

# Towards a Fair Appeal: Rethinking Medicare Provider Agreement Termination Appeals

Dexter R. Golinghorst\*

*ABSTRACT: Medicare is a significant contributor to the health care system in the United States. In order to deliver care, the Centers for Medicare and Medicaid Services (“CMS”) contracts with providers using “provider agreements.” CMS enforces its regulations through a survey review process, which may result in a notice of termination of the provider agreement for noncompliance. Currently, providers can appeal to an Administrative Law Judge; but, the termination proceeds anyway, regardless of whether or not an appeal decision has been issued. This has created chaos for providers, who are forced to attempt to secure a temporary restraining order against CMS, which often fails, or to try to avail themselves of the protection of bankruptcy law. This appeals process is inadequate to ensure that providers are able to truly exercise their right to an appeal. Without a means to stay termination of the provider agreement while waiting for an appeal decision, providers face the harsh reality that even if they win their appeal, they may have already felt the consequences of a terminated agreement. Under the current system, a provider may be forced to close because of their terminated agreement only to find out they were correct after an appeal decision issued months after the impact of the termination has already been felt. This possibility alone demands modification of the Medicare provider agreement appeals framework. This Note argues that the statutory framework establishing the process for Medicare provider agreement appeals should be amended to include a stay of termination until an appeal decision is issued.*

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\* J.D. Candidate, The University of Iowa College of Law, 2019; Master of Health Administration Candidate, The University of Iowa College of Public Health, 2020; B.A., The University of Iowa, 2016. I would like to thank my family for their unending support in my educational endeavors, and the staff of the *Iowa Law Review* for their excellent advice during the editing process.

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## I. INTRODUCTION

Medicare provides protection and health care coverage for 44 million Americans.<sup>1</sup> This represents 15% of the total population of the United States, mainly including those 65 years of age and older.<sup>2</sup> This number is projected to reach a striking 79 million by 2030, which will create substantial “administrative and fiscal challenges to the system.”<sup>3</sup> But, the federal government does not provide any actual care; it only pays for it.<sup>4</sup> Thus, Medicare requires agreements between providers and the Centers for

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1. BEN UMANS & K. LYNN NONNEMAKER, AARP PUB. POL'Y INST., THE MEDICARE BENEFICIARY POPULATION 1 (Jan. 2009), [https://assets.aarp.org/rgcenter/health/fs149\\_medicare.pdf](https://assets.aarp.org/rgcenter/health/fs149_medicare.pdf).

2. *Id.* at 2 (“A little more than half of current aged Medicare enrollees are between the ages of 65 and 74, though the older segments of the population are growing. Today, individuals over the age of 85 account for a little more than 10 percent of the total Medicare population, but their use of Medicare services and their overall impact on the program are substantial.” (footnotes omitted)).

3. *Id.* at 3 (noting this figure is “more than double the year 2000 enrollment”).

4. This Note does not address any services or agreements of the Veterans Administration, which acts as both payer and provider of medical care.

Medicare and Medicaid Services (“CMS”)<sup>5</sup> to deliver the services covered by the program.<sup>6</sup>

But what happens when a provider and the government disagree? What happens if the government decides that a provider has broken the rules? The answers to these questions lie within complex statutes and regulations designed to ensure providers comply with the goals of the legislation.<sup>7</sup> The current process available to providers for challenging a CMS determination to terminate a Medicare Provider Agreement is inadequate because it risks erroneously terminating a providers’ agreement before an appeal is heard. More important than the providers’ own interest in preserving their agreement, CMS could eliminate beneficiaries’ only source of care in their community if a provider agreement is terminated prematurely. Thus, the ultimate victims of a wrongful termination brought on by an inadequate appeals process are the patients themselves.<sup>8</sup> The appeal framework sets up a system in which providers faced with termination of their provider agreements are forced to make quick decisions to protect their entire entity. The system allows a provider to appeal a CMS decision to an Administrative Law Judge (“ALJ”), then to the Department Appeals Board; only after the exhaustion of these remedies may the provider seek the protection of the judiciary.<sup>9</sup> This is often a long, expensive process.<sup>10</sup> Providers often face termination in a matter of days, leaving them little choice but to attempt to avail themselves of other remedies in order to preserve their provider agreement.

Some of these “creative” strategies include attempting to obtain temporary restraining orders (“TRO”) against CMS to prevent termination of the provider agreement<sup>11</sup> or declaring bankruptcy.<sup>12</sup> While requests for TROs will be fact-specific inquiries, it is unclear why it is necessary for the courts to be clogged with such injunction requests in the first place or, conversely, how a system could fail so miserably as to incentivize a health provider to declare bankruptcy just to garner protection while it awaits an appeal decision. This

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5. CMS is part of the Department of Health and Human Services. CMS’s mission broadly includes administering Medicare and Medicaid and other government health programs including the Children’s Health Insurance Program (“CHIP”) and the insurance marketplaces created by the Affordable Care Act. *History*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Jun. 20, 2018, 2:36 PM), <https://www.cms.gov/About-CMS/Agency-Information/History/index.html>. CMS is a relatively new agency, celebrating its 50th anniversary in 2015. *Id.*

6. *See* UMANS & NONNEMAKER, *supra* note 1, at 3. Medicare funds are dispersed between a wide variety of providers including hospitals (both inpatient and outpatient), skilled nursing facilities, home health care, managed care organizations, and prescription drug coverage. *Id.*

7. *See infra* Part II.

8. *See infra* Section II.C.

9. *See infra* Part III.

10. *See infra* Section III.A.

11. *See infra* Section III.A.

12. *See infra* Section III.B.

Note suggests a straightforward solution: a stay pending appeal. Legislatively amending the statute to include a stay of termination of provider agreements is more equitable to the parties and will result in greater stability for those providers seeking to comply with federal regulations and remain a paid provider with CMS. The Note proceeds as follows: Part II discusses the origins of the Medicare Act (“Act”) and explains the current appeals process; Part III explores the problems it creates in federal courts and in the bankruptcy context; Part IV presents a legislative solution to the problem, establishing a stay of the provider agreement termination until the appeals process is complete; and Part V concludes by suggesting that amending the governing statute to include a stay pending appeal is the best solution to properly balance the interests of providers and CMS.

## II. MEDICARE PROVIDER AGREEMENT FRAMEWORK

To understand the challenges providers face when they appeal adverse CMS determinations, a brief overview of the history of Medicare is necessary. Section A examines the statutory framework of the Medicare program. Section B discusses Medicare requirements and regulations with which eligible providers must comply. Section C tracks providers’ current statutory appeal rights.

### A. BRIEF HISTORY OF MEDICARE ENACTMENT

Medicare was a legislative response to previous failed attempts at enacting national health care in the United States.<sup>13</sup> Early on, some Americans received health insurance from fraternal groups or unions, but “the vast majority of Americans lacked adequate protection against the costs of illness,” and minorities were especially vulnerable.<sup>14</sup> Although early attempts at national health care garnered support, it quickly gave way to political pressure from interest groups that rallied against a national health insurance program.<sup>15</sup> While the 1940s and 1950s saw growth in the health insurance provided by employers, much of the elderly population, whose medical costs were substantially higher than those of younger people, remained without insurance coverage.<sup>16</sup> Private providers were unwilling to offer coverage because “the expensive medical needs of the elderly simply made them a bad risk not worth insuring.”<sup>17</sup> Thus, the problem of how to deal with the rising cost of retirees’ healthcare was a salient political issue.

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13. JONATHAN OBERLANDER, *THE POLITICAL LIFE OF MEDICARE* 18 (2003).

14. *Id.* (“[B]lack, women, and the elderly were commonly excluded from existing plans.”).

15. *See id.* at 20–21.

16. *Id.* at 23.

17. *Id.*

Though salient, a national health insurance program still faced staunch political opposition.<sup>18</sup> As a result, the Truman Administration focused its efforts on providing care to the elderly through the Social Security Act, which provided a framework under which the beneficiaries were viewed as “deserving,” because they would contribute financially to the program.<sup>19</sup> This offered the legitimacy necessary to overcome the stigma associated with government welfare programs.<sup>20</sup> Medicare faced many political stall-outs and blocks from conservatives in Congress and was seemingly defeated until democrat Lyndon B. Johnson was re-elected in 1964, alongside striking Democratic majorities in both the House of Representatives and the Senate.<sup>21</sup> Seeing that passage was inevitable, Representative Wilbur Mills, an Arkansas Democrat and Chair of the House Ways and Means Committee, combined three competing proposals into a plan that was politically acceptable to each stakeholder.<sup>22</sup> Against this backdrop, Medicare was signed into law by President Johnson in 1965.<sup>23</sup>

### B. MEDICARE REQUIREMENTS AND REGULATIONS

To qualify as a Medicare beneficiary, one must (1) be 65 years of age or older; (2) suffer from certain disabilities; or (3) have end stage renal disease.<sup>24</sup> The program is divided into separate Parts, each providing a different type of insurance. Part A provides Hospital Insurance, Part B provides Medical Insurance, Part C offers Medicare-Choice Plans, and Part D provides some prescription drug coverage.<sup>25</sup> Because this Note focuses on the appeals

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18. Among those opposed to a national health insurance program were Southern Democrats, Republicans, and powerful interest groups, including the American Medical Association. THEODORE R. MARMOR, *THE POLITICS OF MEDICARE 17–18* (2d ed. 2000).

19. OBERLANDER, *supra* note 13, at 24.

20. *Id.* at 25; *see also* MARMOR, *supra* note 18, at 11 (“[T]he proponents . . . turned from the health problems of the general population to those of the aged. As a group, the aged could be presumed to be both needy and deserving because, through no fault of their own, they had lower earning capacity and higher medical expenses than any other age group.”).

21. OBERLANDER, *supra* note 13, at 29.

22. *Id.* at 30–31. Wilbur Cohen, who was an assistant secretary for legislation in the Department of Health, Education, and Welfare at the time, and one of the most influential policymakers associated with Medicare drafting, was particularly impressed with Mills’ move. *Id.* (“[T]he most brilliant legislative move I’d seen in 30 years. The doctors couldn’t complain because they had been carping about Medicare’s shortcomings and about its being compulsory. And the Republicans couldn’t complain, because it was their own idea. In effect, Mills had taken the AMA’s [American Medical Association] ammunition, put it in the Republicans’ gun, and blown both of them off the map.” (quoting RICHARD HARRIS, *A SACRED TRUST* 187 (1966))).

