemental objection to the proposed transfer. The Stipulated Order also provides that the Debtors may file a reply to the HHS supplemental objection no later than October 18, 2019 and a hearing date is set for October 23, 1019 at 10:00 a.m.

remains an open question with respect to the Medicare Provider Agreements at issue in this contested matter.

The United States objects to the Motion specifically because it improperly asks the Court to grant the Debtors authority to "sell" the Medicare Provider Agreements under section 363 without: (a) paying a cure amount of approximately $2,037,371.45, as may be later adjusted under the Medicare Statute for outstanding Medicare overpayments; and (b) requiring Strategic Global Management, Inc. ("Buyer") to assume all of the Debtors' obligations under the Medicare Provider Agreements and federal law, including the obligation to assume liability for any pre-closing Medicare overpayments.

If this Court were to determine not to treat the Medicare Provider Agreements as subject to section 365 based on the definition of a provider's rights (or lack thereof) in provider agreements under applicable non-bankruptcy law, that logic leads inexorably to the conclusion that the Medicare Provider Agreements are not property of the estate that can be "sold" pursuant to section 363 at all. As a result, the only way that the Medicare Provider Agreements could be assigned to the Buyer (rather than automatically terminating upon the sale of the operating assets) would be a situation in which CMS determines according to its regulatory discretion that a "change of ownership," or CHOW, of the provider is occurring in full compliance with the Medicare Statutes.

The Bankruptcy Court has no jurisdiction to usurp the statutory authority of CMS to determine whether a valid CHOW is occurring, and nothing in section 363 or any other section of the Bankruptcy Code enables the Court or the Debtors to transform a Medicare Provider Agreement into a property interest of the Debtors or their estates in contravention of the Medicare Statute, which defines and strictly limits the Medicare Provider Agreements and the Debtors' ability to participate in the Medicare program. Even to the extent that the Court decides, despite binding precedent in this Circuit to the contrary, that the Medicare Provider Agreements gave the Debtors some property interests -- in the form of rights to payment on claims for past services provided -- that could be property of the estates and subject to section 363, the Assignment of Claims Act, 31 U.S.C. § 3727 bars any assignment of such claims against the United States, particularly because the Debtors seek to do so in a manner that would purport to unlawfully extinguish the United States' offset rights.

II. STATUTORY AND REGULATORY BACKGROUND

A. Requirements to Become a Medicare Provider

As of the Petition Date, the Debtors were parties to Medicare Provider Agreements with the Secretary of HHS, acting through CMS ("Secretary"), under which they receive payment for services provided to Medicare beneficiaries pursuant to Title XVIII of the Social Security Act. *See* 42 U.S.C. §§ 1395-1395lll and its implementing regulations ("Medicare Statute").[3]

In order to be eligible for reimbursement for services provided to Medicare beneficiaries under Part A of the Medicare program, a health facility, such as a hospital, hospice, skilled nursing facility, or community mental health center must enter into an agreement with the Secretary, called a Health Insurance Benefit Agreement (commonly known as a "Medicare Provider Agreement"). 42 U.S.C. § 1395cc; 42 C.F.R. § 400.202 (defining "provider"); *see also* 42 C.F.R. §§ 489.2, 489.3. A new provider must apply to HHS and be approved for initial enrollment and certification before it may obtain payment for services provided to Medicare beneficiaries. *See* 42 C.F.R. § 488.1, 488.3, 489.1, 489.2 and 489.10. The certification process enables HHS to determine, *inter alia*, that the provider is qualified to provide health care services to patients. *See* 42 C.F.R. § 489.10-12 (requirements for obtaining Provider Agreement).

The transfer of a Provider Agreement is strictly limited and must be approved by CMS before the transfer is effective. Provider Agreements may only be assigned upon CMS' determination that there is a valid "change of ownership." 42 C.F.R. §§ 489.18, 489.18(c); *United States v. Vernon Home Health, Inc.*, 21 F.3d 693, 696 (5th Cir. 1994), *cert. denied,* 513 U.S. 1015 (1994). When an assignment is approved, the new provider becomes subject to all statutory and regulatory terms and conditions under which the Provider Agreement was originally issued including the original provider's quality history and adjustment of payments to account for prior overpayments and underpayments. *Vernon*, 21 F. 3d at 696 (citing 42 C.F.R. § 489.18(d)). When CMS approves an assignment, the "new" provider does not have to meet the initial Medicare survey and certification

[3] The Debtors' Medicare Provider Numbers are as follows: (1) St. Francis: 05-0104; (2) St. Vincent Medical: 05-0502; (3) St. Vincent Dialysis: 05-2582; and (4) Seton: 05-0289.

requirements because the "new" provider is merely stepping into the shoes of the "old" provider with the same Provider Agreement. Importantly, subject to certain requirements, there is no break in Medicare reimbursement for services provided to Medicare beneficiaries during the change of ownership processing period. *See* CMS Publ. 100-08, Chapter 15, § 15.7.7.1.5.

By contrast, if a new provider opts not to accept assignment of the Provider Agreement, the Provider Agreement is voluntarily terminated. 42 C.F.R. § 489.13(c); CMS Publ. 100-08, Chapter 15 § 15.7.7.1.5. In that case, the new provider is treated as a new applicant to the Medicare program and cannot receive payments for covered services until after CMS determines that the new provider meets Medicare enrollment and certification standards. 42 C.F.R. § 489.13(c); CMS Publ. 100-08, Chapter 15 § 15.7.7.1.5. In that case, there is no retroactive payment for covered services for the period before CMS determines that the new provider is qualified to participate in the Medicare program. 42 C.F.R. § 489.13(c); CMS Publ. 100-08, Chapter 15 § 15.7.7.1.5 ("If the Buyer rejects assignment of the provider agreement, the Buyer must file an initial application to participate in the Medicare program. In this situation, Medicare will never pay the applicant for services the prospective buyer provides before the date on which the provider qualifies for Medicare participation as an initial applicant.").

Additionally, Medicare regulations specifically prohibit the sale or transfer of billing privileges or a Medicare billing number, except pursuant to a valid change of ownership. 42 C.F.R. § 424.550; *see also* 42 C.F.R. § 424.535(a)(7) (revocation of Medicare enrollment for knowingly selling Medicare billing number unless exception applies). To obtain CMS approval of a change of ownership of a provider number, the applicant must submit CMS Form 855A.

B. Payment and Reconciliation of Medicare Reimbursement

The Secretary contracts with Medicare Administrative Contractors (generally referred to herein as "payment contractors"), typically private insurance companies, to administer payment to providers for Medicare covered services. Payment contractors make advance payments based upon estimates (generally on a monthly basis) to providers in accordance with the Medicare Statute and regulations and perform the day-to-day administration of Medicare, *e.g.* audit and reimbursement activities. 42 U.S.C. § 1395k-1; 42 C.F.R. §§ 421.400 -421.404.

