AMERICAN BANKRUPTCY INSTITUTE

2017 Central States Bankruptcy Workshop

Health Care Insolvency

Daniel F. Dooley, Moderator
MorrisAnderson; Chicago

Thomas D. Anthony
Frost Brown Todd; Cincinnati

Wendy D. Brewer
JensenBrewer, LLC; Fishers, Ind.

Scott B. Davis
Grant Thornton LLP; Charlotte, N.C.

Daniel A. DeMarco
Hahn Loeser & Parks LLP; Cleveland

CONCURRENT SESSION

2017

MORRIS ANDERSON
Trusted advisors delivering practical solutions

Healthcare Insolvency: Is it ObamaCare, TrumpCare, or WhoCares?

Dan Dooley – MorrisAnderson - Chicago
Scott Davis – Grant Thornton - Charlotte
Dan DeMarco – Hahn Loeser - Cleveland
Tom Anthony – Frost Brown Todd – Cincinnati
Wendy Brewer – Jensen Brewer - Indianapolis

ABI Central States Conference

June 9-10, 2017

MORRIS ANDERSON

Healthcare Insolvency Topical Outline

1. Continuing Consolidation of Small into Bigger Entities and Unique Valuation Issues
2. Regulating Constraints Conflicts Within Bankruptcy
3. Circuit Split (9th/11th) on Bankruptcy Court Jurisdiction Over Medicare Disputes
4. Patient Ombudsman – Role Evolution
5. Medical Records Retention in A Wind Down

Distressed healthcare

Prepared for ABI Central States Bankruptcy Workshop

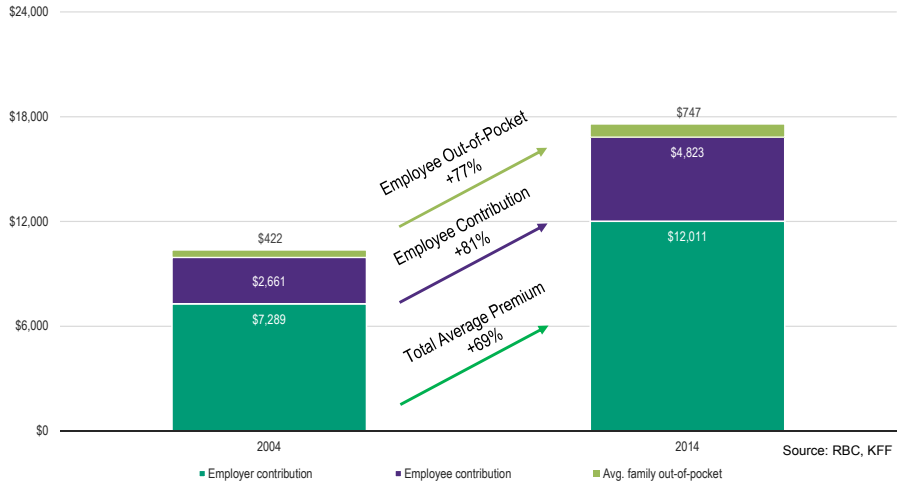
June 2017

Grant Thornton
An instinct for growth™

US HEALTHCARE INDUSTRY

Families & insurers are paying more than ever

Annual Family Coverage Premium Growth, 2004-2014



ACA drives increase in premiums

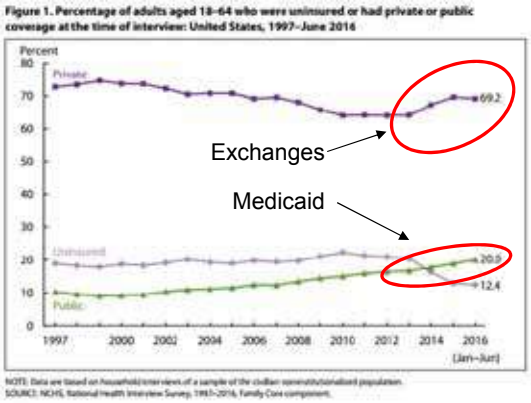
Over time, insurance premiums have increased. Rates are predicted to continue to increase under ACA, along with expected employee contributions. These increases may be caused by an increase in the percent of premiums spent directly on providing care along with increased insurer taxes implemented with the ACA.

US HEALTHCARE INDUSTRY

Despite increases in the number of insured, patient out-of-pocket costs have increased

ACA causes spike in total insured, costs increase for employee-sponsored PPO plans

- Annual medical costs for a hypothetical family of 4 have increased from $20,728 to $25,826 from 2012 to 2016, according to the Milliman Medical Index
- Uninsured rates dropped from ~20% in 2013 to ~12% in June of 2016 for adults aged 18-64



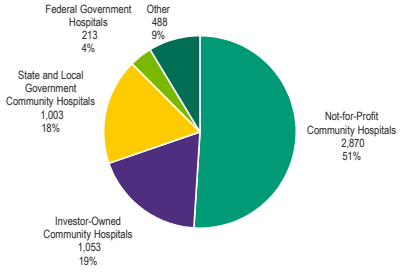
The Milliman Medical Index is an actuarial analysis of the projected total cost of healthcare for a hypothetical family of four covered by an employer-sponsored preferred provider organization (PPO) plan. Unlike many other healthcare cost reports, the MMI measures the total cost of healthcare benefits, not just the employer's share of the costs, and not just premiums. The MMI only includes healthcare costs. It does not include health plan administrative expenses or profit loads.

Will high-deductible plan enrollment continue to increase, raising average individual medical costs? Will the uninsured percentage of the US population increase under the replacement for the ACA? How will providers respond?

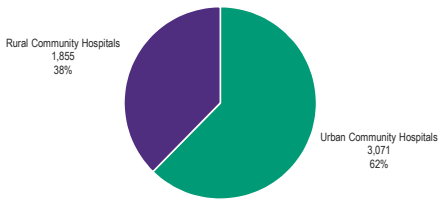
US HEALTHCARE INDUSTRY

US Hospital Breakdown (~5,700)

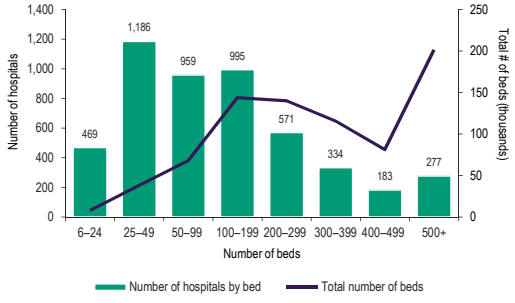
Registered hospital composition[1]



Community hospital composition by location[1]



Community hospital composition by number of staffed beds and total beds by hospital size[2]



Community Hospital Definition[1]

Community hospitals are defined as all non-federal, short-term general, and other special hospitals. Other special hospitals include obstetrics and gynecology; eye, ear, nose, and throat; rehabilitation; orthopaedic and other individually described specialty services. Community hospitals include academic medical centers and other teaching hospitals if they are non-federal short-term hospitals. Excluded are hospitals not accessible by the general public, such as prison hospitals or college infirmaries.

Sources: 1. American Hospital Association – 2014 AHA Annual Survey 2. Centers for Disease Control and Prevention; *Table 89. Hospitals, beds, and occupancy rates, by type of ownership and size of hospital: United States, selected years 1975-2010.* https://www.cdc.gov/nchs/hus/contents2014.htm

US HEALTHCARE INDUSTRY

The US hospital industry is highly competitive

Threat of new entrants

- High capital requirements
- Licensure, accreditation, and regulation
- High operating costs
- Shortage of skilled and specialized professionals
- Uncertainty surrounding plans for healthcare reform

Low

Buyer power

- Medicare and Medicaid dictate pricing
- Insurers hold negotiating power in determining service reimbursement rates
- Patients have little control over the cost of care
- Limited but increasing price transparency

High

Rivalry among competitors

- Hospitals compete on access to care, quality of care, breadth of services, and ability to attract and retain providers
- Pressures from healthcare reform are increasing consolidation, though the industry remains largely fragmented
- Increasing consolidation, although the industry remains largely fragmented

Threat of substitutes

- Urgent care and retail centers
- Cost-advantaged specialty hospitals, surgery centers, and imaging centers

High

Supplier power

- Limited supply of providers
- Limited sources for many key inputs
  - Drugs
  - Medical devices
  - Information technology
- Highly unionized

High

Source: 1. IBISWorld Industry Report – Hospitals in the U.S., December 2016; Grant Thornton analysis

US HEALTHCARE INDUSTRY

Health Care Key Trends

MASSIVE SHIFT

Cost reduction and improving quality outcomes across two paradigms:

Unit of Service ("Fee For Service")

Traditional cost management to reduce the cost of episodes of care through process efficiency, lowering supply costs and maximizing technology enablement

Per Insured Life ("Population Health")

Reducing costs across the value chain by improving care coordination, reducing duplicate services and treatment variation, and proactively caring for at-risk patients

Revenues	Consolidation	Quality = $	MD Red Ink	Revenue Cycle Risk	Informatics/Technology
Provider reimbursement for services is slowing and in some cases is being reduced	40% of hospitals are stand-alone. Horizontal & vertical consolidation is increasing	Quality and paying for quality is gaining momentum. Medicare /Medicaid has been a key driver.	We are seeing mid-sized health systems losing $50M to $75M a year within hospital physician enterprises	New reimbursement methods for health care systems and patient portion of payments are increasingly making revenue cycle even more complex	There is an explosion in technology: EMR, interoperability mobile devices, and patient/customer experience

RISK

New Regulations | Compliance Analytics | Cyber Security | New Business Models | Clinical Reputation

US HEALTHCARE INDUSTRY

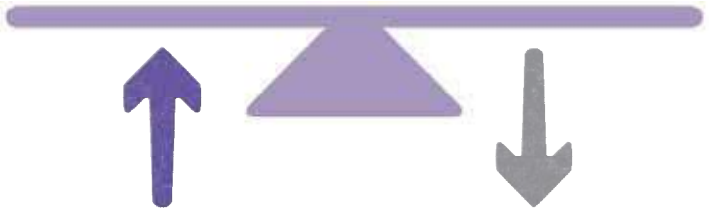
This isn't getting any better – hospitals are going to continue to fail

More

- Aging population
- Migration to lower cost settings of care
- Risk-taking by providers
- Pricing transparency
- Vertical integration
- Consolidation
- Distress
- Closures

Less / Fewer

- Insured
- Volume
- Reimbursement



US HEALTHCARE INDUSTRY

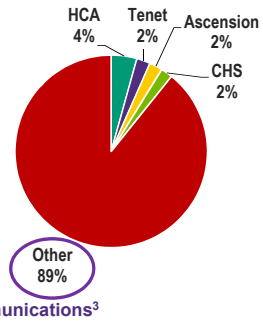
Health Systems / Hospital Triage

EMERGENCY OR URGENT?	VITALS
• Cash / unrestricted investments on-hand • Accounts Receivable valuation • Days operating expenses in accounts payable • Leverage • Capital expenditures (historical and planned)	• Market Share / competition • Service-line mix • Acuity • Payor mix • Commercial payor rates • Physician strategy / relationships • Management / governance • Labor costs • Average length of stay • Quality

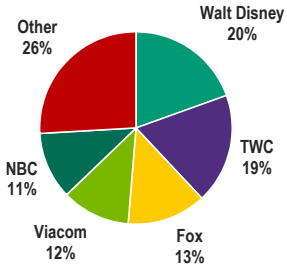
US HEALTHCARE INDUSTRY

US hospital industry is highly fragmented as the top four players serve roughly 11% of the market, far less than in other industries

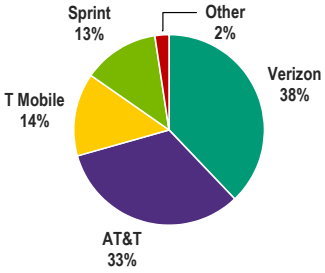
US Hospitals[1]



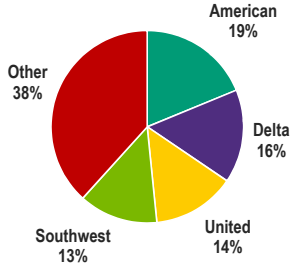
Cable Networks[2]



Wireless Telecommunications[3]



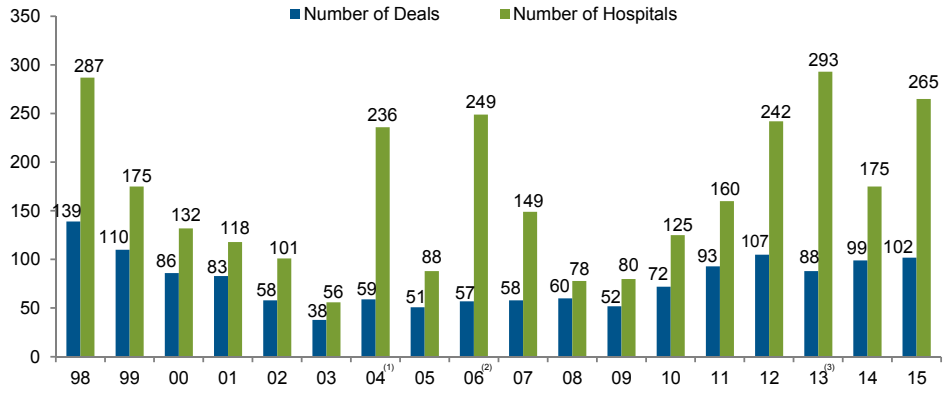
Domestic Airlines[4]



Sources: 1. IBIS World: Hospitals in the US, March 2017 2. IBIS World: Cable Networks in the US, March 2017 3. IBIS World: Wireless Telecommunications Carriers in the US, February 2016 4. IBIS World: Domestic Airlines in the US, September 2016

US HEALTHCARE INDUSTRY

Announced hospital mergers and acquisitions, 1998-2015



Source: Irving Levin Associates, Inc. (2016). *The Health Care Services Acquisition Report*, Twenty-Second Edition.