23. CTRS. MEDICARE & MEDICAID SERVS., *supra* note 5; *see also* MARMOR, *supra* note 18, at 45 (“The electoral outcome of 1964 guaranteed the passage of legislation on medical care for the aged. Not one of the obstacles to Medicare was left standing. . . . In addition, President Johnson’s dramatic victory over Goldwater could be read as a popular mandate for Medicare.”).

24. 42 U.S.C. § 1395c (2012).

25. *See id.* §§ 1395c to 1395i-5 (Part A); §§ 1395j to 1395w-4 (Part B); §§ 1395w-21 to 1395w-29 (Part C); §§ 1395w-101 to 1395w-152 (Part D).

process available to providers with Medicare provider agreements, this Note will primarily focus on Medicare Part A.

Generally described as “Hospital Insurance,” Medicare Part A specifically provides limited coverage for inpatient hospital services<sup>26</sup> and post-hospital care services<sup>27</sup> for “any spell of illness,”<sup>28</sup> home health services,<sup>29</sup> and hospice care<sup>30</sup> to qualified enrollees.<sup>31</sup> In enumerating specific requirements, Medicare expressly does not compensate providers for all of the care elderly patients may require.<sup>32</sup>

In order to execute the Medicare program, CMS enters into contracts with providers qualifying under the statute, known as provider agreements. Provider agreements are “an agreement between CMS and . . . [health care] providers . . . to provide services to Medicare beneficiaries.”<sup>33</sup> The Social Security Act imposes extensive requirements to enroll as a provider.<sup>34</sup> Hospitals must file an agreement with the Secretary of Health and Human Services agreeing, among other things, to not charge an individual for items or services covered under the Act,<sup>35</sup> to maintain professional standards and improvement review processes,<sup>36</sup> and to maintain medical records for a period of at least five years.<sup>37</sup> Providers also must comply with federal civil rights legislation.<sup>38</sup> Once it is determined that a provider complies with the statutory standards, the Secretary may enter into a provider agreement with the hospital.<sup>39</sup> CMS then notifies a provider of its acceptance and sends it two

26. *Id.* § 1395x(b). This coverage provides inpatient care at a hospital for such things such as room and board, nursing, facilities, social work, and therapeutic and diagnostic services. *Id.*

27. *Id.* § 1395x(i). Post-hospital care includes care provided to a patient after transfer from a hospital following a stay of not less than three days. These transfers are usually to a skilled nursing facility. *See id.* For an overview of the requirements of skilled nursing facilities in the Medicare context, see *id.* § 1395i-3.

28. A “spell of illness” begins on the first day an individual receives inpatient services under Part A and concludes sixty days after the individual is no longer receiving those inpatient services. *Id.* § 1395x(a).

29. Home health services includes coverage for items such as periodic nursing care, physical and occupational therapy, medical supplies, and more. *See id.* § 1395x(m) (listing the full slate of covered home health services).

30. Hospice care covers services for terminally ill patients and includes, among other items, nursing care, therapies, social services, and counseling. *See id.* § 1395x(dd) (listing the full slate of covered hospice services).

31. *Id.* § 1395d(a)(1)–(5).

32. *See id.* § 1395d(b) (laying out services expressly excluded from coverage under Medicare Part A).

33. 42 C.F.R. § 489.3 (2017).

34. *See generally* 42 U.S.C. § 1395cc (setting the requirements necessary to qualify as a provider and obtain an agreement).

35. *See id.* § 1395cc(a)(1)(A)–(B).

36. *Id.* § 1395cc(a)(1)(F)(i).

37. *Id.* § 1395cc(a)(1)(I)(ii).

38. 42 C.F.R. § 489.10(b).

39. *Id.* § 489.11.

copies of the provider agreement.<sup>40</sup> The provider must then sign both copies, return them to CMS, and provide a letter to the agency “indicating whether it has been adjudged insolvent or bankrupt” or whether it is involved in any pending bankruptcy proceedings.<sup>41</sup> Although bankruptcy is not explicitly a reason to deny an agreement,<sup>42</sup> CMS may consider it in deciding whether to renew or accept a provider agreement.<sup>43</sup> CMS will then notify the provider of its acceptance of the provider agreement and give the agreement’s effective date.<sup>44</sup> CMS views its ability to grant or deny agreements to be of “paramount importance.”<sup>45</sup>

Once an agreement is formed, hospitals must meet the statutory requirements set forth by Congress in the Act, as well as additional regulatory requirements imposed by the Secretary of Health and Human Services through CMS.<sup>46</sup> Additionally, hospitals must comply with state and local laws, and be properly licensed.<sup>47</sup> Thus, providers must be cognizant of more than just federal law, even though the federal government is the only payer under the Medicare provider agreement. Medicare compliance is facilitated cooperatively between CMS and state agencies, through a review process known as surveying.<sup>48</sup> Surveys are conducted both randomly and based on complaints.<sup>49</sup> Random surveys can either be broad, searching for comprehensive compliance with Medicare regulation, or narrowly tailored by CMS.<sup>50</sup> However, allegations of noncompliance usually focus on specific

40. *Id.* § 489.11(a)(2).

41. *Id.* § 489.11(b).

42. *See id.* § 489.12.

43. Though a history of bankruptcy is not an express reason to deny a provider agreement, the agency is still concerned with entering provider agreements with entities that are or have been parties to bankruptcy proceedings. *See id.* This is because the Medicare rules require providers to meet certain standards that bankruptcy proceedings can negate. *See, e.g.,* 42 U.S.C. § 1395l(t) (2012); *Parkview Adventist Med. Ctr. v. United States ex rel. Dep’t of Health & Human Servs.*, 842 F.3d 757, 764–66 (1st Cir. 2016) (explaining that the terminated provider no longer satisfied the definition of “hospital” required by the statute). This further demonstrates why bankruptcy may not be an adequate route for saving provider agreements. *See infra* Section III.B.

44. 42 C.F.R. § 489.11.

45. Adrienne Dresevic & Donald H. Romano, *The Medicare Enrollment Process—CMS’s Most Potent Program Integrity Tool*, HEALTH LAW., Apr. 2011, at 1, 1 (2011) (“[CMS’s] ability to deny or revoke billing privileges [is] a means of protecting the Medicare program . . . and its beneficiaries from fraud and abuse.”).

46. 42 C.F.R. § 482.1(i)–(ii) (“The Secretary may impose additional requirements if they are found necessary in the interest of the health and safety of the individuals who are furnished services in hospitals.”).

47. *Id.* § 482.11.

48. *Id.* § 488.10. Each state has their own State Survey Agency. In many states, the surveyors are housed in the state department of public health or its equivalent. CTRS. FOR MEDICARE & MEDICAID SERVS., STATE SURVEY AGENCY DIRECTORY (2017), [https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/State\\_Agency\\_Contacts.pdf](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/State_Agency_Contacts.pdf).

49. Random surveys “are conducted on a representative sample basis.” 42 C.F.R. § 488.9(a).

50. *Id.*

allegations.<sup>51</sup> Failure to comply with surveys alone can lead to termination of the provider agreement.<sup>52</sup>

Providers facing a finding of noncompliance after a survey are subject to a range of consequences. A finding that a provider is noncompliant with one or more regulations means that the provider no longer meets the requirements to participate in Medicare.<sup>53</sup> Consequently, the provider will, at minimum, continue to be under surveillance by the state agency until found to be complying, or be subject to another survey.<sup>54</sup> Most severely, however, the provider may be subject to termination of their provider agreement.<sup>55</sup> Once a state agency finds a violation, it certifies the noncompliance and CMS determines if the provider agreement will be terminated.<sup>56</sup>

Just as the Act provides requirements for forming agreements, it also provides for terminating provider agreements.<sup>57</sup> Both providers and the Secretary have the power to terminate, subject to regulation promulgated by the agency. The processes and regulations for termination are different depending on which party (the provider or the government) seeks to initiate the termination.<sup>58</sup> Generally, “[t]he Secretary . . . upon such reasonable notice to the provider and the public as may be specified in regulations, may refuse to renew or may terminate . . . an agreement” where the Secretary determines (1) the provider failed to comply with the terms of the agreement; (2) the provider no longer meets the definition of a provider; (3) the provider is excluded from being allowed to participate in Medicare; or (4) the provider has been convicted of a felony which is detrimental to the best interests of Medicare.<sup>59</sup>

42 U.S.C. § 1395cc provides the statutory basis for CMS’s development of regulations for terminating provider agreements.<sup>60</sup> CMS may terminate Medicare provider agreements for failing to comply with statutory or regulatory requirements for participation in Medicare.<sup>61</sup> In addition to a lengthy list of regulations, with which all providers must comply, hospitals are subject to further regulations that provide grounds for termination of Medicare provider agreements.<sup>62</sup> Hospitals with emergency departments are

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51. *Id.* § 488.9(a)(2).

52. *Id.* § 488.9(b)(2).

53. *Id.* § 488.9(c)(1).

54. *See id.*

55. *See id.* § 488.9(c)(3).

56. *Id.* § 488.24.

57. 42 U.S.C. § 1395cc(b) (2012).

58. This Note focuses only on the termination process and regulations available to the government through CMS. For the regulations related to provider termination of the provider agreement, see 42 C.F.R. § 489.52 (2017).

59. 42 U.S.C. § 1395cc(b)(2).

60. 42 C.F.R. § 489.1.

61. *Id.* § 489.53.