Under the Medicare payment system, actual reimbursement cannot be determined until the end of a cost-reporting period. Within five months after the end of each fiscal year, the provider must submit financial information in the form of a cost report verifying the actual amount of reimbursements owed to it for the past fiscal year. 42 C.F.R. §§ 413.1, 413.20, 413.24(f); *see also* 42 U.S.C. § 1395g and 1395hh (conferring authority upon the Secretary to require submission of cost reports). Once the provider submits the cost report, the payment contractor audits the cost report and determines the provider's actual, rather than estimated, reimbursement amount for the year. 42 U.S.C. §§ 1395g; 1395x(v)(1)(A)(ii); 42 C.F.R. § 413.24. If a provider's cost report shows that Medicare overpaid the provider for the prior fiscal year, this cost report constitutes a final overpayment (or underpayment) determination, and the provider must pay the overpayment to Medicare (or Medicare must pay the underpayment to the provider). 42 C.F.R. § 405.378(c)(iv). Under this prescribed payment mechanism, CMS cannot definitively determine whether a provider owes CMS for overpayments relating to a particular fiscal year until after the provider submits that year's cost report and CMS completes its audit.

When the reimbursement amount is finally determined, the payment contractor issues a Notice of Amount of Medicare Program Reimbursement ("NPR"), which advises the provider whether it was overpaid or underpaid for that cost year. 42 C.F.R. §§ 413.60, 405.1803. The NPR determination is final unless it is revised by the payment contractor or appealed to the Provider Reimbursement Review Board. 42 C.F.R. § 405.1807. In that regard, if a provider is dissatisfied with the payment contractor's determination of a Medicare reimbursement (which meets the applicable amount in controversy requirement), it may, within 180 days of the date the NPR is issued, contest the payment contractor's determination by requesting a hearing before the Provider Reimbursement Review Board. 42 U.S.C. § 1395*oo*(a); 42 C.F.R. § 405.1835. After the Secretary reviews the decision, the provider may seek review in federal district court. 42 U.S.C. § 1395*oo*(f)(1). Such review is appellate in nature. In addition, by motion of the payment contractor or the provider, or at the direction of CMS, final cost report determinations in NPRs are subject to reopening for up to three years from their issuance in order to make corrections. 42 C.F.R. § 405.1885.

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III. HHS'S PROOFS OF CLAIM

On March 20, 2019, HHS filed its proofs of claim for Medicare overpayment amounts. The known amounts that the Debtors presently owe as cure payments under 11 U.S.C. 365 to HHS are: (a) $197,564.61 for St. Vincent Medical [Claim No. 3584]; (b) $1,695,055.18 for St. Francis [Claim No. 3588]; and (c) $114,751.66 for Seton [Claim No. 3587]. However, the information presently available to HHS indicates that a final audit must be completed for many of the Debtors' pre-petition cost-report years, and various cost-reports currently remain pending. Therefore, until the Debtors' cost reports and audits are completed for all pre-petition periods, HHS will not know the exact amount of its pre-petition claims and reserves the right to amend its proofs of claim accordingly.

IV. ARGUMENT

The Debtors ask the Court to authorize them to enter into an Asset Purchase Agreement ("APA") (Docket No. 2305) that purports to transfer the Medicare Provider Agreements, without successor liability, despite the fact that the Medicare Provider Agreements were not defined by Congress as something transferable between private parties. A provider agreement may not legally transfer unless CMS determines pursuant to its regulatory authority that the provider itself is changing ownership (whether through a sale of the equity or assets), in which case the provider effectively retains its provider agreement, maintaining provision of services to Medicare beneficiaries during transition of ownership to the successor in full compliance with the Medicare Statute. That cannot happen under this APA, which contemplates a clean break in operations as of the closing date with severance of pre- and post-closing liabilities and depends on having the Court void the Medicare Statute's requirement to obtain CMS' determination that a valid CHOW is occurring.

The Debtors push the envelope even further by attempting to re-write the Medicare Statute and redefine the Medicare Provider Agreements as licenses, without any basis in the Medicare Statute or any other law. To the contrary, the Medicare Statute sets the parameters of the Medicare Provider Agreements as uniquely designed to meet their statutory purpose of providing a means to reimburse healthcare providers who provide Medicare-covered services to Medicare beneficiaries in compliance with the Medicare Statute, and not by reference to any common law property interest

such as a "license." *See e.g.* APA, Sections 1.7, 1.7(b) and 1.7(u). Neither the Debtors nor this Court has the authority to redefine the Medicare Provider Agreements to enlarge the Debtors' rights beyond those Congress set forth in the Medicare Statute.

A. The Medicare Statute Bars Assignment of Provider Agreements Absent CMS Determination of a Change of Ownership of the Provider with Full Successor Liability, Regardless of Whether Section 365 Applies.

Over the past approximately quarter century, debtors and bankruptcy courts have treated Medicare provider agreements as executory contracts subject to 11 U.S.C. § 365, because that treatment in bankruptcy fully comports with the Medicare Statute and has allowed smooth transitions of healthcare facilities providing Medicare covered services to beneficiaries when healthcare debtors or their business operations transitioned to new ownership in bankruptcy. *See, e.g.*, *University Med. Ctr. v. Sullivan (In re University Med. Ctr.)*, 973 F.2d 1065, 1075-79 (3d Cir. 1992); *In re Heffernan Mem'l Hosp. Dist.*, 192 B.R. 228, 231 n.4 (Bankr. S.D. Cal. 1996); *In re Vitalsigns Homecare, Inc.,* 396 B.R. 232 (Bankr. D. Mass. 2008) (treating Medicare provider numbers as executory contracts)*; United States v. Consumer Health Servs.*, 171 B.R. 917 (Bankr. D.C. 1994), *rev'd on other grounds*, 108 F.3d 390 (D.C. Cir. 1997); *In re Slater Health Center, Inc.*, 294 B.R. 423, 432 (Bankr. D.R.I. 2003); *In re St. Johns Home Health Agency, Inc.*, 173 B.R. 238, 242 n.1 (Bankr. S.D. Fla. 1994); *Matter of Visiting Nurse Ass'n, Inc.*, 121 B.R. 114, 119 (Bankr. M.D. Fla. 1990); *In re Tidewater Mem'l Hosp.*, 106 B.R. 876, 883 (Bankr. E.D. Va. 1989) (and cases cited therein). Indeed, in *Heffernan*, the Bankruptcy Court for the Southern District of California held that the Medicare provider agreement is an executory contract providing for advance payments based on estimates and expressly permitting the withholding of overpayments from future advances. *Heffernan*, 192 B.R. at 231 n.4.[4]

[4] If the Medicare Provider Agreements are executory contracts, the Anti-Assignment Act bars their assumption and assignment absent consent of the United States. The Federal Anti-Assignment Act provides:

> The party to whom the Federal Government gives a contract or order may not transfer the contract or order, or any interest in the contract or order, to another party. A purported transfer in violation of this subjection annuls that contract or order so far as the Federal Government is concerned, except that all rights of action for breach of contract are reserved to the Federal Government.