(1) In 2004, the privatization of Select Medical Corp., an operator of long-term and acute-care hospitals, and divestiture of hospitals by Tenet Healthcare Corporation helped to increase the number of hospitals affected.

(2) In 2006, the privatization of Hospital Corporation of America, Inc. affected 176 acute-care hospitals. The acquisition was the largest health care transaction ever announced.

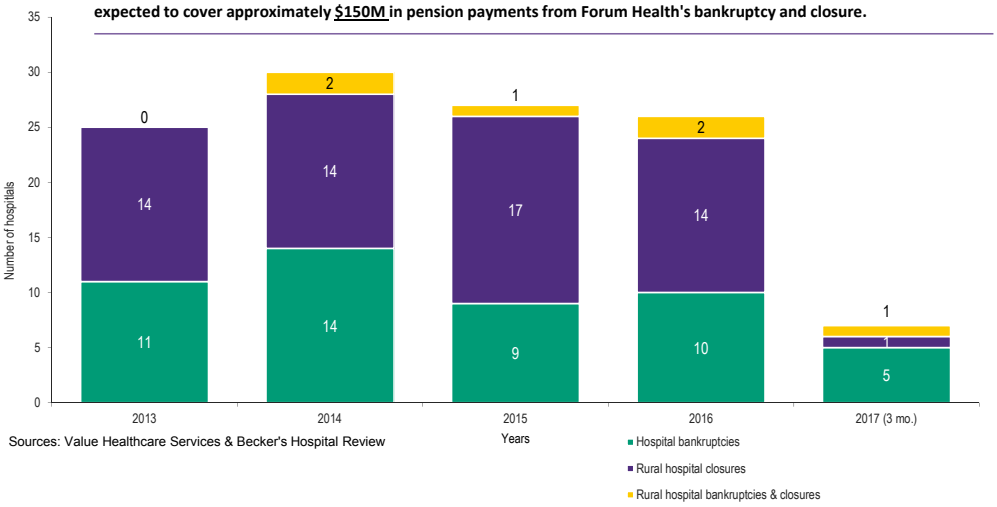
(3) In 2013, consolidation of several investor-owned systems resulted in a large number of hospitals involved in acquisition activity.

Chart 2.10 in 2009 and earlier years' Chartbooks.

US HEALTHCARE INDUSTRY

Hospital Bankruptcies and Closures

The PBGC has potential exposure to these hospitals – and claims can run into the many millions of dollars. In 2010, the PBGC expected to cover about $267M for the unfulfilled pension guarantees for St. Vincent Catholic Medical Center and in 2011, expected to cover approximately $150M in pension payments from Forum Health's bankruptcy and closure.



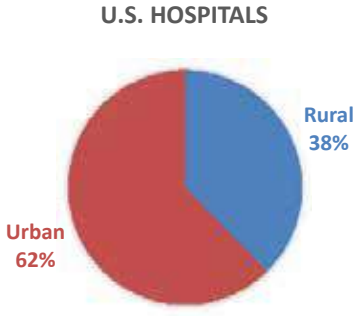
Sources: Value Healthcare Services & Becker's Hospital Review

Adapt or Go Away – Hospitals Face Difficulties in Modern Healthcare Arena

When the Affordable Care Act came into full effect in 2014, many hospitals struggled to adapt to new federal requirements. This pressure was manifested in an increased number of bankruptcies and closures – 30 in total in 2014, according to Value Healthcare Services and Becker's. This number represents thousands of laid-off hospital employees, many of whom are in rural areas with few other options for employment. Even still, the struggle remains: earlier this year, 16 hospitals had their credit ratings downgraded by Fitch, Moody's and Standard & Poor's in one month.

US HEALTHCARE INDUSTRY

Rural hospitals per HRSA from 2010 to 2016



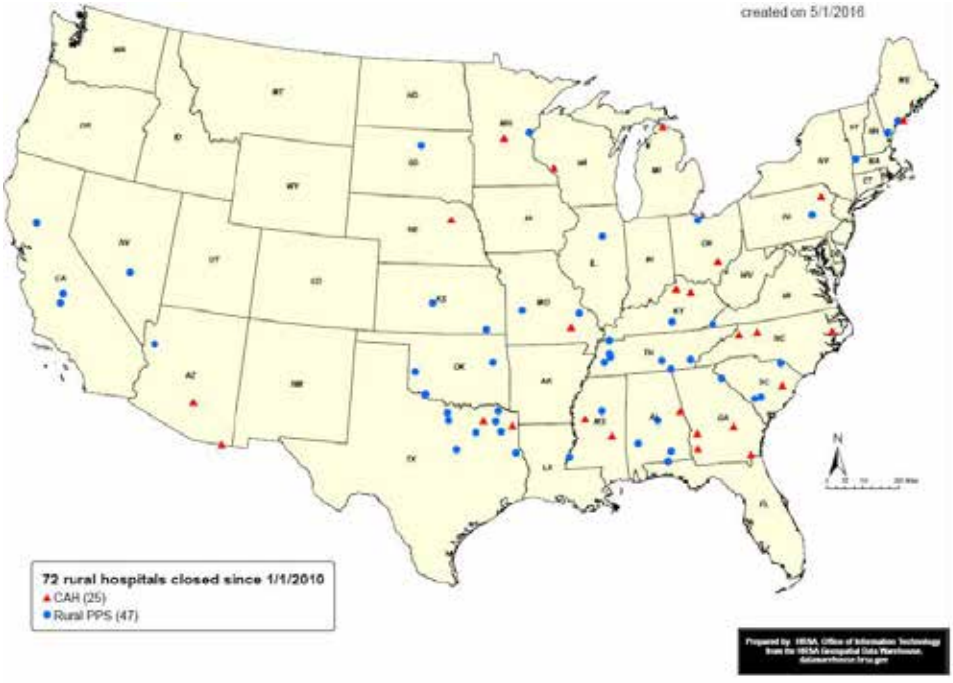
Rural hospital types

	Number	Percent
Critical Access Hospitals*	992	54%
Sole Community Hospitals*	241	13%
Rural Referral Centers*	204	11%
Medicare Dependent Hospitals*	148	8%
PPS Rural Hospitals	269	15%
	1,855	100%

* = Enhanced or supplemental reimbursement under Medicare

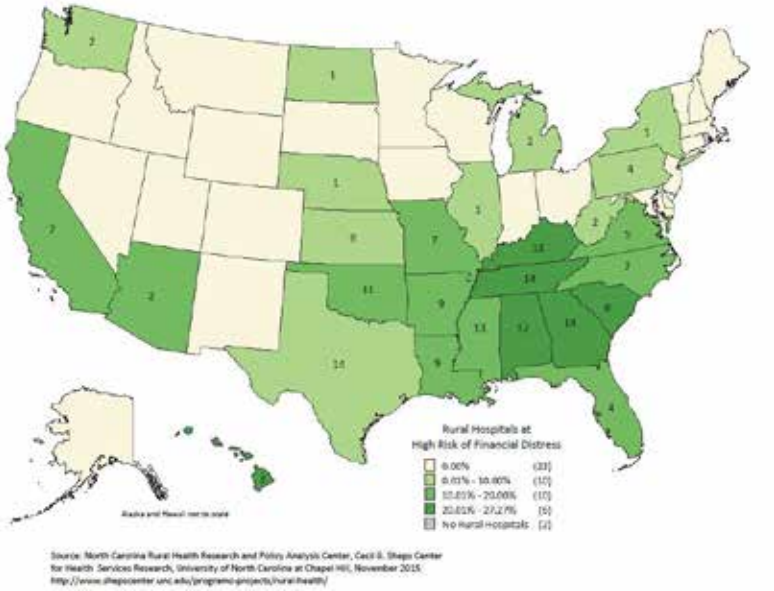
US HEALTHCARE INDUSTRY

Closed rural hospitals per HRSA from 2010 to 2016



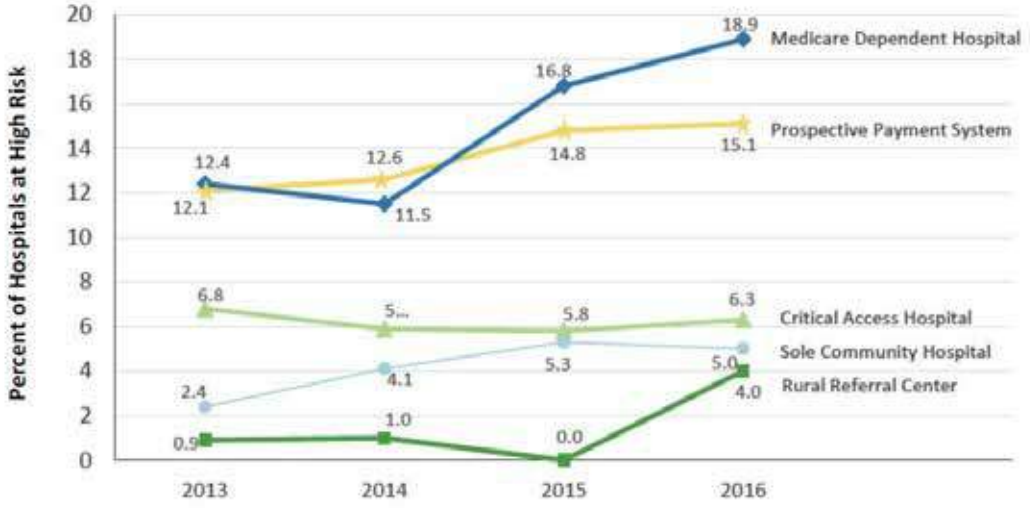
US HEALTHCARE INDUSTRY

Number and percentage of rural hospitals at high risk of financial distress in 2016 per NCRHR



US HEALTHCARE INDUSTRY

Proportion of rural hospitals at high risk of financial distress by CMS payment type, 2013-2016 per NCRHR



CONTACT INFORMATION

Scott Davis
Partner
Distressed Healthcare Leader
T: 704.632.3540
C: 704.906.9441
E: Scott.Davis@us.gt.com

June 9, 2017

Thomas D. Anthony
Frost Brown Todd LLC
301 E 4th Street
Cincinnati, Ohio 45202
E-mail: tanthony@fbtlaw.com
Office phone: 513.651-6191
Cell: 513-205-1459

4832-2398-9559

Potential Changes affecting the Affordable Care Act

Understanding healthcare reform

- PPACA is still work-in-process
- PPACA is mostly insurance reform
- Reformed revenue stream for providers
  - Fee-for-service is being phased out
  - Pay for performance is being phased in
- Dramatic impact on employers
- Need to adapt

Frost Brown Todd

USA Health Care Spending

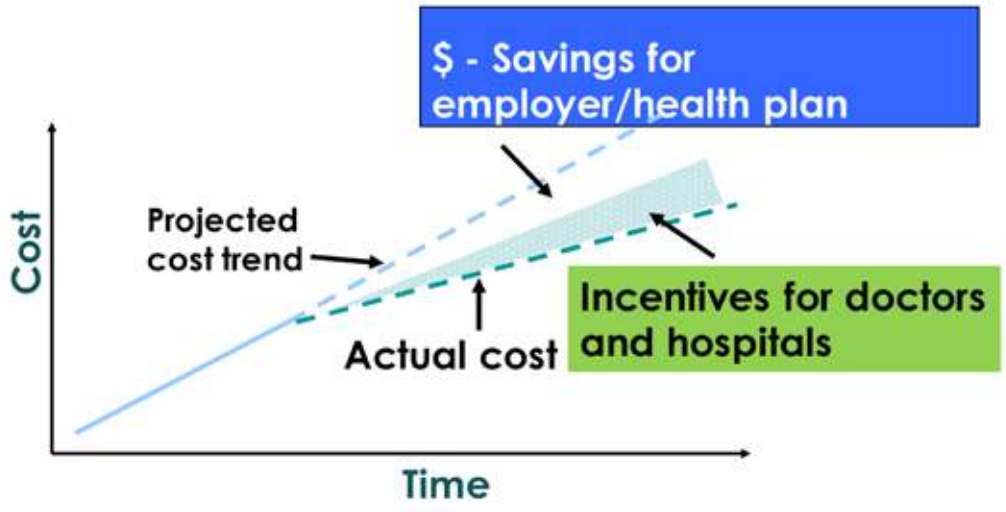
- 2009 Health care was 17.9% of GDP

Affordable Care Act adopted March 2010

- 2012 Health care was 17.2% of GDP
- 2015 Health care was 17.8% of GDP

Frost Brown Todd

Understanding the Cost Curve



Litigation Efforts

- 28 state legislatures have sued
- 4 favorable US Supreme Court decisions
- 6 US Court of Appeals decisions
- Many cases (est. 170) are still being litigated

Current legislative efforts: 2 R's; 3 R's; or 4 R's?

- 10 Amendments already adopted
- 20,000 - 33,000 pages of Regulations
- HR 45, HR 596; and HR 3121 would all **"Repeal and Replace"**
- S 339 Ted Cruz - **Restores** former laws, pre-2010
- Four drafts in 2017 House Energy and Commerce Committee's health panel
- **Repeal, Replace, Restore, and/or Repair**

Insurance exchanges

- Insurance exchanges in financial trouble
- Federal subsidies at 12.6% of projected
- Healthy individuals not enrolling
- Enrollees' medical costs 250% of projections
- Commercial insurers withdrawing
- Aetna Humana merger blocked by FTC
- Limited choices/reduced access for enrollees
- 2017 Premiums increasing 22%-30%

"Access" under PPACA – Where are we now?