62. *Id.* § 489.53(a) (listing numerous regulatory requirements for providers generally).



subject to termination if they fail to “examine, treat, or transfer emergency medical condition cases appropriately” or if they fail to report certain violations and fail to conspicuously post information required under the Act.<sup>63</sup> Typically, CMS must give at least 15 days’ notice before the termination takes effect.<sup>64</sup> In the case of immediate jeopardy,<sup>65</sup> however, CMS gives the hospital an initial 23 days’ notice of the termination.<sup>66</sup> If the deficiencies are not corrected, CMS gives another notice to the provider and the public<sup>67</sup> “at least 2, but not more than 4, days” prior to the termination of the provider agreement.<sup>68</sup>

Termination of a Medicare provider agreement can have massive consequences for a health care provider’s bottom line. In 2016, health care expenditures grew 4.3 percent to a whopping \$3.3 trillion.<sup>69</sup> This equated to \$10,348 per person and represented 17.9 percent of the GDP.<sup>70</sup> Of these remarkable numbers, Medicare alone accounted for 20 percent of the total national health expenditures and increased 3.6 percent to \$672.1 billion, in total.<sup>71</sup> During this same time, hospital expenses grew 4.7 percent to \$1.083 trillion in 2016, which was slower than the 5.9 percent increase in 2015.<sup>72</sup> Medicare funding is a crucial player in the health care market and recent

63. *Id.* § 489.53(b) (specifying notice requirements for individual rights and participation in the program).

64. *Id.* § 489.53(d).

65. Immediate jeopardy is “a situation in which the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a [patient].” *Id.* § 489.3.

66. *Id.* § 489.53(d)(2)(A).

67. The notice to both the provider and public “states the reasons for, and the effective date of, the termination, and explains the extent to which services may continue after that date.” *Id.* § 489.53(d)(3). As of October 1, 2017, CMS eliminated the old rule of publishing notice in local newspapers and elected to post termination notices on the CMS website for a period of six months to “reach the maximum number of people within a community.” Memorandum from David R. Wright, Dir., Survey & Certification Grp., Ctrs. for Medicare & Medicaid Servs., to State Survey Agency Dirs. (Aug. 18, 2017), <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-42.pdf>. Consequently, the public will have to go to the CMS website in order to receive notice of current provider agreement terminations. See *Termination Notices*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Termination-Notices.html> (last visited Aug. 11, 2018). For an example of the previously utilized local newspaper notice, see Evan Hendershot, *Agency Terminates Medicare Reimbursements for Rosebud Hospital*, DAILY REPUBLIC (Mar. 1, 2016, 7:38 PM), <http://www.mitchellrepublic.com/news/3959680-agency-terminates-medicare-reimbursements-rosebud-hospital> (discussing the termination of the provider agreement with Rosebud Hospital in South Dakota).

68. 42 C.F.R. § 489.53(d)(2)(i)(B).

69. *NHE Fact Sheet*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Apr. 17, 2018, 8:29 AM), <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealth-expenddata/nhe-fact-sheet.html>.

70. *Id.*

71. *Id.*

72. *Id.* (stating the comparative health expenditure growth rate in 2015 was 5.9%).

trends suggest health care spending in the United States will only continue to increase.<sup>73</sup>

C. *TRACKING CURRENT STATUTORY APPEAL RIGHTS FOR QUALIFYING  
MEDICARE PROVIDERS UNDER MEDICARE*

Providers who disagree with CMS's decision to terminate their provider agreement may appeal the termination to an ALJ.<sup>74</sup> The appeals process is often expensive.<sup>75</sup> Following the hearing and the ALJ's decision, the provider may then appeal to the Departmental Appeals Board, and if still left dissatisfied, the provider may seek judicial review of the Board's decision.<sup>76</sup> However, the statute does not stay termination of the provider agreement during the appeals process.<sup>77</sup> 42 U.S.C. § 405(h) spells out the judicial review available to providers, which is made applicable to Medicare by 42 U.S.C. § 1395ii.<sup>78</sup> Section 405(h) aims to lay out the sole means by which a court may review decisions to terminate a provider agreement in compliance with the process available in § 405(g).<sup>79</sup> Section 405(g) lays out the sole process of judicial review available in this type of dispute.<sup>80</sup>

73. CTRS. FOR MEDICARE & MEDICAID SERVS., NATIONAL HEALTH EXPENDITURE PROJECTIONS 2015-2025 1 (2015), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2015.pdf> ("Health spending is projected to grow 1.3 percent faster than Gross Domestic Product (GDP) per year over this period; as a result, the health share of GDP is expected to rise from 17.5 percent in 2014 to 20.1 percent by 2025.").

74. 42 C.F.R. §§ 489.53(e), 498.5(b) (2017).

75. Barbara L. Miltenberger & Lane A. Greer, *Practical Consideration for Appeals to the Departmental Appeals Board*, J. HEALTH CARE COMPLIANCE, Jan.-Feb. 2014, at 5, 7 ("Appeals to the DAB [Departmental Appeals Board] may be more expensive than expected."). Some strategies exist to reduce these expenses, but they may adversely affect the appealing party's outcome. *Id.* ("One way to reduce expenses is to forgo a hearing and submit the case either on the briefs and exhibits alone or by summary judgment.").

76. 42 C.F.R. § 498.5(c).

77. *Id.*; see also 42 C.F.R. § 489.53(e) (providing a right to appeal a termination but not providing for a stay pending such appeal).

78. 42 U.S.C. § 1395ii (2012).

79. 42 U.S.C. § 405(h). The statute establishes both exclusivity of judicial review under 405(g) and bars at least certain types of jurisdiction:

The findings and decision of the Commissioner of Social Security after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Commissioner of Social Security shall be reviewed by any person, tribunal, or governmental agency *except as herein provided*. No action against the United States, the Commissioner of Social Security, 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.

*Id.* (emphasis added); see also *Shalala v. Ill. Council on Long Term Care, Inc.*, 529 U.S. 1, 10 (2000) ("Section 405(h) purports to make exclusive the judicial review method set forth in § 405(g)."). For a discussion of the current circuit split concerning how expansive the jurisdiction bar is, see *infra* Section III.B.2.

80. 42 U.S.C. § 405(g). The statutory review procedure states that,

The Supreme Court has endorsed the process, for nearly two decades, since its decision in *Shalala v. Illinois Council on Long Term Care, Inc.*, holding that providers are required to abide by the provisions of § 405(g) providing for judicial review only *after* the administrative appeal process is complete.<sup>81</sup>

Even with existing appeal rights, providers must think carefully about whether, and how, to appeal.<sup>82</sup> Without a stay pending appeal, hospitals facing termination of their provider agreement, in reality, could be facing complete closure, because their appeal of CMS's decision to terminate their provider

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Any individual, after any final decision of the Commissioner of Social Security made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Commissioner of Social Security may allow.

*Id.* The statute further lays out proper venue, as well as fact-finding procedures, evidentiary requirements, and appeal rights. *See id.*

81. *Ill. Council*, 529 U.S. at 23–24. In upholding Medicare's administrative review procedures, the Court noted that,

The Council's members remain free, however, *after* following the special review route that the statutes prescribe, to contest in court the lawfulness of any regulation or statute upon which an agency determination depends. . . . And a court reviewing an agency determination under § 405(g) has adequate authority to resolve any statutory or constitutional contention that the agency does not, or cannot, decide, including, where necessary, the authority to develop an evidentiary record.

*Id.* (emphasis added) (citations omitted). But, providers *must* wait for agency decisions to be finalized before asking a court for relief. *Id.* at 24 ("At a minimum, however, the matter must be presented to the agency prior to review in a federal court."). This approach has been heavily criticized for violating providers' due process rights. *See generally, e.g.,* Ruqaiyah A. Yearby, *A Right to No Meaningful Review Under the Due Process Clause: The Aftermath of Judicial Deference to the Federal Administrative Agencies*, 16 HEALTH MATRIX 723 (2006) (evaluating constitutional and statutory problems presented by federal administrative agency reviews of Medicare compliance hearings). In the nursing home context, these due process rights were realized as a result of the legislative changes. *Id.* at 749 ("The evolution from an informal hearing process to a formal hearing process to challenge noncompliance findings reflects Congressional intent to provide nursing homes with procedural due process by providing a full evidentiary hearing."). However, following the decision in *Illinois Council*, nursing home appeals do not fully allow providers to exercise their due process rights. *Id.* at 765 ("Currently, HHS is not complying with the mandated hearing process of the Medicare regulations. . . . Nursing homes do not have the right to appeal determinations of noncompliance unless a certain remedy is imposed, although they are deprived of Medicare payments in later actions based of [sic] these findings.").

82. Miltenberger & Greer, *supra* note 75, at 9. The authors note unequivocally that appeal may be essential in many cases:

The first critical step in the process is determining whether or not to file an appeal. There are many considerations that go into this step. Initially, the provider must consider the consequences for failing to file an appeal. *In some cases, the consequences are so great that failing to file an appeal is essentially not an option.*

*Id.* (emphasis added).

agreement would be too slow and the contract will have already terminated by the time the appeal is resolved.<sup>83</sup> As some commentators adeptly put it:

The hospital has the right to appeal . . . but in the meantime, its cash flow could be reduced to a point where it cannot stay in business and provide its services to Medicare beneficiaries. The right to appeal CMS's decision is, in many instances, a meaningless right, because it takes years to proceed through the Medicare Program's appeals process. In the meantime, many hospitals risk being forced to close their doors during this time because they cannot pay their bills if Medicare does not pay them.<sup>84</sup>

The slow processing of these appeals and its impact on providers cannot be overstated. The Office of Medicare Hearings & Appeals ("OMHA") has seen substantial increases in the average processing time for any given appeal.<sup>85</sup> Just two years ago, Fiscal Year 2016, the average amount of time required to process a claim was an astonishing 877.2 days (nearly two and a half years).<sup>86</sup> Worse still, the most recent data shows the average amount of time required for Fiscal Year 2017 has increased in each quarter and the estimated time required for an ALJ's decision is 1,108.7 days (nearly three years).<sup>87</sup> Undoubtedly, having to wait almost three years before receiving a decision has a drastic effect on a provider, who depends on the outcome for its survival.

This problem causes harm beyond just the providers themselves. Community members and patients rely on these providers for care and, by extension, the provider agreement ensures the provider remains open to provide their care.<sup>88</sup> While some urban communities may be able to absorb a facility closure, most rural areas cannot.<sup>89</sup> This not only harms patients, who will no longer have easy access to health services, but also the community at large, as the hospitals are often crucial players in rural economies.<sup>90</sup> This could also negatively impact travel times for patients requiring specific

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83. 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, 31 (2015) ("[S]low resolution of the claim by the Medicare appeals process could be that hospital's death knell.").