41 U.S.C. § 6305(a).

And in *Vitalsigns Homecare*, the bankruptcy court for the District of Massachusetts treated Medicare provider numbers as executory contracts[5] based on a rationale that applying section 365 to the provider numbers is an appropriate harmonization[6] of the Bankruptcy Code and the Medicare Statute. *Vitalsigns Homecare*, 396 B.R. at 240-41. The court reasoned that "the provider number and the provider agreement are part and parcel of a complicated statutory scheme. It appears that the provider agreement, the statute, and the regulations form an arrangement that imposes both benefits and burdens on the provider. It cannot accept the benefits without the attendant burdens." *Vitalsigns Homecare*, 396 B.R. at 240; *see also In re Raintree Healthcare Corp.*, 431 F.3d 685 (9th Cir. 2005) (Debtor cannot assign to the purchaser greater rights than it had in the Medicare provider agreement); *In re Diamond Head Emporium*, 69 B.R. 487, 494 (Bankr. D. Hawaii 1987) ("A debtor may not pick and choose those portions that it wishes to enforce and reject those that it does not deem desirable. That is black letter law engraved in stone.").

According to the Medicare Statute, and coincidentally section 365, the Debtors cannot "sell" the Medicare Provider Agreements, but may be able to assume and assign them if CMS determines a CHOW is occurring, all existing defaults are cured, and the Buyer provides adequate assurance that it will perform, including assuming all of the burdens, (*i.e.,* successor liability) along with the

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The Anti-Assignment Act precludes the Debtors from selling the hospital entities and transferring and/or assuming and assigning the Medicare Provider Agreements to any successful bidder without the consent of the United States. *See, e.g., Matter of West Elecs., Inc.,* 852 F.2d 79, 83-84 (3d Cir. 1988) (no assignment of an executory contract with a federal agency under the Bankruptcy Code without the United States consent). At present, the United States has not provided its consent. Accordingly, this Supplemental Objection should be sustained upon these grounds alone. *See also In re Catapult Entm't, Inc.*, 165 F.3d 747, 750 (9th Cir. 1999), *cert. dismissed*, 528 U.S. 924, 120 S. Ct. 369 (Mem) (U.S. Oct. 12, 1999) (No. 98-1915) (debtor-in-possession may not assume executory contract over non-debtor's objection if applicable non-bankruptcy law would bar assignment to hypothetical third-party); *see also In re CFLC, Inc.*, 89 F.3d 673, 680 (9th Cir. 1996) (patent licenses are non-assignable under federal common law).

[5] Debtors cite *In re Texscan Corp.*, 976 F.2d 1269 (9th Cir. 1992), for the proposition that the Ninth Circuit has adopted the Countryman test to determine if a contract is executory. *See* Reply, 16. However, that case did not involve a Medicare provider agreement, the Medicare Program, or any other federal statutory scheme that would need to be harmonized with the Bankruptcy Code.

[6] "'[W]hen two statutes are capable of co-existence, it is the duty of the courts, absent a clearly expressed congressional intention to the contrary, to regard each as effective. The courts are not at liberty to pick and choose among congressional enactments.'" *Id.* at 240 (quoting *Morton v. Mancari*, 417 U.S. 535, 551 (1974)).

benefits under the Medicare Provider Agreements.[7] 11 U.S.C. § 365(a), (b); 42 C.F.R. § 489.18(c) and (d) (upon a change of ownership, the existing provider agreement is automatically *assigned* to the new owner, subject to all applicable statutes and regulations and terms and conditions under which it was originally issued); *see, e.g.*, *Vernon*, 21 F.3d at 696 (new owner that accepted *assignment* of Medicare provider agreement was liable for overpayments of prior owner); (new owner of a skilled nursing facility was liable for penalties assessed on basis of former owner's actions); *Eagle Healthcare Inc. v. Sebelius*, 969 F. Supp. 2d 38, 40 (D.D.C. 2013) ("An *assigned* Provider Agreement is subject to all of the terms and conditions under which it was originally issued.") (emphasis added); *see also In re Charter Behavioral Health Sys., LLC*, 45 Fed. Appx. 150, 151, 2002 WL 2004651, *1 n.1 (3d Cir. June 3, 2002) (observing that "[i]f the new owner elects to take an *assignment* of the existing Medicare Provider Agreement, it receives an uninterrupted stream of Medicare payments but assumes successor liability for overpayments and civil monetary penalties asserted by the Government against the previous owner") (citing 42 C.F.R. § 489.18(d); *Deerbrook Pavilion, LLC v. Shalala*, 235 F.3d 1100, 1103-05 (8th Cir. 2000).

The Debtors' Reply posits that the Medicare Provider Agreements can be transferred to the Buyer without CMS' determination that a CHOW is occurring and without successor liability under the Medicare Statute. The Debtors rely primarily on cases holding or stating in dicta that, outside of a bankruptcy case, a Medicare provider agreement is not a contract.[8] *See, e.g., PAMC, Ltd. v.*

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7 Because the Medicare Statute's payment mechanism involves upfront payments subject to adjustment through cost report auditing before actual reimbursements are determined, assumption and assignment of a Medicare provider agreement requires not just cure of overpayments determined as of the date of the assumption and assignment under section 365(b)(1)(A), but also adequate assurance of future performance under section 365(b)(1)(C), including assumption of liability for later determined overpayments, regardless of whether they relate to requested reimbursements for services provided before the assumption and assignment. *Vernon*, 21 F.3d at 6964 (purchaser "accept[ed] the automatic assignment of the provider agreement," making it jointly and severally liable with seller for overpayments, pursuant to Medicare regulations at 42 C.F.R. § 489.18(d)).

8 Debtors cite *NLRB v. Bildisco & Bildisco*, 465 U.S. 513, 522 n.6 (1984) for the proposition that "executory contracts" must, to fall within Section 365, be contracts *per se*. *See* Reply, 15-16. However, *Bildisco* did not require a contract *per se* and only defined "executory contract" in passing, because the definition of "executory contract" was not being litigated. *Id.* at 521-522 ("it is not disputed by the parties that an unexpired collective-bargaining agreement is an executory contract"). What the parties disputed in *Bildisco* was the standard that governed the rejection of collective-bargaining agreements. *Id.* at 521. *Bildisco's* holding on the standard governing the rejection of

Sebelius, 747 F.3d 1214, 1221 (9th Cir. 2014) (quoting *Mem'l Hosp. v. Heckler*, 706 F.2d 1130 (11th Cir. 1983)); *Hollander v. Brezenoff*, 787 F.2d 834 (2d Cir. 1986).[9] *See* Reply, 11. It is true that courts outside the bankruptcy context have ruled that Medicare provider agreements do not give rise to contract rights on the part of providers. Regardless of whether the Medicare Provider Agreements are to be treated in this case as executory contracts or not, the Debtors are incorrect that section 365 of the Bankruptcy Code is the only bar to transfer of the Medicare Provider Agreements as contemplated in the APA. Even if section 365 does not apply, the transaction contemplated by the APA would contravene the Medicare Statute and, as discussed in more detail below, section 363 of the Bankruptcy Code does not apply to Medicare provider agreements or override the Medicare Statute. Accordingly, the issue whether section 365 applies to the Medicare Provider Agreements is not determinative of the issues of whether Debtors should be authorized to enter into the APA or whether the Court could authorize an assignment of the Medicare Provider Agreements over the objection of CMS and in contravention of the Medicare Statute.

B. The Debtors Cannot Sell the Medicare Provider Agreements under 11 U.S.C. Section 363 because Pursuant to the Provisions of the Medicare Act, the Debtors Have no Property Interests in them to Sell.