- Exchange enrollees fell from 10.2 million in 2015 to 9.2 million in 2017
- Approx. 12.3 million enrolled in Medicaid/CHIP
- 2015 hospital uncompensated care fell by $7 **billion**
- Medicare all-cause 30-day readmission rate down approx. 17.5%

Frost Brown Todd

Responding to the situation

Frost Brown Todd

Consolidation: Insurers as owners

- Anthem – CIGNA merger?
- Aetna – Humana merger blocked
- Highmark acquired West Penn Allegheny Health System
- Humana acquired Concentra (worksite safety and urgent care centers)
- Wellpoint/Anthem acquired CareMore—(special needs and Medicare Advantage)
- United Health Group purchased Monarch, the largest physician group in Orange County, CA, with 2,300 members
- United/Optum acquires Surgical Care Affiliates - 205 surgery centers

Frost Brown Todd

Hospital consolidation

- Tenet acquired Vanguard and now has 77 hospitals in 30 markets
- Community Health acquired HMA and now operates a network of 206 hospitals
- Catholic Health East merged with Trinity and now has 82 hospitals in 21 states
- Louisville - Kentucky One
- St Elizabeth and TriHealth in SW Ohio/NKY 10 hospitals and 850 MD's

Frost Brown Todd

The Rise of the (Medical) Machines

The Terminator. 1984 Metro-Goldwyn-Mayer Studios Inc. James Cameron, Director.

Frost Brown Todd

13

Meet your new doctor

- WALGREENS - 8200 stores
- Merging with Rite Aid 4800 stores
- Primary care, vaccinations, and urgent care
- Chronic disease monitoring
- Merged Alliance Boots (Swiss) 4600 stores in 27 countries
- Now largest pharmacy chain in the world
- 13,000 USA locations vs 6,000 hospitals

- *-Source: www.walgreens.com*

Frost Brown Todd

Consolidation Trend: TeamHealth

- TeamHealth (MD staffing model)
  1. 9,600 professionals
  2. emergency medicine
  3. anesthesia
  4. urgent care
  5. specialty hospitalists
  6. pediatrics
  7. 850 sites
  8. 46 states.
  9. NYSE listed; Knoxville HQ

Frost Brown Todd

15

What is the reason for these consolidations?

Jerry Maguire. 1996 TriStar Pictures. Cameron Crowe, Director.

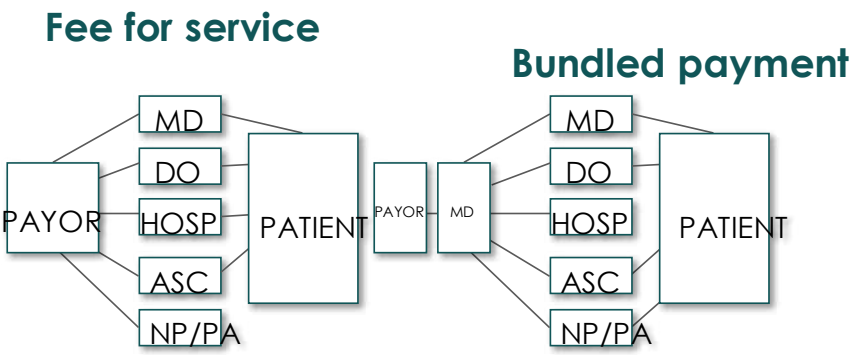
Frost Brown Todd

16

Bundled payments

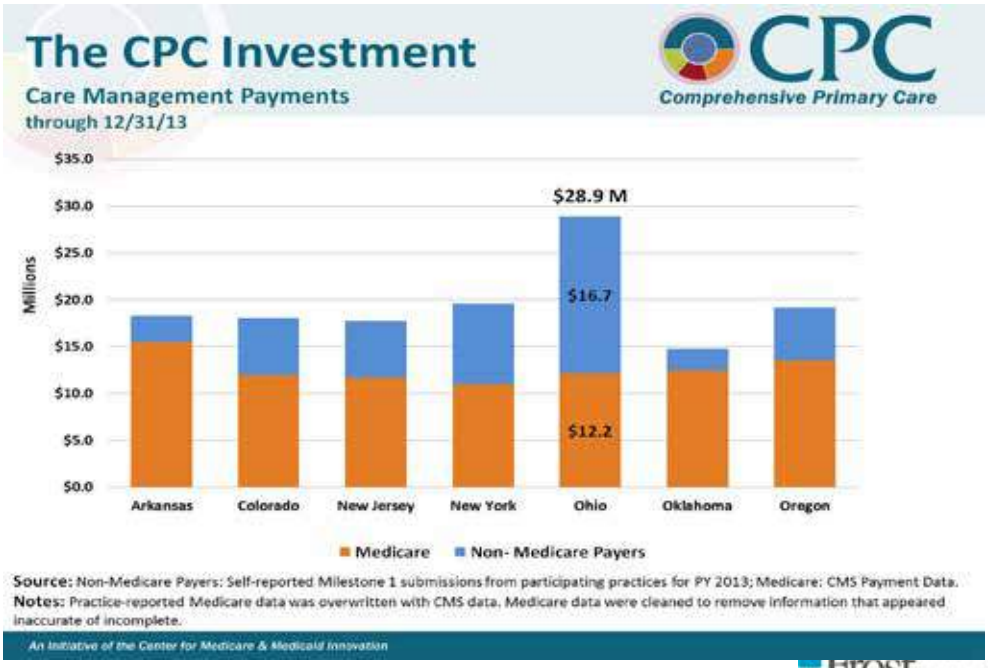
Frost Brown Todd LLC

Fee for service vs. bundled payment



Fixed amount per episode, illness, or injury

Frost Brown Todd LLC



Frost Brown Todd LLC ATTORNEYS

Where do we go from here?

- Costs to repeal: $210 Billion
- Costs to continue $660 Billion

Frost Brown Todd LLC ATTORNEYS

Observations

- Donald Trump is a capitalist
- In a capitalist society, the laws of "The Market" are supreme
- Forces of supply and demand vs Government
- Consider the impact of market forces on health care
- Executive Orders to minimize ongoing impact of Affordable Care Act

Likely Changes or Repeal

- Individual coverage mandates – vs market based incentives coupled with tax penalties
- Employer coverage mandates
- Medicaid expansion
- Scope of subsidies of programs and Exchanges
- Minimum "Essential" Benefits
- Funding for abortions
- "Cadillac tax" on expensive employer health plans

Surviving (but maybe "Repaired" in some form):

- MIPS/MACRA
- Medicare cuts to hospital payments and DSH
- Age 26 children on parents' insurance
- Pre-existing condition coverage
- Fee-for-service phase out
- Pay for performance phase in
- Accountable Care Organizations
- Bundled payments
- Exchanges with repairs to stabilize
  - Reduced premiums
  - Better access to care

23

Vision for the Future

- **Everything that can be invented has been invented.**
  —**Charles H. Duell**, *Commissioner, U.S. Patent Office, 1899*

- **If you don't know where you are going, sometimes you wind up some place else.**
  —**Yogi Berra**, *New York Yankees, 1962*

- **The future isn't what it used to be.**
  —**Stewart Brand**, *Author of* The Whole Earth Catalogue, *2009*

24

Vision - Adapt

"It is not the strongest of the species that survive, nor the most intelligent, but the one most responsive to change."

—Charles Darwin, 1859

Frost Brown Todd

25

Thank you for joining us!

QUESTIONS?

Frost Brown Todd

American Bankruptcy Institute
Central States Conference
Traverse City, Michigan

Friday June 9, 2017 at 10:45 a.m. EST and Saturday June 10, 2017 at 9:30 a.m. EST

Health Care Insolvency; is it ObamaCare, TrumpCare or WhoCares?

Prepared By: Thomas D Anthony
Frost Brown Todd LLC, Cincinnati, Ohio

Regulatory Considerations:

A. The Anti-Kickback Statute

1. The Federal anti-kickback statute ("AKS") provides criminal penalties and civil monetary penalties for individuals and entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce business for which payment may be made under a federal healthcare program. The type of remuneration involved has been very broadly interpreted to include any kind of kickbacks, bribes, and rebates. The statute applies to any such remuneration whether made directly or indirectly, overtly or covertly, in cash or in kind. 42 USC §1320a-7B(b).

2. A number of "safe harbors" have been adopted to create exceptions to the prohibitions of the AKS. If an arrangement meets one of the applicable safe harbors, it is fully protected from both criminal and civil liabilities under the Anti-kickback Statute. However, failure to meet all of the requirements of an applicable safe harbor does not necessarily make the conduct illegal.

3. Safe Harbors that are typically used for Hospital transactions are as follows:

(a) Space, Equipment, and Personal Services and Management Contracts. Hospitals may rent space and equipment as part of the transaction. The Hospitals also enter Administrative Services Agreements and Participation Agreements with the hospital facilities and other participating providers. These arrangements may be structured to be within AKS Safe Harbors. The Safe Harbors for space rental, equipment rental, and personal services and management contracts all contain the same following requirements: (1) a written agreement; (2) duration of at least one year; (3) the aggregate compensation must be specified in advance; (4) the premises, equipment, or services covered be specifically identified in advance; (5) if the agreement is not for full-time services, the agreement must also specify the schedule of intervals, the precise length, and the exact charge for each interval; (6) the agreements must specifically cover all space, equipment or services that will be involved for the term of the agreement; and (7) payments must be based on fair market value and cannot vary based on the volume or value of referrals or business generated between the parties. 42 C.F.R. § 1001.952.

(i) Safe Harbor for Investment Interests. Occasionally, individual physicians obtain ownership interests in the Hospital as part of a transaction. If they do, a Safe Harbor is available for those investment interests. The Safe Harbor requires the following:

(ii) Exceptions from AKS that allow an investment in a Hospital are available for investment in healthcare entities that are located in Medically Underserved Areas ("MUAs").

(iii) Small Investment Interests, also known as the 40/40 rules: for smaller investments in Hospitals that are not in publicly held companies nor in MUA's, the following requirements must be met:

(iv) No more than forty percent (40%) of the value of the investment interests of each class of investments may be held in the previous twelve (12) month period by investors who are in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for, the Hospital.

(v) No more than forty percent (40%) of the gross revenue of the entity in the previous fiscal year or previous twelve (12) month period may come from referrals or business otherwise generated from investors in the Hospital.

(vi) The terms on which an investment interest is offered to a passive investor, who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity, must be no different than the terms offered to other passive investors.

(vii) The terms on which an investment interest is offered to an investor who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity must not be related to the previous or expected volume of referrals, items, or services furnished, or amount of business otherwise generated, from that investor to the entity.

(viii) There may not be any requirement that a passive investor make referrals to, be in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity as a condition for remaining as an investor.

(ix) The entity or any investor may not market or furnish the entity's items or services (or those of another entity as part of cross-referral agreement) to passive investors differently than to non-investors.

(x) Neither the entity nor any investor (nor other individual or entity acting on behalf of the entity or any investor in the entity) may loan funds to or guarantee a loan for an investor who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity if the investor uses any part of such loan to obtain the investment interest.

(xi) The amount of payment to an investor in return for the investment interest must be directly proportional to the amount of the capital investment of that investor. 42 C.F.R. § 1001.952(a).

4. Investment in Entities in Medically Underserved Areas (MUA's). This safe harbor can apply to MUAs that are located in either rural or urban areas. Be sure to check the sources of this designation because many urban areas do qualify. This safe harbor modifies the 40/40 Investor Rule. Instead, the special rule for MUA's allows up to 50% of the value of the investment interest of each class of investments to be held by investors who are in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the Hospital. However; there is a requirement that at least 75% of the business in the previous fiscal year or previous twelve (12) month period be derived from services furnished to persons in an MUA or who are members of a medically underserved population ("MUP").

B. The Stark Law

The "Stark Law" is named after long time California Congressman Pete Stark, who introduced the statute reputably after a family member had an undesirable experience with medical treatment by a physician. The Stark Law prohibits physicians from ordering "Designated Health Services" (DHS) for Medicare patients from entities with which the physician (or an immediate family member) has a "financial relationship." The Center for Medicare and Medicaid Services (CMS) has issued regulations and guidance interpreting the Stark law. The regulations appear at 42 CFR §411.350 et seq.

If physicians or medical groups are involved in the Hospital in any way, there are a number of definitions in the Stark Law that are key to interpreting and applying it to these arrangements. Physicians can be involved by having compensation arrangements, ownership or both. This definition can include medical directorships:

1. "Financial Relationship" includes both compensation arrangements, and investment and ownership interests.

2. "Referral" means "the request or establishment of a plan of care by a physician that includes the provision of the designated health service." Courts interpreting this law and the Anti-Kickback Statute have applied a very broad reading to the term, "referral."

3. "Designated Health Services" ("DHS") means the following: clinical laboratory services; physical therapy, occupational therapy, and speech language pathology services; radiology and certain other imaging services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment, and supplies; prosthetics, orthotics, and prosthetic devices; home health services and supplies; outpatient prescription drugs; and inpatient and outpatient hospital services. 42 U.S.C.1395nn.

While Stark includes a general prohibition on self-referrals, more importantly, it includes a number of exceptions within which most Hospital transactions are structured.

Specifically, the statute and regulations provide a list of exceptions that apply to ownership and compensation arrangements involving physicians.

Hospital arrangements between providers with referral relationships, such as a physician or physician practice and a hospital, will generally constitute a "financial relationship." Accordingly, it is critical that the arrangements between these providers satisfy the requirements of the applicable Stark exceptions. The exceptions that most directly apply to Hospitals are:

4. Personal Services Arrangements

The exception covers independent contractor arrangements (not employment) and requires: (1) a written agreement that specifies the services covered by the arrangement; (2) that the arrangement cover all of the services to be provided by the physician to the entity; (3) that the term of the agreement must be for one year or more; (4) that the aggregate services contracted for must not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement; (5) that the compensation to be paid over the term of the agreement be set in advance, may not exceed fair market value, and not be determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties; and (6) that the arrangement not violate any state or federal law, like the anti-kickback statute.

5. Fair Market Value Exception. Since the personal services arrangements exception only applies to covered services provided by the physician to the Hospital, be sure to consider the converse exception that protects services provided by the Hospital to the physician or physician practice. 42 U.S.C. § 1395nn(e)(3); 42 CFR 411.357(D) et seq.