84. *Id.* at 20.

85. *Average Processing Time by Fiscal Year*, U.S. DEP'T OF HEALTH & HUMAN SERVS., <https://www.hhs.gov/about/agencies/omha/about/current-workload/average-processing-time-by-fiscal-year/index.html> (last visited July 18, 2018) (providing a table showing a steady increase in the number of days required to process an appeal).

86. *Id.*

87. *Id.*

88. Maizel & Potere, *supra* note 83, at 31 (noting that without a Medicare provider agreement, many hospitals cannot remain operational).

89. George M. Holmes et al., *Underserved Populations: The Effect of Rural Hospital Closures on Community Economic Health*, 41 HEALTH RES. & EDUC. TR. 467, 467-68 (2006) ("[T]he closure of a hospital can have detrimental effects on a rural community.").

90. *Id.* at 477 (finding that a rural community that loses its only hospital also suffers a \$703 decrease in per capita income in 1990 currency).

procedures.<sup>91</sup> Thus, where a provider is forced to close before its appeal can be heard due to the termination of its provider agreement, significant harm is done to the entire community in which the provider practices. Of course, this does not mean that providers who are breaching regulatory requirements deserve to remain open; certainly, they do not and should be shuttered. Rather, this Note advocates only that an accused provider should not be punished before its appeal of CMS findings can be heard.

### III. THE SCRAMBLE TO SAVE THE PROVIDERS' AGREEMENT

Because there is no stay pending appeal and providers are required to exhaust all administrative remedies before they can get in to court, providers are left scrambling to preserve their provider agreements during the appeal process. Many providers rush to the nearest federal district court anyway, attempting to obtain a temporary restraining order (“TRO”) against CMS until the appeal is resolved. Others file bankruptcy in an attempt to protect their provider agreements. This section explores the judicial inefficiency created by the absence of a stay pending appeal in the Medicare provider appeal process. Section A demonstrates the varied outcomes in federal district courts for providers seeking TROs, and Section B outlines the process by which providers try to use bankruptcy law to save their agreements.

#### A. SPLIT AMONG COURTS GRANTING TROs AGAINST CMS

The danger posed by termination of a Medicare provider agreement is a very real threat, which leaves many providers with no other options but to run to a federal district court seeking an emergency TRO, to prevent CMS from terminating the provider agreement before the appeals process is complete. Generally, to be successful in seeking a TRO, the moving party:

[M]ust establish . . . (1) a substantial likelihood of success on the merits; (2) that irreparable injury will be suffered if the relief is not granted; (3) that the threatened injury outweighs the harm the relief would inflict on the non-movant; and (4) that entry of relief would serve the public interest.<sup>92</sup>

However, success in these cases is rare,<sup>93</sup> and many of the successful cases involve nursing homes, which represent only a fraction of the providers who

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91. See John D. Birkmeyer et al., *Regionalization of High-Risk Surgery and Implications for Patient Travel Times*, 290 J. AM. MED. ASS'N 2703, 2706 (2003) (noting that rural patients “travel[] significantly longer for surgery than patients living in nonrural areas”).

92. GOS Operator, LLC v. Sebelius, No. 12-0035-WS-N, 2012 WL 175056 at \*4 (S.D. Ala. Jan. 20, 2012); see FED. R. CIV. P. 65.

93. LAW OFFICES OF JASON M. HEALY, TERMINATION OF MEDICARE/MEDICAID PARTICIPATION AND PROVIDER CHALLENGES 1 (2012), [www.healylawdc.com/images/Appeals\\_Legal\\_Alert\\_-\\_Termination\\_of\\_Participation\\_Challenges\\_-\\_April\\_2012.pdf](http://www.healylawdc.com/images/Appeals_Legal_Alert_-_Termination_of_Participation_Challenges_-_April_2012.pdf).

contract with Medicare.<sup>94</sup> For example, in *GOS Operator, LLC v. Sebelius*,<sup>95</sup> the plaintiff operated a skilled nursing home, of which only a few residents were Medicare beneficiaries whose payment was governed by a Medicare provider agreement with CMS.<sup>96</sup> After multiple surveys conducted by the Alabama Department of Public Health (“ADPH”), the facility received a letter on December 2, 2011, stating that ADPH recommended “[t]ermination of [their] provider agreement effective January 21, 2012, unless [they] achieve[d] substantial compliance before that date.”<sup>97</sup> The facility was revisited January 4–8, 2012, and was notified via letter dated January 18, 2012, that CMS would be moving forward with termination effective January 21, 2012, a mere three days later.<sup>98</sup> Even though the facility initiated an appeal seven days prior, CMS “apparently intend[ed] to terminate the Provider Agreement.”<sup>99</sup> Because CMS indicated that it would move forward with termination despite the appeal, the provider was forced to initiate the lawsuit seeking emergency injunctive relief to prevent the termination of the contract.<sup>100</sup> The facility did not request any ruling on the merits of the decision to terminate and instead “[sought] only to preserve the status quo pending the outcome of the administrative hearing” by enjoining [CMS] from terminating . . . [the] provider agreements ‘until its challenges to [CMS’s] actions have been heard and decided by an administrative law judge . . . .’”<sup>101</sup>

Proceeding under that framework, the court then analyzed the provider’s claim. The court had no trouble finding irreparable harm, concluding that the absence of a TRO would be “both irreparable and potentially catastrophic.”<sup>102</sup> Next, the court found there would be a substantial likelihood of success on the merits, based solely on a claim that CMS violated the provider’s procedural due process rights, specifically recognizing the precarious situation this Note seeks to remedy:

The problem is that no administrative hearing will occur before the termination of [the] Provider Agreement. Given the parade of

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94. *What Part A Covers*, MEDICARE.GOV, <https://www.medicare.gov/what-medicare-covers/part-a/what-part-a-covers.html> (last visited Aug. 13, 2018) (noting that Medicare Part A providers alone include hospitals, skilled nursing facilities, nursing homes, hospice, and home health services).

95. *GOS Operator*, 2012 WL 175056, at \*6 (granting provider nursing home’s request for a TRO against CMS). Other courts have reached similar conclusions in granting a TRO against CMS. *See* *Peak Med. Okla. No. 5, Inc. v. Sebelius*, No. 10–CV–597–TCK–PJC, 2010 WL 4809319, at \*1, \*5 (N.D. Okla. Nov. 18, 2010); *Ridgeview Manor of Midlands, L.P. v. Leavitt*, No. 3:07-cv-861-JFA, 2007 WL 1110915, at \*9 (D.S.C. Apr. 9, 2007).

96. *GOS Operator*, 2012 WL 175056, at \*1.

97. *Id.* (first alteration in original).

98. *Id.* at \*2.

99. *Id.* at \*3.

100. *Id.*

101. *Id.* (quoting Verified Complaint for Injunctive Relief and Mandamus ¶ 6, *GOS Operator, LLC v. Sebelius*, 2012 WL 175056 (S.D. Ala. Jan. 20, 2012) (No. 12–0035–WS–N)).

102. *Id.* at \*4.

horribles that plaintiff shows is substantially certain to be triggered by such termination, by the time any administrative hearing happens, it will be too late to put Humpty Dumpty back together again. [The Provider] will be shut down, its business destroyed, its residents uprooted and scattered to the four winds, and its operator likely in bankruptcy. To afford plaintiff an administrative hearing only after these devastating events have already occurred would be a futile, empty, hollow exercise.<sup>103</sup>

In balancing the harms and weighing the public interest, the court concluded that there was “no indication that defendants will be harmed in any respect” and the public interest was in favor of the provider to prevent “transfer trauma,” as a result of having to move all of the residents to a new facility.<sup>104</sup>

Nonetheless, the fact some courts seem to recognize the problem facing providers in these situations and issue TROs offers little hope in the face of the nearly impossible task that is trying to operate as a health facility without a Medicare provider agreement.<sup>105</sup> Other providers have not been so successful. In a case similar to *GOS Operator*, a provider filed suit against CMS three days before it faced the termination of its provider agreement, but the district court did not grant the TRO.<sup>106</sup> Avoiding what it called an “interesting” jurisdictional argument, the court decided the claim using the same framework for a TRO as discussed above.<sup>107</sup> In *Somerset Place, LLC*, the Secretary did “not contest that Somerset ha[d] a protectable property interest; rather . . . that the procedures available to [the Provider] ‘fully satisf[y] the constitutional requirements for due process.’”<sup>108</sup> The Court found that opportunities to submit plans or corrections, and the conditional

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103. *Id.* at \*5.

104. *Id.*

105. Commentators have noted the difficult choices facing providers whose provider agreements are terminated by CMS:

In termination cases, the provider also must consider whether to file a companion case in federal court to attempt to obtain a temporary restraining order . . . or a preliminary injunction to stop the termination until a decision can be heard on the merits. The provider should be prepared for a Motion to Dismiss filed by CMS for lack of jurisdiction, arguing that the provider must first go through the administrative appeal process before submitting the case to federal court. In the meantime, the termination will not be stopped. While this is a difficult hurdle, some providers have prevailed in federal court actions.

Miltenberger & Greer, *supra* note 75, at 9.

106. *Somerset Place, LLC v. Sebelius*, 684 F. Supp. 2d 1037, 1038 (N.D. Ill. 2010). Some courts have declined to issue the TRO based on jurisdictional question. *See* *Forum Healthcare Grp. v. Ctrs. for Medicare & Medicaid Servs.*, 495 F. Supp. 2d 1321, 1326 (N.D. Ga. 2007) (“[T]he Court lacks jurisdiction to address Plaintiffs’ claim for an injunction.”).

107. *See supra* note 92 and accompanying text.