The Motion and APA contemplate a transfer of the Debtors' assets, including the Medicare Provider Agreements, to the Buyer, **"**free and clear of all claims, Excluded Liabilities, and liens (including any successor liability) to the maximum extent provided by law and within the meaning of, and in compliance with, Section 363(f) of the Bankruptcy Code." *See* Motion, generally 49-52.

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collective-bargaining agreements was promptly overturned by statute. *See In re Century Brass Prod., Inc.*, 795 F.2d 265, 272 (2d Cir. 1986).

[9] Debtors may also seek to rely upon a recent decision in *In re Center City Healthcare, LLC dba Hahnemann University Hospital, et al*., Case No. 19-11466-KG, United States Bankruptcy Court for the District of Delaware**,** for the proposition that a Medicare Provider Agreement is not subject to section 365 and may be sold pursuant to 11 U.S.C. § 363 as an asset, free and clear of all liabilities, including successor liability, pursuant to a sale order entered on September 10, 2019 (Docket No. 681) ("Delaware Sale Order"). However, as of September 16, 2019, the Delaware Sale Order is subject to an order granting a stay pending appeal before the U.S. District Court for the District of Delaware, Case No. 1:19-cv-01711-RGA (Docket No. 17). As a result, the Delaware Sale Order is not a final order and has no precedential value upon this Court. Moreover, the decision is squarely in violation of the Third Circuit's holding in *University Med. Ctr.*, 973 F.2d 1065, 1075-79, *i.e.*, that Medicare provider agreements are executory in nature and subject to the requirements of 11 U.S.C. § 365.

The Court should not authorize the Debtors to sell the Medicare Provider Agreements under section 363 because the Debtors have no legally cognizable property interests in them to sell. The Ninth Circuit unequivocally ruled that section 363 only authorizes sale of property of the estate, and that the question of whether the *estate* has any property rights in the assets proposed to be sold must be determined by the Court before any sale can be approved, rather than left for determination in post-sale disputes over proceeds. *Warnick v. Yassian (In re Rodeo Canon Dev. Corp)*, 362 F.3d 603, 607-608 (9th Cir. 2004), *withdrawn and modified by* 126 Fed. Appx. 353, 2005 WL 663421 (9th Cir. 2005).

A debtor's property interests are defined under applicable non-bankruptcy law, "to reduce uncertainty, to discourage forum-shopping, and to prevent a party from receiving a 'windfall merely by reason of the happenstance of bankruptcy.'" *Butner v. U.S.*, 440 U.S. 48, 55 (1979) (citing *Lewis Manufacturers National Bank*, 364 U.S. 603, 609 (1961). Although the definition of property of the estate is broad under section 541 and includes all legal or equitable interest of the debtor in property, the Debtors' alleged rights (if any) in the Medicare Provider Agreements do not fit within that broad definition.

The Ninth Circuit, along with the majority of courts of appeal, has held that Medicare providers have *no property interest* in their participation in the Medicare program, whether that be through provider agreements or provider numbers. *Erickson v. U.S. ex rel. Dept. of Health and Human Servs.*, 67 F.3d 858, 862 (9th Cir. 1995) (Medicare provider had no takings claim against the government for exclusion from Medicare program because he had no property interest in participation in the Medicare program); *Shah v. Azar*, 920 F.3d 987, 997-98 (5th Cir. 2019) (health care providers have no property interest in continued participation or reimbursements under the Medicare program because they "are not the intended beneficiaries of the federal health care programs"); *Parrino v. Price*, 869 F.3d 392, 397-98 (6th Cir. 2017)(same); *Koerpel v. Heckler*, 797 F.2d 858, 863-65 (10th Cir. 1986) (provider had no property interest in eligibility for Medicare reimbursement); *Cervoni v. Sec'y of Health, Educ. and Welfare*, 581 F.2d 1010, 1019 (1st Cir. 1978). Consistently, the CMS/State of Operations Manual clearly states that the Provider Agreement and the CCN, also called the "provider number," are not "property" that can be sold by a provider.

See State Operations Manual § 3210.1E. Although the definition of property of the estate is broad under section 541, and includes all legal or equitable interest of the debtor in property, the Debtors' alleged rights (if any) in the Medicare Provider Agreements do not fit within that broad definition. In other words, the Debtors' statutory right to bill CMS and to receive payments for Medicare services rendered is not an interest in property. It is merely a right to payment, subject to whatever defenses, recoupment, setoff rights and claims the government might have with respect to those claims for payment, and, as such, do not constitute property of the estate.

To the extent that the Debtors have any rights at all in connection with the Medicare Provider Agreements, those rights are defined and strictly limited by the Medicare Program and were not enhanced by the Debtors' bankruptcy filing to transform them into freely alienable property rights. *Mission Product Holdings, Inc. v. Tempnology, LLC,* 139 S. Ct. 1652, 1663 (2019) (acknowledging "general bankruptcy rule" that "[t]he estate cannot possess anything more than the debtor itself did outside bankruptcy."); *Moody v. Amoco Oil Co.*, 734 F.2d 1200, 1213 (7th Cir. 1984), *cert denied*, 469 U.S. 982 (1984) ("whatever rights a debtor has in property at the commencement of the case continue in bankruptcy – no more, no less."); *see also PBGC v. Airways, Inc. (In re Braniff Airways, Inc.)*, 700 F.2d 935, 942 (5th Cir. 1983) (lease of airport terminal space not transferable under section 363 without compliance with applicable non-bankruptcy law requiring federal agency approval); *FAA v. Gull Air, Inc. (In re Gull Air, Inc.)*, 890 F.2d 1255, 1262 (1st Cir. 1989) (recognizing debtor's limited property interest in airline landing slots under revised non-bankruptcy law and holding that Bankruptcy Code did not enhance those rights).

Under the Medicare Program, the Debtors have no property interests under the Medicare Provider Agreements (as defined in the Medicare Program) to sell them, and the Medicare Program specifically prohibits the sale of Medicare numbers or other Medicare-related privileges. The only mechanism by which a provider number can transfer is when CMS determines according to its regulatory authority that the provider is changing ownership through a valid CHOW under the Medicare Statute. 42 C.F.R. § 424.550; *see also* 42 C.F.R. § 424.535(a)(7) (revocation of Medicare enrollment for knowingly purporting to sell Medicare billing number unless exception applies, including a change of ownership); *see supra,* Section II.A. While the Medicare Statute does enable a

smooth transition of ownership of facilities participating in the Medicare Program, which may include assumption and assignment of a Provider Agreement under section 365, this process for a smooth transition can occur legally only upon CMS' approval in the form of a determination of compliance with CHOW requirements. *Supra*, Section II.A.; 42 C.F.R. § 489.18.