The fair market value exception excepts an arrangement that meets the following conditions: (1) The arrangement is in writing and is signed by the parties; (2) the arrangement covers only specific items or services; (3) the agreement is for one year or more, (subject to certain exceptions); (4) the compensation must be set in advance, consistent with fair market value, and not determined in a manner that takes into account the volume or value of referrals or other business generated by the referring physician; (5) compensation for any rental of equipment that is covered by the agreement may not be determined using a formula based on (i) a percentage of the revenue attributable to the services performed or business generated through the use of the equipment; or (ii) per unit of service rental charges, to the extent that such charges reflect services provided to patients referred by the lessor to the lessee; (6) the arrangement must commercially reasonable; and (7) the arrangement must further the legitimate business purposes of the parties; (8) the arrangement and the services provided under it may not violate any other federal law including the anti-kickback statute. 42 CFR §411.357(l). Please note that this exception is of limited value because it may only be used when no others are available.

6. Rental of Office Space

In the Hospital transactions, some leases are utilized instead of acquisitions. In some cases, the Hospital may lease to or from physicians or medical groups. To be lawful, these arrangements with physicians or medical groups must meet an exception under Stark. The exception for the rental of space is met if : (1) the lease is set out in writing, signed by the parties, and identifies the

premises that must be used exclusively by the lessee, (2) the term is of at least one year; (3) the space rented or leased does not exceed that which is "reasonable and necessary" for legitimate business purposes; (4) any payments for the use of common areas do not exceed the lessee's pro rata share of expenses for common space; (5) the rental charges over the term of the lease must be set in advance, be consistent with fair market value, and not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties; and (6) the lease must be commercially reasonable and structured as if no referrals were made between the parties. 42 CFR 411.357

7. Equipment Rental: for leases of equipment between the Hospital and physicians or medical groups, this exception states that:

(a) The lease must be set out in writing and signed by the parties;

(b) Must specify the equipment covered by the lease;

(c) The equipment must be used exclusively by the lessee, when in use by the lessee;

(d) The lease term must be at least one year;

(e) The equipment rented or leased must not exceed that which is ''reasonable and necessary;"

(f) The rental charges over the term of the lease must be set in advance, consistent with fair market value, and not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties; and

(g) The lease must be commercially reasonable.

8. Isolated Transactions

The isolated transactions is frequently used in Hospital transactions. This exception generally applies to any acquisition of the assets of a physician or medical practice, including when they are being acquired by a Hospital. With so many physicians now being employed by Hospitals, this exception is often needed in these transactions. Occasionally, The acquisition transaction must:

(a) Be a single event or one-time sale of property;

(b) Be consistent with fair market value and may not take into account, directly or indirectly, the volume or value of any referrals between the parties;

(c) Be commercially reasonable; and

(d) No additional transactions may occur between the parties for six months, unless those transactions satisfy another Stark exception. Certain changes or adjustments may be made after the closing if they are not related to the volume or value of referrals, and are a normal part of "post closing adjustments" normally associated with acquisition transactions.

Special rules were recently issued allowing installment payments, if the following are met: they must be immediately negotiable, or guaranteed by a third party, or similarly enforceable in the event of a default. 42 CFR 411.357(A)(iv).

9. Indirect Compensation. Indirect compensation arrangements with physicians or medical groups are occasionally found to exist in Hospital transactions. To meet the exception, these arrangements between physicians, hospital facilities and Hospitals must satisfy the following requirements:

(a) The compensation received by the physician from the Hospital must be at fair market value and may not taking into account the volume or value of referrals;

(b) Be set out in writing and signed by the parties;

(c) Specify the services covered; and

(d) The arrangement may not violate the Anti-Kickback Statute or any other laws or regulations. 42 CFR 411.357(P).

C. Other Legal Concerns:

1. Corporate Practice of Medicine

Approximately 23 states have laws imposing prohibitions on the "Corporate Practice of Medicine." The laws usually address a state's prohibition of the ownership or operation of medical practices by anyone who does not have a medical license. Hospitals may be challenged with violating these laws if the Hospital actively operates the medical practices, directly manages the practices financial activities, or employs most or all of the personnel required to operate the practices. Certain states (like Texas) are known to be especially challenging in this regard and strictly enforce these laws. However, these laws have been eroded in many states that have them on the books, but no longer enforce them, or allow for various corporate or trust arrangements to easily circumvent them.

2. Tax Exempt Organization Issues

If the parties form a joint venture that includes both a tax exempt facility, hospital operator, hospital or health system, and for profit taxable entities, steps must be taken to protect the tax exemption of the tax exempt entities. The exemption from federal income tax under section 501(a) of the Internal Revenue Code (the "Code") fundamentally requires that the tax exempt organization must maintain control of most major decisions that are made by the joint- ventured Hospital. Further, the Hospital must be operated principally in support of the tax exempt purposes of the tax exempt entities. An organization with an exemption under section 501(c)(3) of the Code must be organized and operated exclusively for charitable, religious, educational, scientific, or literary purposes. Revenue Ruling 98-15 provides guidance for the types of decisions that must be made by the tax exempt organization. These decisions include:

(a) Hospital's capital & operating budgets, compensation of taxable physicians and entities;

(b) Borrowings, debt, or sales of assets exceeding certain amounts, like $100,000 or $500,000 for example;

(c) Asset sale, merger, consolidation, affiliation, joint venture, or dissolution of the Hospital;

(d) Strategic and long-range plans of Hospital;

(e) Any decision affecting the tax-exempt status of an owner of the Hospital;

(f) Participating provider agreement with any 3rd party payor;

(g) Any changes in the mission, purposes, philosophy or values of the Hospital;

(h) Formation of subsidiaries;

(i) Any quality or performance programs; and

(j) Approval of the executive officers.

The reserved powers may be exercised by establishing appropriate voting authority at the board level, or by allowing these decisions to be made by the hospital board.

D. Certificates of Need

Medical facilities in many states are generally required to obtain a Certificate of Need from the state government, with certain exceptions. The certificate of need process can be politicized and protracted. In most cases, any "interested party" can object to a transfer of a certificate of need, and appeal any decision that is made on transfers of CON's.

One exception to certificate of need requirements that is often found relates to private physician offices, stating that nothing in the Certificate of Need statute shall be construed to authorize the licensure, supervision, regulation or control in any manner of "private offices and clinics of physicians."

This private office exemption applies if all of the following requirements are met:

1. The practice is 100% owned in an organizational form recognized by the state as one in which the listed professions can be practiced by a group of physicians;

2. The practice primarily provides physician services (evaluation and management codes) rather than services or equipment covered by the state health plan;

3. Services or equipment covered by the state health plan which are offered or provided at the office are primarily provided to patients whose medical conditions are being treated or managed by the practice;

4. A physician or physicians licensed to practice and practicing in state within the practice and claiming the exemption are responsible for all decisions regarding the care and treatment provided to patients;

5. Patients are treated on an outpatient basis and are not maintained overnight on the premises of the office or clinic;

6. Services or equipment covered by the state health plan that are offered or provided at the office are related to the professional services offered to patients of the practice; and

7. Major medical equipment of less than of certain dollar limits like $2,000,000.

SELECTED RULES

Rule 1021. Health Care Business Case

(a) Health Care Business Designation. Unless the court orders otherwise, if a petition in a case under chapter 7, chapter 9, or chapter 11 states that the debtor is a health care business, the case shall proceed as a case in which the debtor is a health care business.

(b) Motion. The United States trustee or a party in interest may file a motion to determine whether the debtor is a health care business. The motion shall be transmitted to the United States trustee and served on: the debtor; the trustee; any committee elected under § 705 or appointed under § 1102 of the Code or its authorized agent, or, if the case is a chapter 9 municipality case or a chapter 11 reorganization case and no committee of unsecured creditors has been appointed under § 1102, on the creditors included on the list filed under Rule 1007(d), and such other entities as the court may direct. The motion shall be governed by Rule 9014.

Rule 2007.2. Appointment of Patient Care Ombudsman In a Health Care Business Case

(a) Order to Appoint Patient Care Ombudsman. In a chapter 7, chapter 9, or chapter 11 case in which the debtor is a health care business, the court shall order the appointment of a patient care ombudsman under § 333 of the Code, unless the court, on motion of the United States trustee or a party in interest filed no later than 21 days after the commencement of the case or within another time fixed by the court, finds that the appointment of a patient care ombudsman is not necessary under the specific circumstances of the case for the protection of patients.

(b) Motion for Order to Appoint Ombudsman. If the court has found that the appointment of an ombudsman is not necessary, or has terminated the appointment, the court, on motion of the United States trustee or a party in interest, may order the appointment at a later time if it finds that the appointment has become necessary to protect patients.

(c) Notice of Appointment. If a patient care ombudsman is appointed under § 333, the United States trustee shall promptly file a notice of the appointment, including the name and address of the person appointed. Unless the person appointed is a State Long-Term Care Ombudsman, the notice shall be accompanied by a verified statement of the person appointed setting forth the person's connections with the debtor, creditors, patients, any other party in interest, their respective attorneys and accountants, the United States trustee, and any person employed in the office of the United States trustee.

(d) Termination of Appointment. On motion of the United States trustee or a party in interest, the court may terminate the appointment of a patient care ombudsman if the court finds that the appointment is not necessary for the protection of patients.

(e) Motion. A motion under this rule shall be governed by Rule 9014. The motion shall be transmitted to the United States trustee and served on: the debtor; the trustee; any committee elected under § 705 or appointed under § 1102 of the Code or its authorized agent, or, if the case is a chapter 9 municipality case or a chapter 11 reorganization case and no committee of unsecured creditors has been appointed under § 1102, on the creditors included on the list filed under Rule 1007(d); and such other entities as the court may direct.

Rule 2015.1. Patient Care Ombudsman

(a) Reports. A patient care ombudsman, at least 14 days before making a report under § 333(b)(2) of the Code, shall give notice that the report will be made to the court, unless the court orders otherwise. The notice shall be transmitted to the United States trustee, posted conspicuously at the health care facility that is the subject of the report, and served on: the debtor; the trustee; all patients; and any committee elected under § 705 or appointed under § 1102 of the Code or its authorized agent, or, if the case is a chapter 9 municipality case or a chapter 11 reorganization case and no committee of unsecured creditors has been appointed under § 1102, on the creditors included on the list filed under Rule 1007(d); and such other entities as the court may direct. The notice shall state the date and time when the report will be made, the manner in which the report will be made, and, if the report is in writing, the name, address, telephone number, email address, and website, if any, of the person from whom a copy of the report may be obtained at the debtor's expense.

(b) Authorization to Review Confidential Patient Records. A motion by a patient care ombudsman under § 333(c) to review confidential patient records shall be governed by Rule 9014, served on the patient and any family member or other contact person whose name and address have been given to the trustee or the debtor for the purpose of providing information regarding the patient's health care, and transmitted to the United States trustee subject to applicable nonbankruptcy law relating to patient privacy. Unless the court orders otherwise, a hearing on the motion may not be commenced earlier than 14 days after service of the motion.

Rule 2015.2. Transfer of Patient In Health Care Business Case

Unless the court orders otherwise, if the debtor is a health care business, the trustee may not transfer a patient to another health care business under § 704(a)(12) of the Code unless the trustee gives at least 14 days' notice of the transfer to the patient care ombudsman, if any, the patient, and any family member or other contact person whose name and address have been given to the trustee or the debtor for the purpose of providing information regarding the patient's health care. The notice is subject to applicable nonbankruptcy law relating to patient privacy.

Rule 6011. Disposal of Patient Records In Health Care Business Case

(a) Notice by Publication Under 351(1)(a). A notice regarding the claiming or disposing of patient records under § 351(1)(A) shall not identify patients by name or other identifying information, but shall:

(1) identify with particularity the health care facility whose patient records the trustee proposes to destroy;

(2) state the name, address, telephone number, email address, and website, if any, of a person from whom information about the patient records may be obtained;

(3) state how to claim the patient records; and

(4) state the date by which patient records must be claimed, and that if they are not so claimed the records will be destroyed.

(b) Notice by Mail Under § 351(1)(b). Subject to applicable nonbankruptcy law relating to patient privacy, a notice regarding the claiming or disposing of patient records under § 351(1)(B) shall, in addition to including the information in subdivision (a), direct that a patient's family member or other representative who receives the notice inform the patient of the notice. Any notice under this subdivision shall be mailed to the patient and any family member or other contact person whose name and address have been given to the trustee or the debtor for the purpose of providing information regarding the patient's health care, to the Attorney General of the State where the health care facility is located, and to any insurance company known to have provided health care insurance to the patient.

(c) Proof of Compliance with Notice Requirement. Unless the court orders the trustee to file proof of compliance with § 351(1)(B) under seal, the trustee shall not file, but shall maintain, the proof of compliance for a reasonable time.

(d) Report of Destruction of Records. The trustee shall file, no later than 30 days after the destruction of patient records under § 351(3), a report certifying that the unclaimed records have been destroyed and explaining the method used to effect the destruction. The report shall not identify any patient by name or other identifying information.

SELECTED STATUTES

§ 333. Appointment of patient care ombudsman

(a) **(1)** If the debtor in a case under chapter 7, 9(*), or 11 is a health care business, the court shall order, not later than 30 days after the commencement of the case, the appointment of an ombudsman to monitor the quality of patient care and to represent the interests of the patients of the health care business unless the court finds that the appointment of such ombudsman is not necessary for the protection of patients under the specific facts of the case.

(2)

(A) If the court orders the appointment of an ombudsman under paragraph (1), the United States trustee shall appoint 1 disinterested person (other than the United States trustee) to serve as such ombudsman.

(B) If the debtor is a health care business that provides long-term care, then the United States trustee may appoint the State Long-Term Care Ombudsman appointed under the Older Americans Act of 1965 for the State in which the case is pending to serve as the ombudsman required by paragraph (1).

(C) If the United States trustee does not appoint a State Long-Term Care Ombudsman under subparagraph (B), the court shall notify the State Long-Term Care Ombudsman appointed under the Older Americans Act of 1965 for the State in which the case is pending, of the name and address of the person who is appointed under subparagraph (A).