108. *Somerset Place*, 684 F. Supp. 2d at 1041 (quoting Defendants’ Memorandum in Support of Motion to Dismiss and in Opposition to Plaintiffs’ Motion for a Temporary Restraining Order at 15, *Somerset Place*, 684 F. Supp. 2d 1037 (No. 10-764)).

acceptance of one of these plans, was enough to satisfy Somerset's due process rights.<sup>109</sup> On irreparable harm, moreover, the court found that even though the provider funded its operations with money received in the previous 60 days, "it is not clear that [the Provider] will not be made whole in the event the ALJ rules in its favor."<sup>110</sup> Finally, the court determined that the Secretary's determination that the facility posed a harm to their residents could not be "disregarded lightly" and denied the provider's request for the TRO.<sup>111</sup>

*B. PROVIDER ATTEMPTS TO USE BANKRUPTCY LAW FOR PROTECTION*

When confronted with a failed or dissolved TRO, some providers next try to protect their provider agreements through bankruptcy proceedings. Such was the case for Bayou Shores, a skilled nursing facility. Bayou Shores was forced to take swift action when DHS provided just one week's notice that it would terminate Bayou Shores' provider agreement.<sup>112</sup> Initially, Bayou Shores successfully obtained a TRO against DHS to prevent it from terminating its provider agreement.<sup>113</sup> However, the order was dissolved just two weeks later when DHS challenged the district court's jurisdiction to hear the case on the grounds that Bayou Shores was first required to exhaust its administrative remedies before seeking judicial review of the termination of its provider agreement.<sup>114</sup> Bayou Shores was subsequently denied a stay pending appeal.<sup>115</sup> Almost immediately after the TRO order was dissolved, Bayou Shores filed for Chapter 11 Bankruptcy in a new attempt to protect its provider agreement through the automatic stay mechanism in bankruptcy law.<sup>116</sup> Many providers take this route, but it is often unsuccessful.<sup>117</sup> This

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109. *Id.* at 1041–42.

110. *Id.* at 1043. The court seemed to operate on the notion that the provider's request for an expedited hearing with an ALJ would be granted. *See id.*

111. *Id.*

112. Shawn M. Riley & T. Daniel Reynolds, *Code Can Protect Your Medicare and Medicaid Provider Agreement*, AM. BANKRUPTCY INST. J., May 2015, at 16, 16.

113. Bayou Shores SNF, LLC v. Burwell, No. 8:14-cv-1849-T-33MAP, 2014 WL 12597033, at \*1 (M.D. Fla. Aug. 1, 2014), order dissolved, No. 8:14-CV-1849-T-33MAP, 2014 WL 4059900 (M.D. Fla. Aug. 15, 2014).

114. Bayou Shores SNF, LLC v. Burwell, No. 8:14-cv-1849-T-33MAP, 2014 WL 4059900, at \*1, \*3–4 (M.D. Fla. Aug. 15, 2014) ("Judicial review of claims arising under the Medicare Act is available only after the Secretary renders a 'final decision' on the claim." (quoting Heckler v. Ringer, 466 U.S. 602, 605 (1984))).

115. Bayou Shores SNF, LLC v. Burwell, No. 8:14-cv-1849-T-33MAP, 2014 WL 4101761, at \*1, \*5 (M.D. Fla. Aug. 20, 2014).

116. *In re* Bayou Shores SNF, LLC, 525 B.R. 160, 165 (Bankr. M.D. Fla. 2014) ("Mere hours after the district court dissolved the temporary restraining order, [Bayou Shores] filed this chapter 11 case. . . . [T]he Debtor sought a ruling from this Court that the automatic stay precluded termination of its Medicare provider agreement." (emphasis added)).

117. *See, e.g., In re* St. Johns Home Health Agency, Inc., 173 B.R. 238, 243–44 (Bankr. S.D. Fla. 1994) (finding the court lacked jurisdiction for the provider's claim, and noting "the possibility that [the provider's] administrative remedy may not provide relief as quickly as St. Johns . . . may require



section first explores the automatic stay provided in bankruptcy law and then explains why this approach alone is insufficient for providers attempting to save their provider agreements from termination during the administrative appeals process.

### 1. Bankruptcy Law's Automatic Stay

Some health providers facing termination of their provider agreement file bankruptcy in an attempt to utilize Chapter 11's automatic stay provisions. While this may seem unconventional, providers are often forced to try any feasible option to preserve their agreements, given the severe consequences of losing federal payments during an appeal. The jump into bankruptcy law as a protection of last resort underscores the problems with the current Medicare appeals process.

Under bankruptcy law, once claims are filed, several of the debtor's assets become subject to an automatic stay.<sup>118</sup> The protection of the automatic stay includes, among other things, "the commencement or continuation, including issuance or employment of process, of a judicial, administrative, or other action or proceeding against the debtor . . . or to recover a claim against the debtor that arose before the commencement of the case under this title."<sup>119</sup> Thus, at first, bankruptcy law seems like a viable option for a provider looking to guard its Medicare provider agreement while it appeals through the current statutory scheme.

However, even though the automatic stay is expansive, it is not all-inclusive.<sup>120</sup> Specifically, one of the largest exceptions the bankruptcy statute carves out of the automatic stay provides no protection for actions where "the commencement or continuation of an action or proceeding [is brought] . . . to enforce [a] governmental unit's or organization's police and regulatory power, including the enforcement of a judgment other than a money judgment."<sup>121</sup> Thus, a provider relying on bankruptcy law as a means to protect their provider agreement may find that such protection is not available to them.<sup>122</sup>

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to survive, is one of the potentially unfortunate consequences of doing business in a heavily regulated field where compensation is highly dependent on administrative processes").

118. 11 U.S.C. § 362(a) (2012).

119. *Id.* § 362(a)(1).

120. *See id.* § 362(b) (noting the exceptions to the automatic stay in § 362(a)).

121. *Id.* § 362(b)(4).

122. Providers try to avail themselves of the bankruptcy court through 28 U.S.C. § 1334's exclusive jurisdiction provision. *See* 28 U.S.C. § 1334. But, even if providers could escape the jurisdictional problems, the First Circuit has recently demonstrated why even the substantive provisions of the automatic stay may not protect providers. *See infra* notes 171–82 and accompanying text.

## 2. Bankruptcy Protection is Not an Adequate Solution

Courts presented with questions about a provider's use of bankruptcy law for protection have left the problem even murkier. While filing for bankruptcy to take advantage of the automatic stay is undoubtedly creative lawyering to preserve a provider's Medicare contract, it is not a sure-fire protection. For example, in some locales, providers face jurisdictional challenges to bringing claims, while other jurisdictions do not allow the application of the automatic stay to cover Medicare provider agreements.<sup>123</sup>

Bayou Shores faced such a jurisdictional battle.<sup>124</sup> Recall that Bayou Shores originally sought and successfully obtained a TRO against CMS to prevent termination of its Medicare provider agreement.<sup>125</sup> Once the TRO was dissolved, Bayou Shores immediately filed for Chapter 11 bankruptcy.<sup>126</sup> The Department of Health and Human Services ("DHHS"), however, challenged the bankruptcy court's subject-matter jurisdiction.<sup>127</sup> The district court acknowledged "[i]t is true that federal courts are generally precluded from exercising federal question jurisdiction over Medicare issues."<sup>128</sup> Nevertheless, the court found it had "independent" jurisdiction based on 28 U.S.C. § 1334,<sup>129</sup> which provided jurisdiction for "all civil proceedings arising under title 11, arising in a case under title 11, or related to a proceeding under title 11."<sup>130</sup> According to the court, when Congress enacted § 1334 in 1984, it did not prevent district courts from exercising bankruptcy jurisdiction over Medicare disputes, including provider agreements.<sup>131</sup> The court acknowledged that other courts have come out the other way on the jurisdictional question<sup>132</sup> but found that the statutory language of 42 U.S.C. § 405(h) is unambiguous and did not preclude bankruptcy jurisdiction over

123. See *infra* notes 138–60 and accompanying text.

124. *In re Bayou Shores SNF, LLC*, 828 F.3d 1297, 1300 (11th Cir. 2016), *cert. denied sub nom. Bayou Shores SNF, LLC v. Fla. Agency for Health Care Admin.*, 137 S. Ct. 2214, 2214 (2017).

125. *Bayou Shores SNF, LLC v. Burwell*, No. 8:14-cv-1849-T-33MAP, 2014 WL 12597033, at \*1 (M.D. Fla. Aug. 1, 2014).

126. *In re Bayou Shores SNF, LLC*, 525 B.R. 160, 165 (Bankr. M.D. Fla. 2014).

127. *Id.* at 165–66. DHHS specifically claimed that "no court has any jurisdiction over any aspect of a Medicare determination, other than to perform a prescribed form of judicial review of a final administrative decision by the Secretary." *Id.*

128. *Id.* at 166 (citing 42 U.S.C. § 405(h)).

129. *Id.*

130. *Id.*

131. See *id.* at 167 ("[N]othing in 42 U.S.C. § 405(h) precludes a court from exercising bankruptcy jurisdiction over Medicare disputes under 28 U.S.C. § 1334." (citing *First Am. Health Care of Ga., Inc., v. U.S. Dep't of Health & Human Servs.*, 208 B.R. 985, 988–89 (Bankr. S.D. Ga. 1996), *vacated on other grounds by First Am. Health Care of Ga., Inc., v. U.S. Dep't of Health & Human Servs.*, No. 96-2007, 1996 WL 282149, at \*2 (Bankr. S.D. Ga. Mar. 11, 1996))).

132. *Id.* (noting that other courts have declined jurisdiction, holding instead that the failing to include section 1334 in the jurisdiction bar of 42 U.S.C. § 405(h) was "essentially a scrivener's error").