The Debtors fail in their attempt to characterize the Medicare Provider Agreements as "licenses" in order to establish through a false syllogism that they must be property interests of the estate subject to section 363. Regardless of whether true licenses may be property interests in some instances, there is no indication in the Medicare Statute, which provides the exclusive definition of Medicare provider agreements, that a provider agreement is a license. Provider agreements are never explicitly referred to as licenses in the Medicare Statute. And the characteristics of provider agreements as defined in the Medicare Statute do not even correspond with those of a license. Licenses have been defined as "governmental authorizations that typically permit an individual to pursue some occupation or endeavor aimed at economic betterment." *Ayes v. Dept of Veterans Affairs*, 473 F.3d 104, 108 (4th Cir. 2006) (citing *Watts v. Pa. Hous. Fin. Co.* ,876 F.2d 1090, 1093 (3d Cir. 1989)). Further, licenses are associated with authorizations that implicate a "government's role as a gatekeeper in determining who may pursue certain livelihoods." *Id.* at 109 (citing *Toth v. Mich. State Hous. Dev. Auth.*, 136F.3d 477, 480 (6th Cir. 1998).

The Medicare Provider Agreements as defined by the Medicare Statute do not serve as an exclusive authorization for any entity to provide healthcare services, and does not even serve as an exclusive authorization to provide healthcare services to individuals who are qualified to receive Medicare covered services. In other words, the Debtors are free to provide healthcare services in exchange for payment from their patients without being required to have a Medicare provider agreement. In contrast, healthcare providers must have licenses from State departments of health to provide healthcare services. In sum, even if some licenses are property interests, Medicare Provider Agreements are not licenses, creating a gaping hole in the Debtors' logic that, despite binding precedent in the Ninth Circuit to the contrary, the Debtors have property interests in the Medicare Provider Agreements that allow them to be sold "free and clear" of CMS' enforcement of regulatory authority and other limitations set forth in the Medicare Statute.

Therefore, because the Debtors have no property interest in the Medicare Provider Agreements, this Court should not approve them being sold under section 363 of the Bankruptcy Code. To the extent the Debtors have rights related to the Medicare Provider Agreements, those rights are limited to those provided in the Medicare Program and do not permit the Debtors to sell the Medicare Provider Agreements, or the Buyer to acquire them, without fully complying with all Medicare Program requirements. As a result, if the Court does not treat the Medicare Provider Agreements as executory contracts, the Buyer cannot acquire them through a "free and clear" section 363 sale in the bankruptcy case.

C. The Assignment of Claims Act, 31 U.S.C. 3727, Prohibits Assignment of Claims for Reimbursement for Past Medicare-covered Services.

The Anti-Assignment of Claims Act, 31 U.S.C. § 3727, prohibits the assignment of any claims, including, without limitation, Medicare claims, against the United States without the United States' consent. *See e.g.*, *United States v. Kim*, 806 F. 3d 1161, 1169 (9th Cir. 2015). Specifically, the Anti-Assignment of Claims Act prohibits the "assignment of any part of a claim against the United States Government or of an interest in that claim; or the authorization to receive payment for any part of that claim," unless certain conditions are met. 31 U.S.C. § 3727 (a)(1)-(2). Those conditions provide that: (1) an assignment may be made only after a claim is allowed, the amount of the claim is decided, and a warrant for payment of the claim has been issued; (2) the assignment shall specify the warrant, must be made freely, and must be attested to by 2 witnesses; (3) the person making the assignment shall acknowledge it before an official who may acknowledge a deed and the official shall certify the assignment; and (4) the certificate shall state that the official completely explained the assignment when it was acknowledged. 31 U.S.C. § 3727(b).

Under the plain terms of the Act, a claim against the United States may not be assigned to a third party unless these technical requirements are met. In effect, the Anti-Assignment of Claims Act serves as a defense that the United States can raise against a claim. *See United States v. Kim*, 806 F. 3d at 1169.

While the United States concedes that it is all but impossible for any assignment to comply with the strictures of the Ant-Assignment of Claims Act because the Treasury no longer uses

warrants, the Government can waive coverage of the Anti-Assignment Act. *Id*. Thus, in modern practice, the language of the Anti-Assignment Act means that the United States has the power to pick and choose which assignments it will accept and which it will not. This serves one purpose of the statute: "to save to the United States 'defenses which it has to claims by an assignor by way of set-off, counter-claim, etc. which might not be applicable to an assignee.'" *Id*. citing *United States v. Shannon*, 342 U.S. 288, 291-92, 72 S.Ct. 281, 284, 96 L.Ed. 321 (1952).

Accordingly, the Debtors cannot sell its Medicare accounts receivable to the Buyer without the consent of the United States, which consent it does not have. While the Debtors may nevertheless argue that the bankruptcy court can order the Medicare accounts receivables to be sold over the United States' objection, which is the "operation of law" exception necessary to avoid the application of the Anti-Assignment of Claims Act, *see United States v. Aetna Casualty & Surety Co.*, 338 U.S. 366, 375-76 (1949), when the bankruptcy court approves a section 363 sale, it is only approving a voluntary action proposed by the Debtors. It is not mandating that the Debtors conduct the sale on certain terms. The court is simply authorizing the debtors to enter into the sale transaction, not requiring the debtors to sell. Accordingly, the sale is still a voluntary action by the Debtors to which the Anti-Assignment of Claims Act applies and with which the Debtors must be in compliance before a sale of those Medicare accounts receivable can be consummated. In particular, waiver of offset rights in claims against the United States may not be permitted except under very stringent circumstances that are not present here, because preservation of the United States' offset rights is one of the fundamental purposes for this long-standing statute. *U.S. v. Shannon*, 342 U.S. at 291-92.

D. Neither CMS' Authority and Jurisdiction to Determine Whether a CHOW is Occurring, nor the United States' Offset and Recoupment Rights, Constitutes an "Interest" in the Medicare Provider Agreements that could be Stripped in a "Free and Clear" Sale under Section 363(f).

The Debtors' Motion is brought under section 363(f) of the Bankruptcy Code. Section 363(f) authorizes certain sales of property "free and clear of any interest in such property."

Specifically, section 363(f) provides:

> (f) The trustee may sell property under subsection (b) or (c) of this section free and clear of *any interest in such property* of an entity other than the estate, only if—

> (1) applicable nonbankruptcy law permits sale of such property free and clear of such interest;
>
> (2) such entity consents;
>
> (3) such interest is a lien and the price at which such property is to be sold is greater than the aggregate value of all liens on such property;
>
> (4) such interest is in bona fide dispute; or
>
> (5) such entity could be compelled, in a legal or equitable proceeding, to accept a money satisfaction of such interest.

11 U.S.C. § 363(f). (Emphasis added).

As a *critical* threshold matter, the Debtors cannot satisfy the preamble requirements of section 363(f), *i.e.,* that the Medicare Provider Agreements may be sold free and clear of HHS's "interest" in said Agreements. The term "interest in property" generally refers to liens and security interests that attach to property of the estate. *See, e.g., In re Shary*, 152 B.R. 724, 725 (Bankr. N.D. Ohio. 1993); *Jandel v. Precision Colors, Inc.* 19 B.R. 415, 419-20 (Bankr. S.D. Ohio 1982).