(b) An ombudsman appointed under subsection (a) shall—

(1) monitor the quality of patient care provided to patients of the debtor, to the extent necessary under the circumstances, including interviewing patients and physicians;

(2) not later than 60 days after the date of appointment, and not less frequently than at 60-day intervals thereafter, report to the court after notice to the parties in interest, at a hearing or in writing, regarding the quality of patient care provided to patients of the debtor; and

(3) if such ombudsman determines that the quality of patient care provided to patients of the debtor is declining significantly or is otherwise being materially compromised, file with the court a motion or a written report, with notice to the parties in interest immediately upon making such determination.

(c) (1) An ombudsman appointed under subsection (a) shall maintain any information obtained by such ombudsman under this section that relates to patients (including information relating to patient records) as confidential information. Such ombudsman may not review confidential patient records unless the court approves such review in advance and imposes restrictions on such ombudsman to protect the confidentiality of such records.

(2) An ombudsman appointed under subsection (a)(2)(B) shall have access to patient records consistent with authority of such ombudsman under the Older Americans Act of 1965 and under non-Federal laws governing the State Long-Term Care Ombudsman program.

(*) See § 901, which does not include § 333 as applicable in chapter 9 cases.

* * *

§ 351. Disposal of patient records

If a health care business commences a case under chapter 7, 9, or 11, and the trustee does not have a sufficient amount of funds to pay for the storage of patient records in the manner required under applicable Federal or State law, the following requirements shall apply:

(1) The trustee shall—

(A) promptly publish notice, in 1 or more appropriate newspapers, that if patient records are not claimed by the patient or an insurance provider (if applicable law permits the insurance provider to make that claim) by the date that is 365 days after the date of that notification, the trustee will destroy the patient records; and

(B) during the first 180 days of the 365-day period described in subparagraph (A), promptly attempt to notify directly each patient that is the subject of the patient records and appropriate insurance carrier concerning the patient records by mailing to the most recent known address of that patient, or a family member or contact person for that patient, and to the appropriate insurance carrier an appropriate notice regarding the claiming or disposing of patient records.

(2) If, after providing the notification under paragraph (1), patient records are not claimed during the 365-day period described under that paragraph, the trustee shall mail, by certified mail, at the end of such 365-day period a written request to each appropriate Federal agency to request permission from that agency to deposit the patient records with that agency, except that no Federal agency is required to accept patient records under this paragraph.

(3) If, following the 365-day period described in paragraph (2) and after providing the notification under paragraph (1), patient records are not claimed by a patient or insurance provider, or request is not granted by a Federal agency to deposit such records with that agency, the trustee shall destroy those records by—

(A) if the records are written, shredding or burning the records; or

(B) if the records are magnetic, optical, or other electronic records, by otherwise destroying those records so that those records cannot be retrieved.

PETITION FOR WRIT OF CERTIORARI

Bayou Shores SNF, LLC respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Eleventh Circuit.

OPINIONS BELOW

The opinion of the court of appeals is reported at 828 F.3d 1297. Pet. App. 1a-71a. The order of the district court granting a stay pending appeal is unreported. Pet. App. 86a-92a. The order of the district court on appeal from the bankruptcy court is reported at 533 B.R. 337. Pet. App. 72a-85a. The orders of the bankruptcy court confirming Petitioner's plan of reorganization are reported at 525 B.R. 160, Pet. App. 95a-124a, and unreported, Pet. App. 125a-145a.

JURISDICTION

The judgment of the court of appeals was entered on July 11, 2016. A petition for rehearing was denied on October 3, 2016. Pet. App. 94a. Justice Thomas extended the time within which to file a petition for a writ of certiorari to and including February 2, 2017. This Court has jurisdiction pursuant to 28 U.S.C. 1254(1).

STATUTORY PROVISIONS INVOLVED

This case primarily involves 28 U.S.C. 1334 and 42 U.S.C. 405(g) and (h). These provisions are reproduced in the appendix to this petition. Pet. App. 146a-150a.

STATEMENT OF THE CASE

This case presents an opportunity to resolve two recurring and important questions that have divided the lower courts. Both questions concern the relationship

between the federal schemes that apply to bankruptcy cases and to claims arising under the Medicare Act.

The Judicial Code provides comprehensive jurisdiction to district courts and bankruptcy courts to deal with all matters connected with a debtor's estate. The courts possess "exclusive jurisdiction" over "all cases under title 11" and "all property of the estate." 28 U.S.C. 1334(a), (e)(1).

The Medicare Act authorizes administrative law judges to hear appeals of claims arising under the statute. One such type of appeal may arise when the government seeks to terminate one of its agreements with a health care provider. In channeling such appeals through administrative review, Section 405(h) of the Medicare Act states that no action shall be brought "under section 1331 or 1346 of Title 28" to recover on any claim arising under the statute. 42 U.S.C. 405(h). Notably absent from Section 405(h) is any bar on actions brought under Section 1334—the statutory basis for district courts' "exclusive jurisdiction" over bankruptcy cases. The significance of this omission has sharply divided the courts of appeals and forms the basis for this Petition.

Petitioner Bayou Shores is a skilled nursing facility that cared for severely ill patients who were difficult to place due to the type and severity of their illness. Pet. App. 96a. Most of its patients had mental illnesses and nearly all were indigent, relying upon Medicaid or Medicare to pay for their care. Pet. App. 97a. In 2014, Bayou Shores received three negative findings in surveys performed by the Agency for Healthcare Administration for the State of Florida ("AHCA"),

which recommended that the Department of Health and Human Services ("HHS") terminate Bayou Shores' provider agreements. Pet. App. 98a-99a. Bayou Shores immediately acted to cure the deficiencies, and faced with a termination threat, timely sought administrative review. Pet. App. 100a-102a. To avoid the immediate cessation of its business while administrative review was underway, Bayou Shores filed for bankruptcy. Pet. App. 103a.

The bankruptcy court, convinced that it possessed jurisdiction over the provider agreements as assets of the estate, presided over Bayou Shores' reorganization. Pet. App. 105a-110a. It enforced the automatic stay to prevent the termination of the provider agreements. Pet. App. 103a-104a. It appointed an independent patient care ombudsman to oversee patient welfare. Pet. App. 115a. It determined that Bayou Shores had provided adequate assurances of future performance under the provider agreements and authorized Bayou Shores' assumption of those agreements. Pet. App. 113a-116a. And it confirmed Bayou Shores' plan of reorganization. Pet. App. 125a-145a.

The district court reversed the confirmation orders, finding that notwithstanding the bankruptcy court's comprehensive jurisdiction over property of the estate, the Medicare Act stripped the court of jurisdiction over Bayou Shores' provider agreements. Pet. App. 78a-84a.

Bayou Shores timely appealed the district court's order to the Eleventh Circuit and moved to stay the termination of its provider agreements pending appeal. Pet. App. 86a-92a. The district court granted a stay, stating that it would be "draconian" to force patients and

their families to move from the facility, disrupting their "dignity based on a jurisdictional debate that has resulted in significant contrary opinions among the circuit courts and the lower courts." Pet. App. 91a.

The Eleventh Circuit affirmed. Acknowledging that "lower courts have split, with some assuming jurisdiction, and others deciding jurisdiction was barred," Pet. App. 30a (footnote omitted), the Eleventh Circuit decided to "align [itself] with the Seventh, Eighth, and Third Circuits and hold that § 405(h) bars § 1334 jurisdiction over claims that 'arise under [the Medicare Act],'" Pet. App. 34a (alteration in original). Additionally, the Eleventh Circuit held that Bayou Shores' claims were properly dismissed because they had not been administratively exhausted before Bayou Shores petitioned for bankruptcy. Pet. App. 60a-62a. Accordingly, the Eleventh Circuit held that the bankruptcy court erred in exercising subject-matter jurisdiction over Bayou Shores' provider agreements.

Because the Eleventh Circuit's decision squarely conflicts with the decisions of other circuits on two important questions of federal law, and because this case is an optimal vehicle through which to address those closely-related questions, the petition for a writ of certiorari should be granted.

A. The Statutory Scheme Governing Bankruptcy

1. Article I of the Constitution assigns to Congress the "Power * * * [t]o establish * * * uniform Laws on the subject of Bankruptcies throughout the United States." U.S. Const. art. I, § 8, cl. 4. Pursuant to that authority, Congress has granted federal courts "original and

exclusive jurisdiction of all cases under title 11." 28 U.S.C. 1334(a).

A "critical feature[]" of every bankruptcy proceeding is the bankruptcy court's "exercise of exclusive jurisdiction over all the debtor's property." *Cent. Va. Cmty. Coll. v. Katz*, 546 U.S. 356, 363-64 (2006); *see also* 28 U.S.C. 1334(e)(1). Congress provided this comprehensive grant of jurisdiction "to ensure adjudication of all claims in a single forum and to avoid the delay and expense of jurisdictional disputes." *N. Pipeline Constr. Co. v. Marathon Pipe Line Co.*, 458 U.S. 50, 87 n.40 (1982) (citing H.R. Rep. No. 95-595, at 43-48 (1977); S. Rep. No. 95-989, at 17 (1978)).

The bankruptcy system includes several other features in service of those goals. As relevant here, the automatic stay prohibits commencement or continuation of certain actions against the debtor, 11 U.S.C. 362(a); a debtor may assume its executory contracts after curing any default, 11 U.S.C. 365; bankruptcy courts may issue all relief "necessary or appropriate" to carry out the bankruptcy process, 11 U.S.C. 105(a); and bankruptcy courts may confirm a debtor's plan of reorganization, vesting all property of the estate in the debtor, free and clear of all claims, 11 U.S.C. 1141. In 11 U.S.C. 106, Congress abrogated the federal government's sovereign immunity with respect to the foregoing provisions, thereby submitting the United States to the jurisdiction of the bankruptcy courts.

2. In 2005, Congress passed the Bankruptcy Abuse Prevention and Consumer Protection Act ("BAPCPA"), which, among other things incorporated specific provisions into the Bankruptcy Code relating to health

care businesses, including skilled nursing facilities. Among other things, it granted a special administrative priority to the winding-up of such businesses, 11 U.S.C. 503(b)(8), and authorized the compensation of a patient care ombudsman from property of the estate, 11 U.S.C. 330(a). Congress also provided that, under circumstances not present here, HHS need not seek relief from the automatic stay to exclude a bankrupt health care business from participation in Medicare.[1] 42 U.S.C. 1320a-7(a) & (b).

B. The Statutory And Regulatory Schemes Governing Participation In The Medicare And Medicaid Programs.

1. Title XVIII of the Social Security Act, 79 Stat. 291, as amended, 42 U.S.C. 1395 et seq., is commonly known as the Medicare Act. To participate in Medicare and Medicaid and receive payment for covered services, a health care provider must enter into a "provider agreement" with HHS. 42 U.S.C. 1395cc, 1396a(a)(27); 42 C.F.R. 442.10-442.42, 489.1-489.29.

Federal and state officials may terminate a provider agreement if they determine that the provider is not complying with its terms or other legal requirements. *See* 42 U.S.C. 1396i-3(h)(2); 42 U.S.C. 1396r(h)(2); 42 C.F.R. 488.406, 488.408(e). Providers

---

[1] Exclusion is distinct from termination. *See* Nathaniel M. Lackman & Keith C. Owens, *Health Care Providers and the Automatic Stay: Is Medicare Termination Different than Exclusion?*, 25-9 Am. Bankr. Inst. J. 32 (2006), http://www.abi.org/abi-journal/health-care-providers-and-the-automatic-stay-is-medicare-termination-different-than.

must be given written notice of any deficiencies noted in the state survey, a statement of any remedies imposed, and a statement of the facility's right to appeal. 42 C.F.R. 488.330(c), 488.402(f). If a sanction is imposed, the provider may in some instances contest the underlying survey findings through a formal evidentiary hearing before an Administrative Law Judge. 42 C.F.R. 498.3(b), 498.5; 42 C.F.R. 431.153(i). Skilled nursing facilities like Bayou Shores may also appeal an adverse hearing decision to HHS's Departmental Appeals Board. 42 C.F.R. 498.80, 42 C.F.R. 431.153(g).

2. The Medicare Act limits a party's ability to pursue claims arising under the Act in federal court. In 42 U.S.C. 405(g), as incorporated into Medicare by 42 U.S.C. 1395ii, Congress provided for judicial review following a final decision by the agency. Congress then limited review of the agency's decision as follows:

> The findings and decision of the [Secretary] after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the [Secretary] shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the [Secretary], or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28, to recover on any claim arising under this subchapter.

42 U.S.C. 405(h).

Section 405 was enacted in 1939 as part of the Social Security Act. As originally drafted, it barred actions brought "under section 41 of Title 28 to recover on any claim arising under sections 401-09 of this chapter." 42 U.S.C. 405(h) (1939). At the time, "§ 41 contained all of that title's grants of jurisdiction to United States district courts," *Weinberger v. Salfi*, 422 U.S. 749, 756 n.3 (1975), including "all matters and proceedings in bankruptcy," 28 U.S.C. 41(19) (1934).

In 1948, however, Congress revised the U.S. Code, extracting the various jurisdictional grants from Section 41 and re-codifying some of them as 28 U.S.C. 1331 to 1348, 1350 to 1357, 1359, 1397, 2361, 2401, and 2402. Pub. L. No. 80-773, 62 Stat. 869, 930–36, 970-71 (1948); 28 U.S.C. 1331–1348, 1350–1357, 1359, 1397, 2361, 2401-2402 (1952). When Congress rewrote Section 41, it did not update Section 405(h), which continued to refer to then-defunct 28 U.S.C. 41.

This Court noted this flaw in its opinion in *Salfi*, 422 U.S. at 756 n.3. The next year, the Office of Law Revision Counsel[2] removed the reference to Section 41 and replaced it with references to 28 U.S.C. 1331 and 1346—the jurisdictional grants for federal questions and suits against the United States, respectively. As one court has surmised, "Clearly the Office of Law Revision Counsel believed that these grants of jurisdiction were the only ones relevant to SSA or Medicare Act claims." *Nurses' Registry & Home Health Care v. Burwell (In re*

---

[2] The Office of the Law Revision Counsel is a body within the U.S. House of Representatives whose purpose is to codify the laws of the U.S. and publish updates to the U.S. Code. *See* 2 U.S.C. 285 et seq.