Medicare provider agreements.<sup>133</sup> Furthermore, the court found that it was not reviewing any findings of fact or agency decision and thus § 405(h) simply did not apply.<sup>134</sup> Accordingly, because Bayou Shores filed under Chapter 11, the court determined it had jurisdiction over the case, and that the disputed Medicare provider agreements fell under that jurisdiction granted by § 1334.<sup>135</sup> Reaching the merits, the court found that Bayou Shores could resume its Medicare provider agreement.<sup>136</sup> Ironically, the court's decision hung on the fact that the Medicare appeals process had not been completed by the time the bankruptcy petition was filed in the district court.<sup>137</sup>

While the jurisdictional finding was a huge win for Bayou Shores, it was short-lived. On appeal to the U.S. District Court for the Middle District of Florida, the court found that the bankruptcy court was barred from exercising subject-matter jurisdiction under § 405(h).<sup>138</sup> The district court disagreed with the bankruptcy court's determination it had jurisdiction "because it ignore[d] the jurisdictional bar contained in the Medicare Act."<sup>139</sup> The court concluded that Bayou Shores "did not exhaust its administrative remedies" before seeking judicial review and thus violated 42 U.S.C. § 405(g), which prevented the bankruptcy court from exercising jurisdiction.<sup>140</sup> The court adopted the majority view that the omission of § 1334 from § 405(h) goes against Congress' intent in enacting the statute.<sup>141</sup>

Bayou Shores appealed to the Eleventh Circuit Court of Appeals, which reviewed the case as a matter of first impression in the circuit.<sup>142</sup> The court's analysis focused on the jurisdiction question.<sup>143</sup> In considering whether § 405(h) barred jurisdiction under 28 U.S.C. § 1334, the court began by looking to the legislative history of § 405(h).<sup>144</sup> The statutory language at issue in § 405(h) provides that "[n]o action against the United States, the Commissioner of Social Security, or any officer or employee thereof shall be brought *under section 1331 or 1346 of title 28* to recover on any claim arising

133. *Id.*

134. *Id.* at 168.

135. *Id.* at 166–67.

136. *Id.* at 168–70.

137. *Id.* at 169 ("Here, the [Medicare provider agreement] appeals process was not complete prepetition. So termination of the Medicare provider agreement in this case was not complete and irreversible as of the petition date. For that reason, the Medicare provider agreement is subject to being assumed.").

138. *In re Bayou Shores*, 533 B.R. 337, 339 (M.D. Fla. 2015).

139. *Id.* at 341.

140. *Id.*

141. *Id.* at 342.

142. *In re Bayou Shores SNF, LLC*, 828 F.3d 1297, 1300, 1303 (11th Cir. 2016), *cert. denied sub nom.*, *Bayou Shores SNF, LLC v. Fla. Agency for Health Care Admin.*, 137 S. Ct. 2214, 2214 (2017); *In re Bayou Shores*, 533 B.R. at 342 ("The Eleventh Circuit has not directly addressed this issue.").

143. *In re Bayou Shores*, 828 F.3d at 1300 ("The appeal turns on the jurisdictional question.").

144. *See id.* at 1304.

under this subchapter.”<sup>145</sup> As Bayou Shores argued, § 1334 is noticeably absent from the express language of the statute and therefore the jurisdiction bar of § 405(h) should not apply.<sup>146</sup> The Eleventh Circuit rejected this argument, finding that the legislative history of § 405(h) betrayed any notion that Congress intentionally omitted § 1334 in order to allow bankruptcy courts to assume jurisdiction over Medicare claims. Digging into the statute’s origins, the court explained that originally, when the Medicare Act was passed in 1939, the language of the statute provided that “[n]o action against the United States, the Board, or any officer or employee thereof shall be brought under section 24 of the Judicial Code of the United States to recover on any claim arising under this title.”<sup>147</sup> This difference, though seemingly innocuous, was “crucial” because “[i]n 1939, ‘section 24 of the Judicial Code’ defined the original jurisdiction granted to district courts, *including* jurisdiction over bankruptcy claims.”<sup>148</sup> Therefore, the original version of § 405(h) barred a district court from invoking bankruptcy jurisdiction over Medicare claims.<sup>149</sup> The court reasoned that the omission of § 1334 was due to a scrivener’s error and that Congress’s intent was to maintain the extension of § 405(h)’s jurisdictional bar to bankruptcy cases.<sup>150</sup>

This did not end the inquiry. Many of the cases addressing the scope of § 405(h) had not expressly addressed whether that section barred jurisdiction under § 1334, and no Eleventh Circuit decision was directly on point.<sup>151</sup> Turning to other jurisdictions for guidance, the court uncovered yet another area of law where providers are left wondering how to proceed. Much like district courts in granting TROs,<sup>152</sup> the circuit courts are split on the question of whether § 405(h) bars jurisdiction under § 1334.<sup>153</sup> The majority of circuits considering the question have held that § 405(h) bars jurisdiction. The Seventh Circuit led the way in *Bodimetric Health Services, Inc. v. Aetna Life & Casualty*. Initially, the Seventh Circuit contemplated whether § 405(h)

145. 42 U.S.C. § 405(h) (2012); *In re Bayou Shores*, 828 F.3d at 1304.

146. *In re Bayou Shores*, 828 F.3d at 1305.

147. *Id.* (quoting Social Security Act Amendments of 1939, Pub. L. No. 76-379, § 205(h), 53 Stat. 1360, 1379 (1939)).

148. *Id.* (emphasis added).

149. *Id.*

150. *See id.* at 1305–10 (explaining that the omission of 28 U.S.C. § 1334 during recodification of section 405(h) was contrary to Congressional intent and is now widely recognized as erroneous).

151. *Id.* at 1310.

152. *See supra* Section III.A.

153. *In re Bayou Shores*, 828 F.3d at 1310. The circuit split can be categorized into two groups:

The first group of cases holds that the jurisdictional bar of § 405(h) applies to cases brought under § 1332 jurisdiction (i.e., diversity jurisdiction), notwithstanding the fact that § 1332 (like § 1334) is not mentioned in the statute. The second group of cases directly considers whether § 1334 jurisdiction can lie in the face of § 405(h).

*Id.* Scholarship on the issue is also, unsurprisingly, split. *Id.* at 1313.

barred jurisdiction under 28 U.S.C. § 1332.<sup>154</sup> The *Bodimetric* court observed, “[c]uriously, this section, on its face, appears to bar actions brought pursuant to federal question jurisdiction and actions brought against the United States but appears to permit actions brought pursuant to diversity jurisdiction.”<sup>155</sup> Even with this observation in mind, the court found that “a close reading of the statute (and its legislative history) does not support such a straightforward result.”<sup>156</sup> Continuing its analysis of the legislative history, the Seventh Circuit concluded that under the original version of § 405(h), “there was little question” that such claims were barred.<sup>157</sup> The court found that when it enacted corrections to the original Act, Congress did not intend the corrections to be interpreted as substantive changes by the courts.<sup>158</sup> Thus, the court concluded that interpreting the newly revised language of § 405(h) would fly in the face of Congressional intent when enacting the legislation.<sup>159</sup> The Third and Eighth Circuits have reached the same conclusion.<sup>160</sup>

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154. *Bodimetric Health Servs., Inc. v. Aetna Life & Cas.*, 903 F.2d 480, 488 (7th Cir. 1990).

155. *Id.*

156. *Id.*

157. *Id.*

158. *Id.* at 489 (“At the same time [of the revisions to the original Act], Congress cautioned the courts not to interpret DEFRA’s ‘Technical Corrections’ as substantive changes . . .”).

159. *Id.* at 489–90 (“Because the previous version of section 405(h) precluded judicial review of diversity actions, so too must newly revised section 405(h) bar these actions . . . [t]he district court . . . properly found that it lacked subject matter jurisdiction to consider Bodimetric’s claims.”).

160. See *Nichole Med. Equip. & Supply, Inc. v. TriCenturion Inc.*, 694 F.3d 340, 346 (3d Cir. 2012) (“[T]he language may at first appear to bar only jurisdiction under §§ 1331 or 1346 of Title 28. However, it is clear that the changes enacted in 1976 were intended only as ‘technical corrections’ and they were therefore not intended to make any substantive change in the statute.”); *Midland Psychiatric Assocs., Inc. v. United States*, 145 F.3d 1000, 1004 (8th Cir. 1998) (“[D]espite its literal wording, sentence three of § 405(h) bars claims based on diversity of citizenship under 28 U.S.C. § 1332 . . . [Congress] labeled the amendment a technical correction, and at the same time made clear that no substantive change in the law was intended.”). Some commentators (though current and former employees of DHHS) argue that this holding is the proper application of § 405(h):

Although the text of section 405(h) seems to extend only to 28 U.S.C. §§ 1331 and 1346, Congress, in fact, set out an exceptionally broad jurisdictional bar for claims arising under the Medicare Act, barring no less than thirty-two separate bases of jurisdiction, including 28 U.S.C. §§ 1332 (diversity) and 1334 (bankruptcy).

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, 128 (2000). Cogan and Johnson argue that allowing jurisdiction under § 405(h) is contrary to legislative intent and has led other courts to reject such holdings. *Id.* at 149 (“Surprisingly, the . . . court arrived at its conclusion without considering (or even discussing) Congress’ directive on construction of the technical correction contained in section 2664, the section’s history, or the overall legislative scheme of the Medicare Act.”). The authors further argue that even aside from the legislative history, the interpretation is actually contrary to the plain meaning of the amending statute and thus is an incorrect application of § 405(h):

This “obvious” conclusion [from *In re Healthback*], however, is not supported by the language of the technical amendment. Although the *Healthback* court purportedly

The circuit courts, however, are not unanimous.<sup>161</sup> The Ninth Circuit, for example, has held that jurisdiction is not barred by § 405(h).<sup>162</sup> In that case, the court had no trouble finding that the exclusions of § 405(h) did not bar jurisdiction under § 1334.<sup>163</sup> Rather than analyzing the legislative history, the court looked at the plain language of the statute.<sup>164</sup> Armed with the text, the court held, “[s]ection 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.”<sup>165</sup>

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identified a “procedure/substance” distinction within the technical correction, Congress expressed no such distinction in sections 2663 or 2664, or for that matter, in any other part of the Medicare or Social Security Acts. Indeed, the language in section 2664, that “none of such amendments shall be construed as changing or affecting . . . interpretation which existed,” admits of no exceptions, and states quite clearly that Congress intended none of the statutes corrected by section 2663 to be interpreted any differently as a result of the technical correction.

*Id.* at 150–51 (second alteration in original).

161. It is important to note, too, that not all circuits have had the opportunity to consider this question.

162. *In re Town & Country Home Nursing Servs., Inc.*, 963 F.2d 1146, 1155 (9th Cir. 1991).

163. *Id.* at 1155 (“The Secretary’s argument based on 42 U.S.C. § 405(h) is . . . unpersuasive.”).

164. *Id.*

165. *Id.* The court rested its decision in part on the unique nature of bankruptcy jurisdiction:

The language of section 1334(b) grants jurisdiction . . . to the bankruptcy court[ . . . and accords with “the intent of Congress to bring all bankruptcy-related litigation within the umbrella of the district court, . . . irrespective of congressional statements to the contrary in the context of other specialized litigation.”

