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IN THE UNITED STATES BANKRUPTCY COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

In re:	
4 WEST HOLDING, INC. *et al.*, Debtors.	CASE NO. 18-30777 (HDH) CHAPTER 11 (Jointly Administered)

UNITED STATES OF AMERICA'S (HHS) LIMITED OBJECTION TO MOTION OF THE DEBTORS FOR ENTRY OF AN ORDER (I) APPROVING THE SETTLEMENT AND COMPROMISE OF CERTAIN CLAIMS PURSUANT TO A SETTLEMENT AGREEMENT; AND (II) GRANTING RELATED RELIEF

The United States of America, on behalf of the Department of Health and Human Services ("HHS"), acting through its designated component, the Centers for Medicare & Medicaid Services ("CMS"), hereby objects to the *Motion of the Debtors for Entry of an Order (I) Approving the Settlement and Compromise of Certain Claims Pursuant to a Settlement Agreement; and (II) Granting Related Relief* (Docket #101). The relief requested by the Motion violates federal law to the extent it allows the assumption and assignment of Medicare Provider Agreements without compliance with all the statutory and regulatory terms under which the Agreements were issued. In support of its objection, CMS states as follows:

1. On March 6, 2018 (the "Petition Date"), the above-captioned debtors (the "Debtors"), filed their voluntary petitions for relief under Chapter 11 of Title 11 of the United States Code (the "Bankruptcy Code").

2. Debtors' cases are being jointly administered, and pursuant to sections 1107(a) and 1108 of the Bankruptcy Code, Debtors continue to operate their businesses and manage their affairs as debtors-in-possession.

3. As of the Petition Date, certain of the Debtors are parties to Medicare provider agreements with the Secretary of HHS (the "Secretary"), acting through CMS, to receive payment for services provided to Medicare beneficiaries pursuant to the provisions of, and regulations promulgated under, Title XVIII of the Social Security Act. 42 U.S.C. §§ 1395-1395lll (the "Medicare Statute").

4. On March 13, 2018, Debtors filed the *Motion of the Debtors for Entry of an Order (I) Approving the Settlement and Compromise of Certain Claims Pursuant to a Settlement Agreement; and (II) Granting Related Relief* (Docket #101) ("the Motion").

5. The Motion provides, among other things, the Transferred Assets to the New Operators includes, "[s]ubject to applicable regulatory and Court approval, any Medicare/Medicaid provider number and any associated numbers . . ." (Docket #101 p. 20 ¶ 33.c.).

6. The Motion provides that at closing, the New Operators shall assume or otherwise be responsible for all liabilities and obligations accruing or arising solely after the Closing ("Assumed Liabilities"). (Docket #101 p. 21 ¶34). The Motion further provides that "[e]xcept for the Assumed Liabilities and cure amounts in association with any transferred contracts, the New Operators shall not assume or be liable for any liability, obligation, debt, claim against or

contract of the Transfer Portfolio facilities or the Debtors." (Docket #101 p. 21 ¶ 34).

7. Finally, the Motion provides "[t]he transfer of the Transferred Assets constitutes a 'sale' within the meaning of section 363 of the Bankruptcy Code" and should be deemed free and clear of all liens, claims, and other interest in such property. (Docket # 101 p. 25 ¶ 43).

8. The Proposed Order states the assets are being "transferred free and clear of all liens, claims, interests, or encumbrances, including without limitation, successor liability claims ("the Encumbrances")". (Docket # 101 Ex. B p. 3 ¶ 6).

9. Certain of Debtors provide long-term acute care services under the Medicare program. To be eligible to do so, a provider must have a valid agreement with the Secretary, called a Health Insurance Benefit Agreement (commonly known as a "Provider Agreement"). 42 U.S.C. § 1395cc; 42 C.F.R. § 400.202 (defining "provider"). A Provider Agreement is defined as an agreement between CMS, acting on behalf of the Secretary, and a health facility, such as a hospital (including a long-term care hospital, such as those owned by debtors), a skilled nursing facility, or a hospice. 42 C.F.R. § 489.3; 42 C.F.R. § 489.2.

10. To obtain a Provider Agreement, a new provider must apply for an initial certification. *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 (grounds for denying a Provider Agreement); *see also* 42 C.F.R. Part 483, subpart B (requirements for long term care facilities).

11. The transfer of a Provider Agreement is strictly limited. Provider Agreements may be assigned only if there is a "change of ownership." 42 C.F.R. § 489.18. When CMS determines that there has been a valid "change of ownership," the existing Provider Agreement is automatically assigned to the new owner. 42 C.F.R. § 489.18(c); *United States v. Vernon Home*

Health, Inc., 21 F.3d 693, 696 (5th Cir. 1994); *Deerbrook Pavillion, LLC v. Shalala*, 235 F.3d 1100, 1103-04 (8th Cir. 2000).

12. An assigned agreement is subject to all statutory and regulatory terms under which it originally was issued, including the adjustment of payments to account for previously made overpayments. *Vernon*, 21 F.3d at 696 (*citing* 42 C.F.R. § 489.18(a), (d)); *Mission Hosp. Reg'l Med. Ctr. v. Burwell*, 819 F.3d 1112, 116 (9th Cir. 2016) (holding that § 489.18(d) "provides continuity of obligations, continuity which is essential to the functioning of Medicare's Prospective Payment System. The regulation takes about an assignment, not a new beginning with a clean slate on new terms."); 42 C.F.R. § 489.18(d) ("[a]n assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued").