Nurses' Registry & Home Health Corp.), 533 B.R. 590, 594 (Bankr. E.D. Ky. 2015). A codification note acknowledged that the amended statute no longer referenced all of the jurisdictional provisions that formerly comprised Section 41. *See* 42 U.S.C.A. 405 (West 1982).

Eight years later, Congress enacted the Law Revision Counsel's changes. *See* Deficit Reduction Act of 1984 ("DRA"), Pub. L. No. 98-369, § 2663(a)(4)(D), 98 Stat. 494, 1162 ("Section 205(h) of such Act is amended by striking out 'section 24 of the Judicial Code of the United States' and inserting in lieu thereof 'section 1331 or 1346 of title 28, United States Code . . . .'"). In enacting the DRA, Congress stated that its amendments should not "be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date." *Id.*, § 2664(b), 98 Stat. at 1171-72.

3. The omission of any mention of Section 1334—the federal subject-matter statute governing bankruptcy claims—from Section 405(h) has become increasingly relevant as the administrative process under the Medicare Act has proven impractical for health care companies facing a financial crisis upon termination of their provider agreements by the government. While facilities terminated from Medicare theoretically have access to expedited administrative review, 42 U.S.C. 1395cc(h)(1)(B), in reality this process is not available to a health care provider facing imminent insolvency. Severe backlogs prevent appeals from being heard in a timely manner. In 2015, the Office of Medicare Hearings and Appeals ("OMHA") reported that the average

adjudication took 572 days, and that this time frame "will continue to increase until receipt levels and adjudication capacity are brought into balance." *See Creating a More Efficient and Level Playing Field: Audit and Appeals Issues in Medicare: Hearing Before the S. Comm. On Finance*, 114th Cong. 38 (2015) (prepared statement of Nancy J. Griswold, Chief A.L.J., OMHA). Indeed, "[d]ue to record receipt levels," OMHA projected in 2015 a 20-24 week delay just to *docket* a new appeal. *See* OMHA, *Adjudication Timeframes*, https://wayback.archive-it.org/3909/20160811195818/http://www.hhs.gov/omha/important_notice_regarding_adjudication_timeframes.html.

Making these delays more problematic, CMS can institute recoupment against a provider's ongoing payments while the provider's appeal is pending. This loss of revenue creates a very high risk of insolvency. *See* Samuel R. Maizel & Michael B. Potere, *Killing the Patient to Cure the Disease: Medicare's Jurisdictional Bar Does Not Apply to Bankruptcy Courts*, 32 Emory Bankr. Dev. J. 19, 29 (2015).

Against this backdrop, health care facilities have increasingly resorted to the bankruptcy courts, where they can resolve any outstanding defaults before assuming their provider agreements as part of a plan of reorganization.

C. Statement of Facts and Procedural History

In 2014, Bayou Shores received three negative findings in surveys performed by the Agency for Healthcare Administration for the State of Florida

("AHCA"), which recommended to HHS termination of Bayou Shores' provider agreements. Pet. App. 98a-99a.

Bayou Shores timely sought administrative review. Pet. App. 102a. To avoid the immediate cessation of its business while administrative review was underway, Bayou Shores filed a chapter 11 case, invoking the district court's jurisdiction pursuant to 28 U.S.C. 1334 and the protection of the automatic stay of 11 U.S.C. 362(a) afforded to property of the estate, as defined in 11 U.S.C. 541(a). Pet. App. 103a-104a. The district court automatically referred the case to the bankruptcy court pursuant to 28 U.S.C. 157(a).

Seven days later, and without requesting relief from the stay, AHCA personnel stormed Bayou Shores' facility, dropping letters at patient bedsides informing them that their Medicaid and Medicare benefits would be terminated and that they were welcome to remain at Bayou Shores but would have to pay for their own care. Pet. App. 119a.

Bayou Shores initially sought emergency injunctive relief from the U.S. District Court for the Middle District of Florida to prevent termination of its provider agreements while it pursued administrative remedies. Pet. App. 102a. On motion of HHS, the district court dismissed Bayou Shores' complaint for lack of subject-matter jurisdiction pursuant to 42 U.S.C. 405(h). Pet. App. 102a-103a.

Bayou Shores then sought emergency relief from the bankruptcy court. Pet. App. 103a. Bayou Shores' motion requested a finding that the automatic stay applied and/or a temporary injunction to protect the flow

of funds to the patients and to allow Bayou Shores to remain open while it pursued administrative remedies. Pet. App. 103a-104a. The bankruptcy court reasoned that it had jurisdiction pursuant to 28 U.S.C. 1334(a) because the provider agreements were property of the estate. Pet. App. 8a. After taking evidence and testimony regarding the termination process, the bankruptcy court concluded that AHCA was acting in its pecuniary interests in electing to terminate patient benefits, and not acting to protect patient health, safety and welfare, so the automatic stay applied. Pet. App. 119a. Further, after receiving testimony on the potential harm to Bayou Shores' patients if they were forcibly removed, the bankruptcy court temporarily enjoined AHCA from removing patients and terminating their benefits while Bayou Shores proceeded through the administrative process. Pet. App. 9a.

AHCA and HHS appealed this decision to the district court (hereinafter the "First Appeals") but did not seek a stay pending appeal. Pet. App. 72a-73a. Meanwhile, the bankruptcy court appointed an independent patient care ombudsman pursuant to 11 U.S.C. 333 to oversee patient welfare. Pet. App. 115a. The ombudsman filed two reports concluding Bayou Shores' patients were well cared-for and content. Pet. App. 115a-116a.

Bayou Shores filed a plan of reorganization, which the bankruptcy court confirmed. Pet. App. 95a-124a. The bankruptcy court again stated its belief that jurisdiction was proper under 28 U.S.C. 1334(a), and rejected HHS and AHCA's argument that 42 U.S.C.

405(h) stripped the bankruptcy court of jurisdiction. Pet. App. 105a-110a. The bankruptcy court reasoned that the plain language of Section 405(h), which refers only to 28 U.S.C 1331 and 1346, did not prevent the bankruptcy court from exercising jurisdiction over the assumption of the provider agreements. *Id.* Moreover, because Bayou Shores appeared to have remedied the cited deficiencies, the bankruptcy court found that Bayou Shores had provided adequate assurances of future performance under the provider agreements, and thus was eligible to assume them under 11 U.S.C. 365(b)(1)(C). Pet. App. 110a-116a. Finding the remainder of the statutory requirements fulfilled, the bankruptcy court confirmed Bayou Shores' plan. Pet. App. 125a-145a.

HHS and AHCA appealed the orders confirming the plan to the district court, which upheld the Secretary's jurisdictional challenge and reversed the confirmation orders with respect to the assumption of Bayou Shores' provider agreements. Pet. App. 72a-85a.

Bayou Shores timely appealed the district court's order to the Eleventh Circuit, which affirmed. Pet. App. 1a-71a. Acknowledging that "lower courts have split, with some assuming jurisdiction, and others deciding jurisdiction was barred," Pet. App. 30a (footnote omitted), the Eleventh Circuit decided to "align [itself] with the Seventh, Eighth, and Third Circuits and hold that § 405(h) bars § 1334 jurisdiction over claims that 'arise under [the Medicare Act],'" Pet. App. 34a (alteration in original). Additionally, the Eleventh Circuit held that Bayou Shores failed to exhaust its administrative remedies before pursuing relief from the

bankruptcy court. Pet. App. 60a-62a. Accordingly, the Eleventh Circuit held that the bankruptcy court erred when it exercised subject-matter jurisdiction over Bayou Shores' provider agreements.

REASONS FOR GRANTING THE WRIT

The Eleventh Circuit's decision in this case deepens an existing split over whether Section 405(h) bars a bankruptcy court from exercising jurisdiction over claims arising under the Medicare Act. It also conflicts with the decisions of at least two other courts of appeals and multiple bankruptcy courts on the question of whether Section 405(h) requires a debtor to exhaust administrative remedies prior to pursuing the relief available to debtors under the Bankruptcy Code.

These conflicts create intolerable discord on important issues of bankruptcy law, Medicare law, federal jurisdiction, and statutory interpretation—and they cannot be resolved without this Court's review. Because this case presents an optimal vehicle for addressing and resolving both conflicts, the petition should be granted.

A. The Eleventh Circuit's Decision Deepened Two Acknowledged Splits About The Meaning Of 42 U.S.C. 405(h).

1. The Split On Section 405(h)'s Jurisdictional Bar

As the Eleventh Circuit recognized, the "[c]ourts [are] split over the application of § 405(h)" to suits arising under Section 1334, which grants district courts "exclusive" jurisdiction over bankruptcy cases. Pet.

App. 26a; 28 U.S.C. 1334; *accord Parkview Adventist Med. Ctr. v. United States*, 842 F.3d 757, 759 (1st Cir. 2016) (recognizing that "there is a circuit split on the lack-of-jurisdiction holding pertaining to § 405(h)"). The "Supreme Court has yet to speak on this precise issue," Pet. App. 21a, but the "arguments for and against jurisdiction have been well developed by circuits ruling in favor of each." *U.S. Dep't of Health & Human Servs. v. James*, 256 B.R. 479, 482 (W.D. Ky. 2000).

1. ***Ninth Circuit.*** On one side of the split is the Ninth Circuit, which held in *Sullivan v. Town & Country Home Nursing Services, Inc. (In re Town & Country Home Nursing Services, Inc.)*, 963 F.2d 1146 (9th Cir. 1991), that "Section 405(h) only bars actions under 28 U.S.C. §§ 1331 and 1346; it in no way prohibits an assertion of jurisdiction under section 1334." *Id.* at 1155. The court held that the omission of Section 1334 makes sense because it "allows a single court to preside over all of the affairs of the estate," pursuant to Section 1334's exclusive and "broad jurisdictional grant over all matters conceivably having an effect on the bankruptcy estate." *Id.*

Accordingly, the Ninth Circuit found that a plain-text reading of Section 405(h) in the context of bankruptcy cases "promotes a congressionally-endorsed objective: the efficient and expeditious resolution of all matters connected to the bankruptcy estate." *Id.* (quotation marks omitted).

The Ninth Circuit's ruling in *Town & Country* is firmly settled in that circuit. In *Do Sung Uhm v. Humana, Inc.*, 620 F.3d 1134, 1141 n.11 (9th Cir. 2010), the Ninth Circuit re-affirmed *Town & Country*'s holding

for bankruptcy jurisdiction, and the court subsequently denied a petition for rehearing *en banc*. *See also* Pet. App. 29a-30a (discussing *Do Sung Uhm*). Thus, the Ninth Circuit's law on this issue will persist unless this Court intervenes.

2. ***Eleventh Circuit.*** The Eleventh Circuit in this case expressly disagreed with the Ninth Circuit, holding that Section 405(h) bars bankruptcy jurisdiction under Section 1334, even though 1334 is not listed. Pet. App. 52a ("[T]his Court is constrained to disagree with the Ninth Circuit's *Town & Country* opinion….").

The Eleventh Circuit aligned itself with the Third, Seventh, and Eighth Circuits. Pet. App. 34a. In the view of these circuits, the fact that Section 405(h) mentions only 28 U.S.C. 1331 and 1346 is the result of a codification error. Contrary to its plain language, they believe the statute was intended to include every grant of jurisdiction that was listed under the *former* version of Section 405(h)—a list that would include dozens of additional sources of jurisdiction not listed in the current version, including the exclusive jurisdiction given to district courts over the debtor's estate. These other circuits do not expressly discuss bankruptcy jurisdiction under Section 1334, but hold that the omission of Section 1332—the statutory basis for diversity jurisdiction—was a scrivener's error susceptible to judicial correction. In this case, the Eleventh Circuit relied on the reasoning of these decisions, creating a circuit split on the jurisdiction of bankruptcy courts to entertain Medicare-related claims. *See* Pet. App. 26a-31a.

Third Circuit. In *Nichole Medical Equipment & Supply, Inc. v. TriCenturion, Inc.*, 694 F.3d 340, 346-47

(3d Cir. 2012), the Third Circuit "agree[d] that the language [of § 405(h)] may at first appear to bar only jurisdiction under §§ 1331 or 1346." *Id.* However, the court concluded that the prior version of Section 405(h) was much more expansive, and that Congress's subsequent listing of only Sections 1331 and 1346 was not "intended to make any substantive change." *Id.* Accordingly, the court held that Section 405(h) "continues to bar virtually all grants of jurisdiction under Title 28," including 28 U.S.C. 1332, which—like Section 1334—is not mentioned in Section 405(h). *Id.*

Seventh Circuit. In *Bodimetric Health Services, Inc. v. Aetna Life & Casualty*, 903 F.2d 480, 488-90 (7th Cir. 1990), the Seventh Circuit likewise addressed whether Section 405(h) barred suits arising just under Sections 1331 and 1346—or instead also bars suits arising under the unlisted diversity provision, Section 1332. *Bodimetric* acknowledged that Section 405(h) "on its face" would permit all actions except those brought under Sections 1331 or 1346. *Id.* at 488. However, the court noted that "[u]pon its *original* enactment, section 405(h) barred all actions brought pursuant to 28 U.S.C. section 41, which, in turn, contained virtually all of the grants of jurisdiction to the United States district courts under Title 28." *Id.* (emphasis in original; alterations and quotation marks omitted). The Seventh Circuit concluded that the subsequent change in language to list just Sections 1331 and 1346 was a mere "technical correction," and that Section 405(h)'s language should be judicially corrected to preclude judicial review of all the grants of jurisdiction listed in the former 28 U.S.C. 41, *id.* at 489, which included not only diversity cases under

Section 1332 (as relevant in *Bodimetric*) but also bankruptcy cases under Section 1334, *see id.* at 488.