*Id.* (citations omitted) (quoting Collier on Bankruptcy ¶ 3.01 (15th ed. 1991)). This view also has some scholarly support. Acknowledging that the majority of cases “appear[] to favor an expansive interpretation of the section 405 jurisdictional bar in bankruptcy cases,” one author suggests the plain meaning of the statutory language requires the result reached by the Ninth Circuit. See Peter R. Roest, *Recovery of Medicare and Medicaid Overpayments in Bankruptcy*, 10 ANNALS HEALTH L. 1, 56–57 (2001) (“[S]ection 405(h) refers only to 28 U.S.C. §§ 1331 (federal question jurisdiction) and 1346 . . . . Under the Supreme Court’s ‘plain meaning’ doctrine, section 405(h) should be read literally as affecting federal court jurisdiction only as to the two jurisdictional statutes to which it specifically refers.”). The evaluation of the legislative history when the statute plainly does not exclude § 1334 is “inappropriate,” and therefore bankruptcy courts do have jurisdiction to hear the provider agreement claims. *Id.* at 59–60 (“Because section 405(h) is clear on its face, resort to any other source to determine its meaning is inappropriate.”). Other commentators were likewise encouraged by the decision of the bankruptcy court’s initial interpretation of 405(h) in *In re Bayou Shores*:

If bankruptcy courts continue to [find the jurisdictional bar does not apply], then filing for bankruptcy would become an important option available to health care providers and suppliers to resolve disputes with CMS and the Medicare Program when they would otherwise go out of business absent the speedy resolution of these disputes.

Maizel & Potere, *supra* note 83, at 20 (emphasis added). These authors again note that the plain meaning of language in section 405(h) is the only proper way for courts to proceed. *Id.* at 46 (“[I]t is not ‘absurd’ to have a bankruptcy exception to Medicare’s exhaustion requirement, particularly in light of the harm that can arise to the debtor due to stopped Medicare payments during the lengthy Medicare review process.” (footnote omitted)).

This is similar to the reasoning the bankruptcy court used when it held it had jurisdiction to hear Bayou Shores' case.<sup>166</sup>

It was against this backdrop that the Eleventh Circuit decided the question in *Bayou Shores*. Despite the plain language of the statute, the court held that the legislative history of the statute required barring jurisdiction under § 405(h), joining the majority of its sister circuits.<sup>167</sup> The court found that Congress clearly instructed no changes to the statute were intended to be substantive.<sup>168</sup>

Because of this circuit split, and varied holdings in federal district courts, reliance on bankruptcy jurisdiction under § 405(h) is, at best, a shot in the dark and, at worst, a means of incurring extra expense in an already expensive attempt to protect the Medicare provider agreement while awaiting the administrative appeal results.<sup>169</sup> Even though the circuits deciding this question have established a majority rule barring jurisdiction under § 405(h), the issue remains unsettled because the Supreme Court has not addressed it.<sup>170</sup>

The jurisdictional question aside, the First Circuit has recently provided an additional reason to think that health care providers will be unable to use bankruptcy law to protect their provider agreements. Parkview Adventist Medical Center ("Parkview") appealed a lower court decision affirming the termination of its provider agreement.<sup>171</sup> Among other things, Parkview claimed the termination of its provider agreement violated bankruptcy law's automatic stay.<sup>172</sup> However, rather than address the circuit split to resolve whether or not the court could retain jurisdiction under § 405(h), the First Circuit instead "assume[d] hypothetical jurisdiction" to reach Parkview's claims on the merits.<sup>173</sup> The court resolved the case by analyzing whether or not the termination of Parkview's provider agreement violated the automatic stay, finding that Parkview should be denied relief "because the record is clear that CMS did not violate the automatic stay provision."<sup>174</sup> Parkview was unable

166. See *In re Bayou Shores SNF, LLC*, 525 B.R. 160, 166 (Bankr. M.D. Fla. 2014) (finding that because § 1334 was not expressly barred in the statutory language, jurisdiction was proper).

167. *In re Bayou Shores SNF, LLC*, 828 F.3d 1297, 1314–22 (11th Cir. 2016), cert. denied sub nom., *Bayou Shores SNF, LLC v. Fla. Agency for Health Care Admin.*, 137 S. Ct. 2214, 2214 (2017).

168. *Id.* at 1319.

169. This Note expresses no view on which line of reasoning related the jurisdictional bar of § 405(h) is correct. Its discussion serves only to underscore the uncertainty of the doctrine in that area of the law and its compounding effect on the predicament providers continue to face when threatened with termination of their provider agreement.

170. *In re Bayou Shores*, 828 F.3d at 1297.

171. *Parkview Adventist Med. Ctr. v. United States ex rel. Dep't of Health & Human Servs.*, 842 F.3d 757, 758–59 (1st Cir. 2016).

172. *Id.* at 759; see also *supra* Section III.B.1 (explaining the automatic stay).

173. *Parkview Adventist Med. Ctr.*, 842 F.3d at 760 ("Rather than add our voice to the circuit split on this difficult issue, we choose to resolve this case on narrower grounds evident from the record.")

174. *Id.* at 760–61.

to avail itself of the protection of the automatic stay because its provider agreement fell into one of the statutory exceptions.<sup>175</sup> Rather than addressing Parkview's argument that the provider agreement is an executory contract<sup>176</sup> that could not be "involuntarily terminate[d],"<sup>177</sup> the court addressed only the government's argument that the provider agreement would fall under the "police and regulatory power" exception under 11 U.S.C. § 362(b)(4).<sup>178</sup>

To determine whether the provider agreement fell into the exception, the court had to decide if CMS's decision to terminate "[was] designed primarily to protect the public safety and welfare."<sup>179</sup> The Court agreed with CMS,<sup>180</sup> finding that termination fit within the exception because CMS terminated in accordance with its statutory authority under the Medicare Act.<sup>181</sup> The court, however, went one step further, effectively slamming the door on future attempts by providers to save their provider agreements through the automatic stay. According to the court, it was well within the police and regulatory power exception to block providers from abusing the bankruptcy protection to avoid CMS termination.<sup>182</sup>

This ruling spells trouble for providers looking for protection under bankruptcy law. It raises flags that courts, even if they have jurisdiction, may still find that bankruptcy law cannot protect provider agreements, despite the

175. *Id.* ("The statutory 'police and regulatory power' exception to the automatic stay under 11 U.S.C. § 362(b)(4) plainly applies.").

176. Executory contracts are given special treatment in bankruptcy law, allowing trustees to reject or accept them with court approval. 11 U.S.C. § 365 (2012). But the provision itself does not define what constitutes an executory contract. "Executory contracts, although not defined in the Bankruptcy Code, are generally considered to be contracts 'on which performance is due to some extent on both sides.'" *In re Tempnology, LLC*, 879 F.3d 389, 395 (1st Cir. 2018) (quoting *In re FBI Distribution Corp.*, 330 F.3d 36, 40 n.5 (1st Cir. 2003)). Because of this, "[c]ourts generally apply one of two tests to evaluate whether a contract is executory for the purposes of section 365 of the Code—the Countryman test and the Functional Test." *In re Cho*, 581 B.R. 452, 461 (Bankr. D. Md. 2018). "Under the Countryman test, courts evaluate whether both parties have unperformed obligations under the contract . . . . Under the Functional test, courts do not consider whether the contract is executory, but simply ask whether assumption or rejection of the contract provides a benefit to the estate." *Id.* at 461 n.16.

177. *Parkview Adventist Med. Ctr.*, 842 F.3d at 763.

178. *Id.* For the substantive provisions of this exception, see *supra* note 121 and accompanying text.

179. *Parkview Adventist Med. Ctr.*, 842 F.3d at 763 (quoting *In re McMullen*, 386 F.3d 320, 325 (1st Cir. 2004)).

180. *Id.* at 764.

181. *Id.*

182. *Id.* The First Circuit bluntly rejected Parkview's attempt to secure a stay, noting that:

[O]ne could reasonably view Parkview's petition as being made for the purpose of evading CMS's efforts to secure compliance with the Medicare statute—exactly the kind of action the police and regulatory power exception is meant to prevent. Because CMS's termination of the Provider Agreement enforced the generally applicable framework of the Medicare statute and advanced a significant public policy interest, the police and regulatory power exception applies, and the automatic stay does not bar the termination.

*Id.* (citation omitted).



arduous burden providers face. Combined with the aforementioned jurisdictional disputes, providers considering bankruptcy law to protect their Medicare provider agreements face a steep uphill battle.<sup>183</sup>

#### IV. A STATUTORY SOLUTION

##### A. IMPLEMENTING A STAY PENDING APPEAL

The current appeals procedures provided for in the Social Security Act and Department of Health and Human Services regulations are insufficient to protect providers from the potentially devastating effects of a premature termination. The current system creates an environment in which a provider may close because CMS terminates their agreement before review of the decision.<sup>184</sup> This danger exists because the termination date will almost undoubtedly occur before any sort of administrative review,<sup>185</sup> shuttering the provider entirely<sup>186</sup> without a ruling from an ALJ on its challenge to CMS's findings. Thus, a provider could reasonably face a scenario in which it is successful in its appeal against CMS, although simply too late. This creates an appeal right without teeth, a mere smoke screen in the name of due process. Medicare contracts are too crucial a part of health care enterprises in the United States to take this risk.<sup>187</sup>

Furthermore, this system has led to judicial inefficiency and chaos in federal district courts with providers rushing in to try and obtain TROs against CMS.<sup>188</sup> But, who can blame the providers in this precarious situation? Faced with closing due to their provider agreements being terminated or rushing into a federal district court in a last-ditch attempt to save their contract, it is easy to see why courts see these claims. The fact that the statute essentially requires this scenario is grounds for concern.

The fact that the statute may incentivize a company to declare bankruptcy in order to avail itself of the automatic stay and bankruptcy protections is even more offensive.<sup>189</sup> It seems a matter of common sense that any meaningful

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183. See Jason W. Harbour & Shannon E. Daily, *First Circuit Declines to Weigh in on Bankruptcy Court Jurisdiction Over Medicare Provider Agreements*, AM. BANKR. INST. J., Apr. 2017, at 22, 100 (“Health care businesses should analyze the potential effects of their actions on their Medicare provider agreements, as a debtor may have limited remedies—or possibly no remedy at all—in bankruptcy court should CMS terminate a debtor’s provider agreement.”).