Principally, the Debtors' attempted sale of the Medicare Provider Agreements under 11 U.S.C. § 363 should also be denied because the United States' regulatory interests in administering the Medicare Program for the benefit of Medicare patients do not constitute an "interest in property" that can be extinguished under 11 U.S.C. § 363(f). *See, e.g., Folger Adam Sec. Inc.*, 209 F.3d at 260; *In re Wolverine Radio*, 930 F.2d 1132, 1146 (6th Cir. 1991) (state assigned credit rating used to determine chapter 11 debtor's payments to the state unemployment fund was not an interest in property that could be extinguished under 11 U.S.C. § 363(f)); *In re Eveleth Mines, LLC*, 312 B.R. 634, 655 (Bankr. D. Minn. 2004) (state taxing authority's use of debtor's pre-sale iron ore production to compute production tax for which purchaser was partially liable held not to be an "interest in property" subject to § 363(f)). *See also In re White Crane Trading Co.*, 170 B.R. 694, 702 (Bankr. E.D. Cal. 1994) (bankruptcy court could not authorize sale that would be inconsistent with consumer protection laws); *In re Welker*, 163 B.R. 488, 489 (Bankr. N.D. Texas 1994) (trustee could not escape regulatory agreement between HUD and the Debtor).[10] Accordingly, there is no

[10] For these same reasons, any transfer obviously may not relieve the purchaser from complying with general Medicare requirements under a provider agreement, such as the requirement that the transferee meet the conditions for participation as a provider of services, including satisfaction of

"interest in property" held by the United States in the Medicare Provider Agreements for the Debtors to sell, pursuant to section 363(f).

Also, the United States' offset and recoupment rights are defenses and not "interests in property" that can be extinguished under section 363(f). The Medicare Act authorizes HHS to exercise recoupment under a Medicare Provider Agreement, but recoupment is not an "interest in property" that can be stripped under section 363(f). *See* 42 U.S.C. § 1395g(a).[11] Moreover, neither setoff nor recoupment constitutes a lien and is not a charge on property. *See, e.g., Newberry v. Fireman's Fund Insurance Co.*, 95 F.3d 1392 (9th Cir. 1996). To the contrary, the "necessary adjustments" language at 42 U.S.C. § 1395g(a) defines the proper payment due to the Medicare provider, and not to HHS. *U.S. Consumer Health Servs. of America*, 108 F.3d 390, 394 (D.C. Cir. 1997). Put another way, the statutory provision of 42 U.S.C. § 1395g(a) defines the Debtors' claims against HHS, not HHS's claims against the Debtors. Thus, "necessary adjustments" or offset and recoupment cannot and are not "interests" that attach to the independently existing property (*i.e.*, the Medicare Provider Agreements); but rather, it is part of the fundamental process by which the amount of payment owed to the provider is actually determined.

Recoupment, "the setting off against asserted liabilities of a counterclaim arising out of the same transaction," is also the principle that allows a creditor to adjust the amounts it owes a debtor. *See Reiter v. Cooper*, 507 U.S. 258, 264, 265 n.2 (1993). It carries with it no right to payment and, hence, it is not a claim under the Bankruptcy Code. *See Sims v. U.S. Dep't of Health & Human Servs. (In re TLC Hosp., Inc.)*, 224 F.3d 1008, 1011 (9th Cir. 2000); *Heffernan Mem'l Hosp. Dist.*, 192 B.R. at 230-31; *Brown v. General Motors Corp.*, 152 B.R. 935, 938 (W.D. Wis. 1993).

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health and safety standards, and civil rights requirements imposed on recipients of federal funds. *See* 42 C.F.R. 489.10 (basic requirements for CMS approval of a provider agreement). While Debtors have not disputed such general regulatory requirements, any order authorizing transfer should make the continuation of such general regulatory obligations explicit.

[11] 42 U.S.C. § 1395g(a) provides, in pertinent part: "The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) and prior to audit or settlement by the Government Accountability Office, from the Federal Hospital Insurance Trust Fund, the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments…" (emphasis added).

Recoupment is not a claim, it is a defense to payment. *See Kosadnar v. Metro. Life Ins. Co. (Matter of Kosadnar)*, 157 F.3d 1011, 1013-14 (5th Cir. 1998); *Chicago Title Ins. Co. v. Seko Inv., Inc. (In re Seko Inv., Inc.)*, 156 F.3d 1005, 1008-9 (9th Cir. 1997); *Conoco, Inc. v. Styler (In re Peterson Distributing, Inc.)*, 82 F.3d 956, 959 (10th Cir. 1996); *Lee v. Schwieker*, 739 F.2d 870, 875 (3d Cir. 1984). Because recoupment is not a claim, it "does not even fall under the broadest interpretation of an "interest in property." *In re Lawrence United Corp.*, 221 B.R. 661, 669 (Bankr. N.D. N.Y. 1998). Indeed, the Third Circuit addressed this precise issue in a general bankruptcy context independent of Medicare considerations and unequivocally held that recoupment does not "constitute an 'interest' for purposes of section 363(f)" and, therefore, may not be extinguished by a bankruptcy sale. *Folger Adam Sec., Inc. v. DeMatteis/MacGregor JV*, 209 F.3d 252, 254-64 (3d Cir. 2000).

E. The Debtors Fail to Satisfy any of the Enumerated Requirements of 11 U.S.C. § 363(f).

As for the enumerated requirements of section 363(f), the Debtors have not established the proper applicability of *any* of the five subparts of section 363(f) as required for a "free and clear" sale of the Medicare Provider Agreements.

Under 11 U.S.C. § 363(f)(1), a sale of a debtor's property may be authorized free and clear of any interest in such property *if* applicable nonbankruptcy law permits the sale of such property free and clear of such interest. As explained in detail above, a Medicare Provider Agreement may be assigned (and not sold) to a purchaser only as part of a valid change of ownership of an ongoing health care business as determined by HHS. 42 C.F.R. § 489.18(d); 42 C.F.R. § 424.550; *supra*, Section II.A. As recognized by the Fifth Circuit in *Vernon*, applicable non-bankruptcy law does not permit the sale of a Medicare Provider Agreement unless it continues to be subject to the Medicare Program, including the requirement that any payments made are subject to adjustments, or recoupment, pursuant to 42 U.S.C. § 1395g(a). Further, under the Medicare Program, any assignee of a Medicare Provider Agreement must accept that provider agreement as is, with full successor liability. *Supra*, Section IV.A. Hence, the Debtors' requested relief, which could be interpreted to broadly abrogate the provisions of the Medicare Act and eviscerate the requirements of the Debtors' Medicare Provider Agreements, cannot satisfy 11 U.S.C. § 363(f)(1).

Under 11 U.S.C. § 363(f)(2), a sale of a debtor's property may be authorized free and clear of any interest in such property *if* the party holding such interest consents to the sale on those terms. Here, HHS does not consent to any sale that violates section 365, the Anti-Assignment Acts or the Medicare Act, and eviscerates the Medicare Provider Agreements of any of their governing terms.

Under 11 U.S.C. § 363(f)(3), a sale of a debtor's property may be authorized free and clear of any interest in such property *if* such interest is a lien. As already noted, *supra*, Section IV.B., the Secretary's statutory obligation to make "necessary adjustments," or recoupment, to payment is neither an "interest" in the Debtors' property nor a lien. Similarly, the United States' regulatory interests in administering the Medicare Program for the benefit of Medicare patients do not constitute an "interest in property" or a lien.