Eighth Circuit. In *Midland Psychiatric Associates, Inc. v. United States*, 145 F.3d 1000 (8th Cir. 1998), another diversity case, the Eighth Circuit likewise held that "despite its literal wording," Section 405(h) should be read as barring all cases whose jurisdiction would previously have been included under 28 U.S.C. 41. *Id.* at 1004.[3]

3. The split on this issue has also deeply divided bankruptcy and district courts across the country. Many have adopted the Ninth Circuit's position that Sections 405(h) and 1334 should be read according to their unambiguous terms and that courts should not "correct" Section 405(h) to incorporate sources of jurisdiction that Congress did not list. *See, e.g.*, *Nurses' Registry*, 533 B.R. at 593–97; *Slater Health Ctr., Inc. v. United States (In re Slater Health Ctr., Inc.)*, 294 B.R. 423, 427-28 (Bankr. D.R.I. 2003), *vacated in part*, 306 B.R. 20 (D.R.I. 2004), *aff'd*, 398 F.3d 98 (1st Cir. 2005); *In re Healthback, L.L.C.*, 226 B.R. 464, 472–74 (Bankr. W.D. Okla. 1998), *vacated*, No. 97–22616–BH, 1999 WL 35012949 (Bankr. W.D. Okla. May 28, 1999).

Other bankruptcy and district courts have adopted the position espoused by the Eleventh Circuit—and held

---

[3] The Sixth Circuit has suggested, although not squarely held, that Section 405(h)'s jurisdictional bar extends beyond just Sections 1331 and 1346. *See BP Care, Inc. v. Thompson*, 398 F.3d 503, 515 n.11 (6th Cir. 2005) ("[I]t is arguable, as a matter of statutory construction, that jurisdiction under 28 U.S.C. § 1361 is precluded by the third sentence of § 405(h).").

that Section 405(h)'s jurisdictional bar applies to bankruptcy cases. *See, e.g.*, *Excel Home Care, Inc. v. U.S. Dep't of Health & Human Servs.*, 316 B.R. 565, 572-74 (D. Mass. 2004); *House of Mercy, Inc. v. Ctrs. For Medicare & Medicaid Servs. (In re House of Mercy, Inc.)*, 353 B.R. 867, 869-73 (Bankr. W.D. La. 2006); *In re Fluellen*, No. 05-40336 (ALG), 2006 WL 687160, at *1 (Bankr. S.D.N.Y. Mar. 13, 2006); *James*, 256 B.R. at 481-82.

4. As commentators have noted, the federal courts "have debated this issue for more than thirty years and are not in agreement on the outcome." Maizel & Potere, 32 Emory Bankr. Dev. J. at 20. While the meaning of Section 405(h) has divided courts for years, there is now a clear circuit split as to its significance for bankruptcy cases. It is time for this Court to resolve this important question of federal jurisdiction.

2. The Split On Section 405's Exhaustion Requirement

The second question presented is intricately linked both practically and analytically with the first. As the Ninth Circuit has noted, the lower courts also "have divided on th[e] question" of whether Section 405—assuming that it does not flatly bar a suit under Section 1334—nonetheless still requires exhaustion of administrative remedies before the bankruptcy court can exercise jurisdiction. *Town & Country*, 963 F.2d at 1154. Lower courts too acknowledge that the courts "have split on this issue." *James*, 256 B.R. at 481-82 (citing the Ninth Circuit and Third Circuit decisions discussed *infra*).

Moreover, the split developed after this Court's decision in *Weinberger v. Salfi*, 422 U.S. 749 (1975). Though *Salfi* held that administrative exhaustion was required for suits brought under Section 405 seeking review of a Medicare decision, the Court did not address whether exhaustion was required where the suit was instead brought pursuant to the "exclusive" and independent authority provided to bankruptcy courts under Section 1334 to administer a debtor's estate, as is the case here. That is the issue on which the lower courts have split.

1. ***Ninth Circuit.*** The Ninth Circuit has held that a bankruptcy court can assert jurisdiction over Medicare-related claims without requiring exhaustion under Section 405. *Town & Country*, 963 F.2d at 1154-55. *Town & Country* reasoned that "'where there is an independent basis for bankruptcy court jurisdiction, exhaustion of administrative remedies pursuant to other jurisdictional statutes is not required.'" *Id.* (citation omitted). The debtor in *Town & Country*, like the Petitioner here, was not seeking "judicial review" of a Medicare decision under Section 405; rather, its claims were brought pursuant to Section 1334, which independently grants the bankruptcy court "exclusive" jurisdiction to administer an estate. 28 U.S.C. 1334. The Ninth Circuit found that the exhaustion requirements of Section 405 therefore did not apply.

Third Circuit. Directly relying on *Town & Country*, the Third Circuit also has held that "the mandate of section 405(h) that the Medicare Act's administrative review procedures be exhausted before judicial review is sought simply does not apply to [a] case" arising under

Section 1334. *Univ. Med. Ctr. v. Sullivan (In re Univ. Med. Ctr.)*, 973 F.2d 1065, 1073-74 (3d Cir. 1992). The Third Circuit found that, like in *Town & Country*, "the Bankruptcy Code supplies an independent basis for jurisdiction," and therefore Section 405(h)'s exhaustion prerequisites were not applicable. *Id.* at 1072. In other words, where a case arises under the Bankruptcy Code, it does not arise under the Medicare Act and therefore the Medicare Act's exhaustion requirements do not apply.

The Third Circuit explained why Congress would have given the bankruptcy court authority to review such issues immediately: it would "advance[] the congressionally-endorsed objective of the 'effective and expeditious resolution of all matters connected to the bankruptcy estate'" by giving one court authority over all matters that conceivably could impact the debtor. *Id.* at 1074 (quoting *Town & Country*, 963 F.2d at 1155).

2. ***Eleventh Circuit.*** In this case, the Eleventh Circuit created a circuit split by concluding that, under Section 405(h), the bankruptcy court could not administer Bayou Shores' provider agreements as part of the estate until after Bayou Shores' administrative claims were exhausted. *See* Pet. App. 60a-62a. Relying in part on *Salfi*, the Eleventh Circuit concluded that "neither Bayou Shores nor the bankruptcy court has explained why standard principles of administrative exhaustion should not prevent a district court from hearing Bayou Shores' case." Pet. App. 61a.

3. While no other courts of appeals have adopted the Eleventh Circuit's position on this issue, the split on exhaustion extends to the lower courts. Many

bankruptcy and district courts have reached the same conclusion as the Eleventh Circuit, requiring exhaustion in bankruptcy cases. *See Parkview Adventist Med. Ctr. v. United States ex rel. Dep't of Health & Human Servs.*, No. 2:15-cv-00320-JDL, 2016 WL 3029947, at *5-8 (D. Me. May 25, 2016) (concluding that Sections 405(g) and (h) "[t]ogether . . . require the exhaustion of administrative remedies through the agency review process before judicial review takes place"), *aff'd*, 842 F.3d 757 (1st Cir. 2016); *Sullivan v. Hiser (In re St. Mary Hosp.)*, 123 B.R. 14, 16-18 (E.D. Pa. 1991); *Rodriguez v. United States (In re Rodriquez)*, No. 09-93431-JB, 2010 WL 2035733, at *3-5 (Bankr. N.D. Ga. Mar. 23, 2010); *Andrews v. Blue Cross & Blue Shield of Mich. (In re Clawson Med. Rehab. & Pain Care Ctr., P.C.)*, 12 B.R. 647 (Bankr. E.D. Mich. 1981).

And on the other side, many bankruptcy and district courts have directly relied on *University Medical* and *Town & Country* to reach the opposite conclusion, holding that Section 405 does *not* require exhaustion for bankruptcy cases. *See Slater Health Ctr., Inc. v. United States (In re Slater Health Ctr., Inc.)*, 306 B.R. 20, 24 (D.R.I. 2004) (citing *University Medical* in support of holding that "[s]ince the Bankruptcy Code supplies an independent basis for jurisdiction, the exhaustion of administrative remedies is not required" under Section 405), *aff'd*, 398 F.3d 98 (1st Cir. 2005); *First Am. Health Care of Ga., Inc. v. Dep't of Health & Human Servs.*, 208 B.R. 985, 988-89 (Bankr. S.D. Ga. 1996) (citing *Town & Country*), *vacated and superseded by consent order*, 1996 WL 282149 (Bankr. S.D. Ga. Mar. 11, 1996); *In re Healthback*, 226 B.R. at 469-70 (citing *University*

Medical and *Town & Country*); *Parker N. Am. v. Resolution Trust Corp. (In re Parker N. Am. Corp.)*, 148 B.R. 925, 929 (C.D. Cal. 1992) (citing *Town & Country*); *Gingold v. United States ex rel. Dep't of Health & Human Servs. (In re Shelby County Healthcare Servs. Of AL, Inc.)*, 80 B.R. 555, 559-61 (Bankr. N.D. Ga. 1987).[4]

Both questions presented by this case involve circuit conflicts ripe for the Court's review. The Ninth Circuit has declined to reverse its decision in *Town & Country*. *See Do Sung Uhm*, 620 F.3d at 1141 n.11. And the Eleventh Circuit denied rehearing in this case without a single judge calling for a vote on the petition. Pet. App. 93a-94a. As a result, there is no realistic prospect that the circuit conflicts will resolve without the Court's intervention.

B. The Questions Presented Are Recurring And Important.

The questions presented in this case are recurring and of exceptional legal and practical importance. The continued uncertainty surrounding them imposes a significant burden on health care providers and their patients. And an enduring circuit split will bring about dramatically different outcomes based on nothing more than geographic happenstance.

---

[4] As the Ninth Circuit noted, courts have found that exhaustion is unnecessary because of an independent grant of judicial review in other contexts as well. *See Town & Country*, 963 F.2d at 1154 (discussing exhaustion requirement of the Federal Tort Claims Act); *see also Ashbrook v. Block*, 917 F.2d 918, 921-23 (6th Cir. 1990); *Zayler v. United States*, 279 F. Supp. 2d 805, 814-15 (E.D. Tex. 2003) (listing cases), *aff'd*, 468 F.3d 248 (5th Cir. 2006).

1. The recurring nature of these issues is shown by the sheer number of lower courts across the country that have weighed in regarding Section 405. *See supra*, at 18-19, 22-23. "[H]undreds of courts, including dozens of bankruptcy courts, have analyzed the applicability of § 405(h) since the 1980s." Maizel & Potere, 32 Emory Bankr. Dev. J. at 25. Yet, as discussed above, they are deeply split on the two questions presented.

The issues have also generated a significant body of scholarly literature, with advocates for both sides. *See generally id.* (arguing Section 405(h) does not bar Section 1334 jurisdiction and exhaustion is not required); Peter R. Roest, *Recovery of Medicare and Medicaid Overpayments in Bankruptcy*, 10 Annals Health L. 1 (2001) (arguing Section 405(h) does not bar Section 1334 jurisdiction); John Aloysius Cogan Jr. & Rodney A. Johnson, *Administrative Channeling Under the Medicare Act Clarified: Illinois Council, Section 405(h), and the Application of Congressional Intent*, 9 Annals Health L. 125 (2000) (arguing Section 405(h) should bar Section 1334 jurisdiction).

2. The questions presented in this case are exceptionally important. *First*, national uniformity in the bankruptcy context is critical; indeed, the Constitution itself notes the importance of "establish[ing] . . . uniform laws on the subject of Bankruptcies throughout the United States." U.S. Const. art. I, § 8, cl. 4. This power to create a uniform system was intended to "secur[e] equality of rights and remedies among the citizens of all the states." 3 Joseph Story, *Commentaries on the Constitution of the United States* § 1102, at 6 (1833). To maintain that uniformity,

this Court frequently grants review to resolve disagreements among courts of appeals in the bankruptcy context. *See, e.g.*, *Harris v. Viegelahn*, 135 S. Ct. 1829, 1836 (2015); *Clark v. Rameker*, 134 S. Ct. 2242, 2246 (2014); *Hall v. United States*, 132 S. Ct. 1882, 1886 & n.1 (2012); *Ransom v. FIA Card Servs., N.A.*, 562 U.S. 61, 68 & n.4 (2011).

Second, the absence of uniformity in this case risks arbitrary and unfairly divergent outcomes. In circuits that reject the Eleventh Circuit's rule, health care providers faced with Medicare termination will be able to reorganize and emerge from bankruptcy relatively unscathed. In circuits that have adopted the Eleventh Circuit's rule, health care providers will be forced to close their doors while waiting perhaps years to proceed through the Medicare Program's appeals process, or more likely, will never survive to see an appeal. Given the backlog in administrative determinations, it would often be "optimistic to expect a final accounting within five years." *First Am. Health Care*, 208 B.R. at 989-90; *accord In re Healthback*, 226 B.R. at 475. Thus, in most cases, "[i]t is beyond question that the Debtor would have long ceased doing business by the time the administrative procedures . . . are exhausted." *First Am. Health Care*, 208 B.R. at 989-90; *accord* Pet. App. 113a ("[I]t is highly unlikely the [administrative] appeals process will be complete before the debtor files for bankruptcy."); Maizel & Potere, *supra*, at 27-29 (under the government's theory, a hospital could face the "fatal dilemma" of being put out of business before being able to challenge an HHS decision).

Requiring exhaustion thereby "disrupt[s]" the "entire bankruptcy scheme," because "the purpose of the bankruptcy statutes, to provide a debtor breathing room to attempt an effective reorganization, would be completely defeated." *In re Healthback*, 226 B.R. at 475.

Third, uncertainty over the questions presented affects all participants in the Medicare and Medicaid Programs. This uncertainty no doubt exists for health care providers. But it also imposes a significant toll on the lives of a provider's patients and their families. A court adopting the Eleventh Circuit's interpretation of Section 405 can cause the debtor's business to "fail immediately," which can "wreak havoc on the lives of [thousands of] patients that are medicated, bathed, clothed, and otherwise cared for by the Debtor's caregivers." *Nurses'*, 533 B.R. at 598. On a moment's notice, those patients would all have to find new facilities equipped to handle their needs, where they would be cared for by unfamiliar staff and subjected to different routines. *See* Pet. App. 89a-90a, 121a-122a (noting that "patients may be at a greater risk if they transfer" due to "a phenomenon known as transfer trauma").