13. 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).

14. With respect to amounts paid to providers, the Medicare Statute states:

> [t]he 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 . . . the amounts so determined, *with necessary adjustments on account of previously made overpayments or underpayments*.

42 U.S.C. § 1395g(a) (emphasis added).

15. The Secretary, through Medicare Administrative Contractors ("MACs"), makes payment for services provided to Medicare beneficiaries by skilled nursing facilities under a

prospective payment system. 42 C.F.R. Part 413, subparts A and J.

16. Medicare-certified institutional providers are required to submit an annual cost report to their respective MAC. *See* 42 U.S.C. § 1395hh (giving the Secretary authority to require submission of cost reports). The MAC audits the cost report for that year and determines the provider's actual, rather than estimated, reimbursement amount for the year. 42 U.S.C. §§ 1395g; 1395x(v)(1)(A); 42 C.F.R. §§ 412.521. The MAC then issues a "Notice of Amount of Medicare Program Reimbursement" (NPR), which determines whether the provider was overpaid or underpaid for that fiscal year. 42 C.F.R. §§ 413.60, 405.1803. The NPR determination is final unless it is revised by the intermediary or revised or overturned on appeal. *See* § 42 U.S.C. §§ 1395oo (a) and (f)(1) (judicial review); 42 C.F.R. § 405.1807 and § 405.1835; *see also* 42 C.F.R. § 405.1885 (permits reopening of final cost report determinations).

17. To participate in the Medicare program, a SNF must be in "substantial compliance" with federal participation requirements at all times. 42 U.S.C. §§ 1395i-3(a)(3), (b)-(d); 42 C.F.R. Part 483, subpart B. CMS or the state health agency, under agreement with the Secretary, periodically conduct onsite surveys of SNFs in order to verify a facility's compliance with Medicare participation requirements. *See* A42 U.S.C. §§ 1395i-3 (g)(1)(A), 1395aa(a); 42 C.F.R. §§ 488.10(a), 488.11, 488.20. CMS may, and in some cases must, impose civil money penalties and other enforcement "remedies" on a SNF that a survey finds to be out of substantial compliance with federal participation requirements. 42 U.S.C. § 1395i-3(h)(2)(A); 42 C.F.R. §§ 488.402(b), 488.406-488.414; 42 C.F.R. § 488.430 (civil money penalties).

OBJECTION

18. Debtors seek an Order rejecting all successor liability after the transfer/sale of the Debtors' assets. ("The Transferred Assets are transferred free and clear of all liens, claims,

interests, or encumbrances, including without limitation, successor liability claims…" (Docket #101 Ex. B (Proposed Order) p. 3 ¶ 6); ("…Debtors conveyance of the Transferred Assets (corresponding to the facilities comprising the Transfer Portfolio) to the New Operators…should be deemed "free and clear" of all liens, claims, and other interests…." (Docket # 101 p. 25 ¶ 43). If Medicare Provider Agreements are assumed and assigned as part of such a sale, the rejection of successor liability violates applicable bankruptcy and Medicare law under which a purchaser must assume all of the burdens, as well as the benefits, arising from the assignment of the Provider Agreements. 11 U.S.C. § 365(a); 42 C.F.R. § 489.18(d); *University Med. Center v. Sullivan* (*In re University Med. Center*), 973 F.2d 1065, 1075 (3d Cir. 1992); *Vernon*, 21 F.3d at 696. *See also In re Charter Behavioral Health Systems, 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*") (emphasis added) (*citing* 42 C.F.R. § 489.18(d); *Deerbrook Pavilion, LLC v. Shalala*, 235 F.3d 1100, 1103-05 (8th Cir.2000); *Vernon*, 21 F.3d at 696 (5th Cir.)).

19. Moreover, the Medicare Statute and its regulations exclusively govern the payment of Medicare reimbursement claims, which precludes court review of reimbursement determinations until the provider complies with the necessary jurisdictional prerequisites. Federal courts lack jurisdiction to review those reimbursement determinations until the Secretary has issued a final administrative decision after exhaustion of all administrative remedies. 42 U.S.C. § 405(h) (as incorporated by 42 U.S.C. § 1395ii); *Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 15 (2000); *In re University Med. Center*, 973 F.2d at 1073 (noting

that, even in bankruptcy, a claim which "arises under" the Medicare Act cannot be reviewed by a court until administrative remedies are exhausted), *quoting Sullivan v. Hiser* (*In re St. Mary Hosp.*), 123 B.R. 14, 17 (E.D. Pa. 1991). Hence, Debtors are not authorized, and this Court lacks jurisdiction, to determine a cure amount setting the final reimbursement amount for its past or current cost reporting years or civil money penalties, if any.

For all the foregoing reasons, CMS objects to the Motion to the extent it (1) allows the assumption and assignment of Medicare Provider Agreements without compliance with all the statutory and regulatory terms under which the Provider Agreements were issued; (2) permits the Debtors or the Court to set a cure amount for the Medicare Provider Agreements; and (3) seeks to limit the United States' right of recoupment.

DATED April 9, 2018.

Respectfully submitted,

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Certificate of Service

On April 9, 2018, I electronically submitted the foregoing document with the clerk of court for the U.S. Bankruptcy Court, Northern District of Texas, using the electronic case filing system of the court. I hereby certify that I have served all parties electronically or by another manner authorized by Federal Rule of Civil Procedure 5(b)(2).

/s/ Donna K. Webb
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