Under 11 U.S.C. § 363(f)(4), sale of a debtor's property may be authorized free and clear of any interest in such property *if* the interest is in bona fide dispute. A debtor has the burden of showing that a bona fide dispute exists. 2 Lawrence P. King, Collier on Bankruptcy ¶ 363.06[5] (15th ed. 1998). This requires a debtor to show that "there is an objective basis for either a factual or legal dispute as to the validity of the debt." *Id*. Thus, whether a dispute is bona fide does not turn on the amount of the debt, but on the validity of the underlying liability.

For instance, in *In re Taylor*, 198 B.R. 142 (Bankr. D. S.C. 1996), the court denied the debtor's motion to sell its nursing homes free and clear of leasehold interests. The debtor argued that the leases were subject to a bona fide dispute because the lessees were in default on their rent and taxes. *Id*. at 163. The court held that the debtor could not sell free of the leasehold unless it proved that the default retroactively terminated the lease entirely. *Id*. Short of that, the lessees' alleged default did not raise a bona fide dispute as to the existence of the "interest" in the lease. *Id*.

Similarly, in the present case, the Debtors may or may not dispute the dollar amount of any specific overpayment that the Secretary may seek to recoup, but overpayment amounts are <u>not</u> the so-called "interest" at stake. The Debtors are actually seeking to avoid HHS's rights and authority under the Medicare Program altogether, including the statutory directive and authority to make "necessary adjustments" when it calculates a provider's proper payment: *that statutory term* is the relevant focus for a § 363(f)(4) analysis. Even assuming *arguendo* that the "necessary adjustments"

term of 42 U.S.C. § 1395g(a) constituted an "interest in property," *there could be no bona fide dispute about the existence of the "necessary adjustments" directive as a component of the Medicare statute.* That is clear from the text of the Medicare statute itself. Thus, no bona fide dispute exists.

Finally, under 11 U.S.C. § 363(f)(5), a sale of a debtor's property may be authorized free and clear of any interest in such property *if* the holder of that interest could be compelled, in a legal or equitable proceeding, to accept a money satisfaction of such interest. No legal or equitable proceeding may compel the Secretary to accept money to disregard or abrogate the statute by which Congress has directed her actions in running the Medicare Program. *See Maryland Dep't of Human Resources v. U.S. Dep't of Agric.*, 976 F.2d 1462, 1480 (4th Cir. 1992) ("An injunction may not strip a federal agency of its power to exercise lawful authority conferred by Congress through statute."). Simply put, a sale free and clear of the Debtors' obligations under the Medicare Act contravenes the very provisions of the Medicare Act itself.

Therefore, in summary, the Secretary's statutory directive to make "necessary adjustments," or recoupment, to a provider's current payment when an overpayment was made, and all of the other regulatory requirements, including a change of ownership and assignment of Medicare Provider Agreements, do not fall within the "interest in property" consideration of 11 U.S.C. § 363(f) in the first place. Furthermore, none of the five sub-criteria of section 363(f) can be met. Accordingly, the Debtors fail to satisfy any portion of 11 U.S.C. § 363(f), and their demand for a "free and clear" transfer of the Medicare Provider Agreements should be denied.

F. HHS is not Estopped from Arguing that the Medicare Provider Agreements May Not Be Sold "Free and Clear" in Bankruptcy Cases.

Contrary to the Debtors' argument, the United States is not estopped from making any arguments in opposition of the Debtors' attempt to "sell" the Medicare Provider Agreements free and clear of regulatory requirements including obtaining a CMS determination of a CHOW and full successor liability, and the Debtors cannot point to any bankruptcy case in which the United States has argued a contrary position. For instance, the United States has consistently taken the position – consistent with the vast majority of bankruptcy courts – that the Medicare Provider Agreements may

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be treated as subject to the requirements of section 365 for purposes of assumption and assignment, to the extent that those requirements are consistent with the Medicare Statute.

The Debtors ask the court to apply judicial estoppel broadly to bar the United States from taking a position allegedly inconsistent with its position taken in cases involving other issues and other litigants. As an initial matter, courts are normally reluctant to apply equitable estoppel against the government. *See United States v. Omdahl*, 104 F.3d 1143 (9th Cir.1997); *United States v. Shampang*, 987 F.2d 1439, 1444 (9th Cir.1993). Moreover, nonmutual offensive collateral estoppel "simply does not apply against the government." *United States v. Mendoza*, 464 U.S. 154, 162 (1984); *National Medical Enterprises, Inc. v. Sullivan*, 916 F.2d 542, 545 (9th Cir. 1990). The Supreme Court's rationale for the non-applicability of nonmutual offensive collateral estoppel against the government is that the United States is inherently different from a private litigant due to the geographic scope and multiplicity of its litigation. *U.S. v. Mendoza*, 464 U.S. at 160.

Furthermore, government litigation frequently addresses legal questions of substantial importance, and therefore allowing the United States to be subject to estoppel would "thwart the development of important questions of law." *Id*. Nonmutual offensive collateral estoppel could not be fairly applied to the United States because it may discretionarily forego appeal in certain cases, despite a likelihood of prevailing, based on government-specific factors, such as limited resources and crowded court dockets, with the expectation of relitigating the issue in an appropriate case with different parties.[12] *Id*. at 161. In essence, the Supreme Court recognized that government litigation in federal courts is sufficiently different from litigation by private litigants, so that "what might otherwise be economy interests underlying a broad application of collateral estoppel are outweighed by the constraints which peculiarly affect the government." *Id*. at 163.

With respect to the doctrine of judicial estoppel, even if it could be stretched to apply here, the Debtors conveniently neglect to acknowledge that they would have to carry a "heavy burden" to estop the United States. *United States v. Omdahl*, 104 F.3d at 1146 (citing *United States v. Shampang*, 987 F.2d at 1443-44) (citing *Yerger v. Robertson*, 981 F.2d 460, 466 (9th Cir. 1992)).

[12] The United States is, however, bound by principles of *res judicata*, which prevents re-litigation of issues between the same litigants. *Id.* at 162.

Specifically, "[i]n addition to the traditional elements of estoppel, the party must also prove that the United States engaged in affirmative conduct beyond mere negligence, that the party would suffer a severe injustice if estoppel is not applied, and that the public would not be burdened by its application." *United States v. Omdahl*, 104 F.3d at 1146. The Debtors did not even attempt to meet their heavy burden to establish grounds for estoppel against the United States. For instance, they did not and could not establish that they would suffer a "severe injustice" if the Medicare Provider Agreements are governed by section 365. Provider Agreements across the country have been treated as executory contracts in bankruptcy by courts across the nation for approximately a quarter century. A determination that the Medicare Provider Agreements in this case are subject to section 365 would not upset any expectations of the Debtors, the Buyer, lenders, other creditors of the estate, or the Medicare beneficiaries, because they have been treated as such by the vast majority of bankruptcy courts.