Because the consequences of that outcome are so dire, the law's uncertainty itself causes a significant burden. As a case progresses from bankruptcy court to district court and then to the circuit (assuming the health care provider can afford to keep appealing), patients can be whipsawed as one court rules that the facility can enjoy bankruptcy protection, then the next court rules to the contrary, as happened here. As the district court noted, "there is a significant factor of human dignity at issue here," because while bankruptcy

and other courts spend years attempting to reconcile the meaning of Section 405, patients and their families are left not knowing whether they will be able to sleep in the same bed on any given night. Pet. App. 89a-90a. It is "draconian to disrupt their dignity based on a jurisdictional debate that has resulted in significant contrary opinions among the circuit courts and the lower courts." Pet. App. 91a.

It is utterly arbitrary that facilities and patients located in some circuits suffer these catastrophic consequences, while facilities and patients in other circuits may continue to operate during the pendency of the administrative appeals. Resolving the circuit splits would provide certainty over whether bankruptcy protection is a viable avenue for a facility's survival.

C. This Case Is An Ideal Vehicle.

1. This case is the perfect vehicle because it presents the Court with the opportunity to resolve *both* sources of uncertainty regarding a bankruptcy court's authority: whether Section 405(h)'s jurisdictional bar applies to suits brought under Section 1334, and whether Section 405 requires exhaustion of cases brought under Section 1334. Both questions presented were squarely resolved by the Eleventh Circuit in this case and were the basis for that court's decision to affirm the district court.

There are two primary reasons why resolving both questions is so important. *First*, there is a significant practical benefit to answering both issues at once. Given the urgency of these bankruptcy proceedings, in the vast majority of cases it will be irrelevant whether a

bankruptcy court can hear Medicare claims *unless* it can hear them immediately (*i.e.*, without waiting years for exhaustion). *See supra*, at 25-26 (explaining that facilities can fail immediately if they cannot proceed through bankruptcy). If the Court resolved just the jurisdictional question, the split on exhaustion would remain, producing the same practical effect as if the bankruptcy court lacked jurisdiction: a complete inability to orderly and timely resolve bankruptcy claims in an area where urgency is critical.

Second, many lower courts view the questions as interrelated. The Eleventh Circuit treated the two questions as separate and alternative inquiries, without overlapping analysis. *See* Pet. App. 60a-62a. However, other courts have concluded that the issues rise and fall together: if Section 405 does not apply to cases brought under Section 1334, then not only can the bankruptcy court hear such suits (Question Presented 1), but the separate exhaustion requirement in Section 405 also does not apply (Question Presented 2). *See*, *e.g.*, *Town & Country*, 963 F.2d at 1154-55; *James*, 256 B.R. at 481-82. Some courts have even combined the issues into a single question: whether there is a "jurisdictional bar on judicial review of unexhausted Medicare disputes." *Nurses' Registry*, 533 B.R. at 592.

Given that the lower courts themselves cannot agree on whether, and to what extent, the analysis for the two questions presented overlaps, this Court should grant a case that presents both issues—as this case does. Otherwise, the Court would risk trying to resolve the "interplay between" these two analytically linked provisions, without the benefit of full briefing on both.

Midland, 145 F.3d at 1002 (noting that district court "complicated matters" by trying to address Section 405(h) without § 405(g)).

For these logical and practical reasons, this Court should answer both questions presented.

2. The petition also presents this Court with a rare chance to resolve these disputed issues, which are often litigated in bankruptcy courts but infrequently reach the appellate courts. "The nature of bankruptcy cases tends to discourage further appellate review in the Article III courts because of the twin concerns of delay and cost associated with prolonged litigation." Troy A. McKenzie, *Judicial Independence, Autonomy, and the Bankruptcy Courts*, 62 Stan. L. Rev. 747, 782 (2010). Only one out of every 1,580 bankruptcy cases reaches the circuit level, compared to one in every 12 non-prisoner civil suits. *Id.* at 783.

Further, in the specific context of Section 405, debtors often go out of business with no appreciable assets in their estates—and the cases become moot—*as a direct result of* the lower courts' rulings on whether bankruptcy protection is available under Section 405(h). *See supra*, at 9-10, 25-26. The catastrophic practical consequences of those lower court rulings regarding Section 405 thereby insulate them from meaningful review by this Court, perpetuating the split in the courts below. This explains why there have been "hundreds" of cases analyzing the significance of Section 405(h) but relatively few circuit decisions. *See* Maizel & Potere, 32 Emory Bankr. Dev. J. at 25.

Petitioner's case presents an opportunity to resolve these circuit splits because it is still ongoing and presents a live controversy. Petitioner has preserved both questions presented at the bankruptcy, district, and circuit courts. And, as the government conceded and the Eleventh Circuit held, there remains an ongoing controversy here because the government has insisted that it "intends to seek recoupment of . . . payments if the bankruptcy court's orders are found to be invalid." Pet. App. 62a; *see also* Eleventh Circ. Br. for Federal Appellees 28-29, 2015 WL 7292479 ("There is, and has been at each stage of this appeal, a live, justiciable controversy . . . ."). By maintaining a live controversy during the years of appeals required to reach this Court, Petitioner's case presents a uniquely optimal vehicle through which this Court can resolve the questions presented.

* * *

The petition squarely presents the Court with the opportunity to resolve circuit splits on two related questions of great importance to bankruptcy and Medicare law. The Court should grant the petition and reverse the Eleventh Circuit.

D. The Decision Below Is Incorrect.

In addition to being inconsistent with the decisions of other courts of appeals and numerous district and bankruptcy courts, the Eleventh Circuit's decisions on both questions presented are incorrect.

1. The Eleventh Circuit held that Section 405(h)'s omission of Section 1334 was a codification error that the court had authority to correct on its own. *See* Pet. App.

35a-52a. This conclusion is contrary to several of this Court's established statutory-interpretation cases.

First, "when [a] statute's language is plain, the sole function of the courts—at least where the disposition suggested by the text is not absurd—is to enforce it according to its terms," because "[i]t is beyond [the judicial] province to rescue Congress from its drafting errors." *Lamie v. United States Tr.*, 540 U.S. 526, 534, 542 (2004) (quotations omitted). All parties agree that Section 405's language is plain and unambiguous: Section 1334 is not included in the list of grants of jurisdiction that are banned under Section 405.

That rule announced in *Lamie* applies even where a party claims the statute unintentionally omitted a term. In *Lamie*, this Court addressed a party's argument that the Court could "read an absent word into the statute" because the omission was "presumably by inadvertence." *Lamie*, 540 U.S. at 538. The Court rejected that argument and made clear that "[i]f Congress enacted into law something different from what it intended, then it should amend the statute to conform it to its intent." *Id.* at 542. If the Court decided to add the missing term on its own, then it would no longer be engaging in "construction of the statute, but [rather], in effect, an enlargement of it." *Id.* at 538 (quotations and alteration omitted). "With a plain, nonabsurd meaning in view, we need not proceed in this way." *Id.; accord Dir., Office of Workers' Comp. Programs, U.S. Dep't of Labor v. Bath Iron Works Corp.*, 885 F.2d 983, 988, 990 (1st Cir. 1989) (Breyer, J.) ("Faced with language that is fairly clear and a statute that makes reasonable sense," "the time . . . to catch, and

to correct, that [drafting] error was before the bill became law, not after.").

The Eleventh Circuit should have followed *Lamie* and held that the plain language of Section 405 controls, unless and until Congress itself changes that statute.

Second, assuming there is a scrivener's error "exception" to this plain-meaning rule,[5] the omission of Section 1334 is *not* a correctable scrivener's error. Scrivener's errors usually refer to minor typographical mistakes such as the "placement of the quotation marks" within a statute, *U.S. Nat'l Bank of Or. v. Indep. Ins. Agents of Am., Inc.*, 508 U.S. 439, 462 (1993)—but not the omission of dozens of statutory grants of federal jurisdiction, as the Eleventh Circuit held here. That is especially true where, as here, Congress would have made this "error" while observing a codification note specifically calling out the omission of those provisions. *See* 42 U.S.C.A. 405 (West 1982).

Even if such a glaring omission could fall into the category of scrivener's errors, such an error may be corrected only where it is "clear beyond question" that the statutory language is, in fact, erroneous. *U.S. Nat'l Bank*, 508 U.S. at 462. That is especially true where the alleged error concerns a provision that would restrict access to the courts. *Abbott Labs. v. Gardner*, 387 U.S. 136, 141 (1967) ("[O]nly upon a showing of 'clear and convincing evidence' of a contrary legislative intent should the courts restrict access to judicial review."). To

---

[5] *See Johnson v. United States*, 529 U.S. 694, 723–24 (2000) (Scalia, J., dissenting) (noting that "[p]erhaps" there is a scrivener's error "exception" to the plain-meaning canon).

warrant correction, the literal reading of the statute must produce an "absurd" outcome. *Lamie*, 540 U.S. at 542. However, the omission of Section 1334 does not produce an "absurd" result. Excluding bankruptcy cases from Section 405(h)'s bar "allows a single court to preside over all of the affairs of the estate," *Town & Country*, 963 F.2d at 1155, thereby advancing Congress's intent that bankruptcy courts "deal efficiently and expeditiously with all matters connected with the bankruptcy estate," *Celotex Corp. v. Edwards*, 514 U.S. 300, 308 (1995).

Finally, even assuming the omission was a scrivener's error, the Court still should not "correct" it, because there are subsequent "considerations suggest[ing] Congress may have intended the change the scrivener worked." *Lamie*, 540 U.S. at 540. When Congress later amended Section 405 by enactment of the Social Security Independence And Program Improvements Act Of 1994, Pub. L. 103-296, 108 Stat. 1464, it had the opportunity to strip bankruptcy courts of Section 1334 jurisdiction over Medicare claims but chose not to do so. If a scrivener's error led to the omission of Section 1334 from Section 405(h) when the DRA of 1984 was enacted, then surely Congress could have fixed this problem. It never did.

Instead, Congress has enlarged the powers of bankruptcy courts, and in particular has recognized their role in presiding over health care bankruptcies. It has provided bankruptcy courts with the power to do everything the bankruptcy court did here: enforce the automatic stay, 11 U.S.C. 362(a); order a debtor to assume an executory contract after curing any default,

11 U.S.C. 365; issue relief "necessary or appropriate" to carry out the bankruptcy process, 11 U.S.C. 105(a); and confirm a debtor's plan of reorganization, 11 U.S.C. 1141. The foregoing actions were authorized by 11 U.S.C. 106, in which Congress also abrogated the government's sovereign immunity with respect to the foregoing provisions. Even if the language of Section 405(h) had been a codification error, Congress's subsequent legislation authorizing the specific actions taken by the bankruptcy court here should control. *Cf. FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 143 (2000) (interpretation of statute appropriately altered where "subsequent statutes more specifically address the topic at hand").

The government cannot satisfy its high burden of showing that the omission of Section 1334 was "beyond question" a scrivener's error that the courts are empowered to correct.

2. The Eleventh Circuit's decision regarding exhaustion was also erroneous. The exhaustion prerequisite of Section 405 does not apply here because Bayou Shores did not seek review of an agency finding or decision before the bankruptcy court. It sought relief pursuant to the independent and "exclusive" grant of jurisdiction in Section 1334. As the Ninth Circuit correctly held, "'[W]here there is an independent basis for bankruptcy court jurisdiction, exhaustion of administrative remedies pursuant to other jurisdictional statutes is not required.'" *Town & Country*, 963 F.2d at 1154-55 (citation omitted).

The argument in favor of requiring exhaustion in bankruptcy cases "is specious," because it "erroneously

attempt[s] to characterize a bankruptcy proceeding as 'judicial review'" under Section 405, when in truth "a bankruptcy proceeding is not making a substantive ruling on Medicare law"—and thus "the doctrine of exhaustion of administrative remedies would not be applicable." *In re Healthback*, 226 B.R. at 470 n.5.

In other words, when a bankruptcy court exercises its power to appoint a health care ombudsman or to order the assumption of a provider agreement, it is solely exercising its authority as a bankruptcy court. *Supra*, at 5-6. It is not reviewing agency findings, nor substituting its judgment for that of the agency. As the bankruptcy court here noted, Bayou Shores' assumption of its provider agreements did not in any way cancel or overturn the deficiencies cited by the agency. Pet. App. 120a-121a. Indeed, the bankruptcy court analyzed the likely outcome of the administrative appeal in determining the feasibility of Bayou Shores' plan, reflecting its understanding that the administrative process would continue unimpeded. Pet. App. 121a-123a. Far from interfering with the administrative process, the bankruptcy court simply exercised its authority under the Bankruptcy Code. *Contra Bd. of Governors, FRS v. MCorp Financial, Inc.*, 502 U.S. 32 (1991) (district court erred in enjoining the Board from prosecuting administrative proceedings).

Under these circumstances, requiring exhaustion of administrative remedies before a bankruptcy court can administer a health care debtor's estate impedes Congressional intent for bankruptcy courts to "deal efficiently and expeditiously with all matters connected with the bankruptcy estate." *Celotex*, 514 U.S. at 308. If

the Eleventh Circuit's interpretation were correct, the government could drive a health care provider out of business while awaiting administrative review. Practically speaking, this would preclude any "attempt [at] an effective reorganization," thereby "completely defeat[ing]" the "purpose of the bankruptcy statutes." *In re Healthback*, 226 B.R. at 475.

CONCLUSION

The petition for writ of certiorari should be granted.

Respectfully submitted,

LINDSAY C. HARRISON
Counsel of Record
JENNER & BLOCK LLP
1099 New York Ave., NW,
Suite 900
Washington, DC 20001
(202) 639-6000
lharrison@jenner.com

February 2, 2017