Moreover, the Debtors' Reply fails to establish grounds for judicial estoppel under the three-part test that they ask the Court to apply: (1) a party's later position must be "clearly inconsistent" with its earlier position; (2) the party has succeeded in persuading a court to accept that party's earlier position, so that judicial acceptance of an inconsistent position in a later proceeding would create the perception that either the first or the second court was misled; and (3) whether the party seeking to assert an inconsistent position would derive an unfair advantage or impose an unfair detriment on the opposing party if not estopped. *See* Reply, 19 (citing *Ah Quin v. County of Kauai Dept. of Trans*, 733 F.3d 267 (9th Cir. 2013)); *see also Committee of Russian Federation on Precious Metals and Gems v. U.S.*, 987 F.Supp. 1181, 1184 (N.D. Cal. 1997) (judicial estoppel focuses exclusively on preventing the use of inconsistent assertions that would result in an "affront to judicial dignity" and "a means of obtaining unfair advantage").

Particularly fatal to the Debtors' argument is the fact that any position the United States may have taken outside of bankruptcy regarding the implications of Medicare Provider Agreements is not "clearly inconsistent" with the position it takes inside a bankruptcy case, *i.e.*, that a Medicare provider agreement should be treated as an executory contract under section 365 insofar as the requirements of section 365 are consistent with that of the Medicare Statute. *See In re Hotel*

Syracuse, Inc., 155 B.R. 824, 837 (Bankr. N.D.N.Y. 1993) (debtor not estopped from arguing lease was not a "true lease" subject to section 365 after asserting in state court that the lease was a commercial lease under state law partly because positions were not clearly inconsistent). Instead, the language quoted by the Debtors as an example of the "completely inconsistent arguments" made by the United States (in *United States of America v. Tenet Healthcare Corp., et al.,* 2005 WL 3784642 (C.D. Cal. Dec. 22, 2005)) is taken out of context to exaggerate what the Debtors could not claim is a "clearly inconsistent" position if the entire argument was quoted. *See* Reply, 19.

In the United States' brief in *Tenet*, it first acknowledged that "a majority of bankruptcy courts treat provider agreements as "executory contracts," and explained that this treatment is not inconsistent with the law outside the bankruptcy context because the bankruptcy arena "is a court of special jurisdiction and practice governed by a particular code that is designed to fulfill certain purposes . . . unique to bankruptcy proceedings – *i.e.*, to determine if the debtor, at the sole option of the debtor, has assumed or rejected the Provider Agreement." *United States of America v. Tenet Healthcare Corp., et al*, 2005 WL 3784642 (C.D. Cal. Dec. 22, 2005). The United States then acknowledged in its brief that HHS cannot force a debtor to assume or reject a provider agreement in bankruptcy, and Medicare Provider Agreements are thus not fully "enforceable as contracts" by HHS against the debtor absent assumption under section 365 of the Bankruptcy Code. *Id*. The United States' argument in *Tenet Healthcare* does not conflict with its position here that the Medicare Provider Agreements are defined by the provisions of the Medicare Statute and clearly acknowledges and distinguishes the bankruptcy-specific characterization of provider agreements. *Id*.

All the other factors of the judicial estoppel test fail here as well. The Debtors cannot establish that the United States would gain an unfair advantage or impose an unfair detriment on the Debtors if it is not estopped from arguing that the Medicare Provider Agreements are subject to section 365 here. In fact, Congress drafted section 365 with the intent of equitably balancing the non-bankruptcy law rights of each creditor to receive the benefit of its bargain with the debtor's opportunity to reorganize. *In re Circle K Corp.*, 190 B.R. 370, 376 (B.A.P. 9th Cir. 1995) (noting that while the debtor must abide by contract provisions during bankruptcy and cure prepetition defaults upon assumption, the creditor is prohibited from enforcing prepetition default remedies).

Therefore, subjecting the United States to the carefully balanced rights and duties set forth in section 365 would not give the United States an unfair advantage implicating the judicial estoppel doctrine, even if nonmutual collateral estoppel applied to the United States.

V. HHS OPPOSES WAIVER OF THE 14-DAY STAY PURSUANT TO FED.R. BANKR.P. 6004(h)

Fed.R.Bankr.P. 6004(h) provides that an order authorizing the sale of property is stayed until the expiration of 14 days after entry of the order, unless the court orders otherwise. HHS objects to any request for a waiver of the 14-day stay. The purpose of the stay is to provide sufficient time for a party to appeal before a sale order is implemented. *See* Advisory Committee Notes to Fed.R. Bankr.P. 6004(h) and 6006(d). Because the transfer of the Medicare Provider Agreements is a significant federal concern involving the potential loss of significant funds derived from the public fisc, HHS requests the full 14-day period to appeal an order, if necessary.

VI. CONCLUSION

Based upon the foregoing, HHS respectfully requests that the Court sustain its objection and deny approval of the Debtors' Motion to sell the Medicare Provider Agreements free and clear of all liens, claims, encumbrances and interests to the Buyer. HHS further requests all other appropriate relief.

Dated: October 15, 2019

Respectfully submitted,

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PROOF OF SERVICE OF DOCUMENT

I am over the age of 18 and not a party to this bankruptcy case or adversary proceeding. My business address is: ***United States Attorney's Office, 300 N. Los Angeles Street, Room 7516, Los Angeles, California 90012***

A true and correct copy of the foregoing document entitled ***SUPPLEMENTAL OBJECTION OF THE UNITED STATES, ON BEHALF OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES AND CENTERS FOR MEDICARE AND MEDICAID SERVICES TO DEBTORS' MOTION FOR THE ENTRY OF AN ORDER AUTHORIZING THE SALE OF PROPERTY FREE AND CLEAR OF ALL CLAIMS, LIENS, AND ENCUMBRANCES; AND MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT THEREOF*** will be served or was served **(a)** on the judge in chambers in the form and manner required by LBR 5005-2(d); and **(b)** in the manner stated below:

1. TO BE SERVED BY THE COURT VIA NOTICE OF ELECTRONIC FILING (NEF): Pursuant to controlling General Orders and LBR, the foregoing document will be served by the court via NEF and hyperlink to the document. On ***October 15, 2019***, I checked the CM/ECF docket for this bankruptcy case or adversary proceeding and determined that the following persons are on the Electronic Mail Notice List to receive NEF transmission at the email addresses stated below:

☒ Service information continued on attached page

2. SERVED BY UNITED STATES MAIL:
On ***October 15, 2019***, I served the following persons and/or entities at the last known addresses in this bankruptcy case or adversary proceeding by placing a true and correct copy thereof in a sealed envelope in the United States mail, first class, postage prepaid, and addressed as follows. Listing the judge here constitutes a declaration that mailing to the judge will be completed no later than 24 hours after the document is filed.

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3. SERVED BY PERSONAL DELIVERY, OVERNIGHT MAIL, FACSIMILE TRANSMISSION OR EMAIL (state method for each person or entity served): Pursuant to F.R.Civ.P. 5 and/or controlling LBR, on ***October 15, 2019***, I served the following persons and/or entities by personal delivery, overnight mail service, or (for those who consented in writing to such service method), by facsimile transmission and/or email as follows. Listing the judge here constitutes a declaration that personal delivery on, or overnight mail to, the judge will be completed no later than 24 hours after the document is filed.

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I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct.

October 15, 2019	LILLIAN ARRATIA	Lillian D'Arratia
Date	*Printed Name*	*Signature*

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