184. See *supra* Section II.B–C (discussing the current appeals process).

185. See *supra* notes 85–87 and accompanying text (noting the drastic average length of time before an administrative agency decision is usually made).

186. See Maizel & Potere, *supra* note 83, at 31 (noting that termination sounds a “death knell” to many providers).

187. Juliette Cubanski & Tricia Neuman, *The Facts on Medicare Spending and Financing*, KAISER FAM. FOUND. (Jun. 22, 2018), <https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing> (noting that Medicare accounts for as much as 20% of all spending on healthcare in the United States).

188. See *supra* Section III.A.

189. See *supra* Section III.B.

appeals process should not force an appellant to declare bankruptcy just to save their provider agreement while waiting for an appeal decision. Even this may not be enough. Providers in the, Third, Seventh, Eighth, and now Eleventh Circuits will find themselves with a jurisdiction problem and thus no meaningful remedy.<sup>190</sup> While similar health providers in the Ninth Circuit can at least get through the courthouse door, there is no guarantee that a bankruptcy claim will be enough to save the provider agreement from termination.<sup>191</sup> And, of course, there is the First Circuit decision that ignores the jurisdictional fray altogether and holds that the police power exception bars application of Medicare provider agreements, thus eliminating bankruptcy law as a basis for protection.<sup>192</sup>

Given the mess created by the timeline imposed on providers by the statute, it is clear that a judicial fix will not adequately solve the problem to restore balance to Medicare provider agreement appeals. Returning to the origin problem itself, this Note suggests that the vast challenges and unfairness caused by the current provider agreement appeal system can be fixed with relatively straightforward statutory changes. Specifically, Congress should amend the appeal provisions of the Social Security Act, to direct the DHHS to change its rules. These changes would create substantive protections by providing a stay of provider agreement terminations until an administrative appeals decision is reached.<sup>193</sup>

To enact a stay pending appeal, language changes are needed in two sections of the Code of Federal Regulations.<sup>194</sup> The first is 42 C.F.R. § 489.53, which lays out the process by which CMS terminates provider agreements.<sup>195</sup> Section 489.53(e) currently provides that “[a] provider may appeal the termination of its provider agreement by CMS in accordance with part 498 of this chapter.”<sup>196</sup> The specific part of section 498 requiring amendment is

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190. See *supra* notes 142–60, 167 and accompanying text (explaining the circuit split and that the Eleventh Circuit has joined the majority of circuits deciding bankruptcy courts do not have jurisdiction to hear Medicare claims prior to an administrative appeals decision).

191. See *supra* notes 171–82 and accompanying text (explaining the First Circuit’s decision in *Parkview Adventist*, which bars providers’ use of bankruptcy protection to save their provider agreements on grounds other than jurisdiction).

192. See *supra* notes 171–82 and accompanying text.

193. This proposal, though similar, is distinct from the automatic stay provided in the bankruptcy code. For a refresher of the provisions, see *supra* Section III.B. The automatic stay only protects certain assets belonging to the estate until such time as the bankruptcy court approves a plan of correction. This proposed stay would apply categorically to provider agreements facing termination by CMS prior to an administrative appeals decision is made. In this way, the stay shields the provider from CMS intervention until such time as its initial appeal rights have been exercised.

194. Changing the language of 42 C.F.R. § 498.5(b) will effectively change the consequences of section 489.53(e). The changes to 498.5(b) are incorporated in 489.53(e) through its own terms.

195. See 42 C.F.R. § 489.53 (2017).

196. *Id.* § 489.53(e).

section 498.5, which establishes appeals rights.<sup>197</sup> In the context of this Note, the statutory fix is needed in section 498.5(b), which provides: “Any provider dissatisfied with an initial determination to terminate its provider agreement is entitled to a hearing before an ALJ.”<sup>198</sup> It is clear from both regulations, that in their current respective forms, there is no stay of the termination of the provider agreement, even though the sections establish a baseline appeals process. In order to effectuate the change, the following language needs to be added to each section:

“The termination of the provider agreement shall be stayed until an initial appeal decision has been issued.”<sup>199</sup>

Political will is a significant obstacle for an amendment like the one this Note proposes. That is to say, Congress and DHHS must be motivated to make changes. Although change requires time and political buy-in, an issue of this magnitude, together with its potential for harm,<sup>200</sup> deserves political action. And CMS, providers, and community members alike have an interest in a meaningful appeals process, as no one stands to gain by taking away health care options for patients.<sup>201</sup> Though CMS has an interest in enforcing their regulations, the agency also has an interest in ensuring their beneficiaries can receive care in their community. Staying the termination of the provider appeal does nothing to limit CMS’ enforcement power. Rather, it simply ensures that providers have an adequate and meaningful opportunity to challenge CMS’s findings prior to the agreement termination. Because the government itself, like the providers, has an interest in making sure appeals are fair, any initial political foot-dragging should not be a deterrent to implementing such a solution.

In addition to the statutory stay, the role of Medicare Administrative Contractors (“MAC”)<sup>202</sup> can be expanded to ensure that providers that actually are found in violation of Medicare regulations are not able to get a windfall after their appeal is heard. Recall that the solution advocated here

197. See generally *id.* § 498.5 (establishing varying appeal rights depending on the party’s specific relationship to CMS).

198. *Id.* § 498.5(b).

199. The new language of section 498.5(b) would read as follows: “Appeal rights of providers. Any provider dissatisfied with an initial determination to terminate its provider agreement is entitled to a hearing before an ALJ. *The termination of the provider agreement shall be stayed until an initial appeal decision has been issued.*” (new language emphasized).

200. See *supra* Part II.

201. See *supra* notes 88–91 and accompanying text.

202. A Medicare Administrative Contractor (“MAC”) is “an agency, organization, or other person” whom CMS contracts with to administer the Medicare system, including payment, education, communication, and other functions. 42 U.S.C. § 1395kk-1(a)(3)–(4) (2012); see *What is a MAC*, CTRS. FOR MEDICARE & MEDICARE SERVS. (Oct. 26, 2017, 1:29 PM), <https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/What-is-a-MAC.html> (“MACs are multi-state, regional contractors responsible for administering both Medicare Part A and Medicare Part B claims.”).

does not envision allowing violating providers to take advantage of the system and remain open despite their non-compliance. Rather, this Note advocates only that the appeals process for providers give an actually meaningful opportunity to challenge CMS's findings. Congress allows MACs to make payments for "clean claims" submitted to Medicare.<sup>203</sup> The MAC system lays a workable foundation to implement the stay proposed herein. The MAC is a separate entity from both CMS and the provider appealing their termination. Yet, MACs still process the payment from government to the provider. This set up lends itself to MACs being able to separate funds in dispute in an appeal. Thus, in addition to the statutory stay, Congress can perfect the appeals process at issue here by granting MACs additional authority to set aside funds that providers would be entitled to if they win on their appeal. In this way, MACs can establish "provider appeal accounts" where money the provider would otherwise be entitled to is held until the dispute is decided on appeal. These accounts would function similarly to escrow accounts.<sup>204</sup> This way, CMS can ensure the provider is not paid for the services whose compliance is in question while the provider agreement termination is appealed. Similarly, providers who are able to obtain a fair appeal after the stay of their termination will know the funds for the disputed services are ready to be paid out if they are successful on appeal. To accomplish this process in unison with a stay of the termination, Congress need only add language to 42 U.S.C. § 1395kk-1(a)(4) providing that MACs have authority to create and manage "stayed termination appeal accounts."<sup>205</sup> The subsection would appear as follows as 42 U.S.C. § 1395kk-1(a)(4)(I):

**(I) Stayed Termination Appeal Accounts**

*Creating separate appeal accounts to be used when a dispute arises between a Medicare provider and CMS, to hold payments owed under the provider agreement until such time as the appeal is heard. Upon successful appeal by the provider, immediately paying such provider the amount owed under the provider agreement held in the account and denying such payment if CMS wins on appeal.*

This extra security to protect the integrity of funds fully advances the goals of the statutory stay and protects premature payment to non-compliers.

**B. THE STATUTORY SOLUTION IS SUPERIOR TO ALTERNATIVES**

Moreover, the proposed statutory amendment is superior to alternative solutions. One readily apparent alternative would be to hire more ALJs with

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203. Clean claims are "claim[s] that [have] no defect or impropriety." 42 U.S.C. § 1395h(c)(2)(B)(i).

204. See, e.g., 12 U.S.C. § 2605.

205. This could be added to the current language as a new sub-section. It would be codified at 42 U.S.C. § 1395kk-1(A)(4)(I).

the goal of decreasing the extended time it takes to obtain an initial ruling on appeal.<sup>206</sup> However, DHHS already employs the second-highest number of ALJs of any federal agency at an average salary of \$163,112.65.<sup>207</sup> The costs of hiring enough new judges to have any measurable impact on the disparity between the time in which CMS terminates a provider agreement and the time an ALJ rules on the appeal would be incredibly expensive.<sup>208</sup> This alternative would also necessarily take an extended amount of time to implement, as any new ALJs would need to be hired and then trained and familiarized with the proper procedures.

The high cost alone is a sufficient reason to reject this alternative. And although there is some initial cost in procedure to changing the rules, the proposed amendment does not incur long-term costs and, most importantly, does not in any way limit CMS's current authority to enforce its regulations. The proposed amendment implementing the stay pending appeal is thus the best solution to solve the problem presented by the current provider agreement framework.

While this solution is strong and would substantially improve the balance between CMS and providers, it is not immune from counter-arguments. Perhaps the most important of these is raised in the instance of a hospital committing a major abuse or violation of CMS regulations.<sup>209</sup> The question becomes: Does the solution in this Note open the door for hospitals that commit serious violations to take advantage of the stay and continue to be paid by the government? The solution advocated here suggests it does not. In the first instance, this Note seeks to address the narrower problem a provider faces when it is either a close call or when CMS makes an erroneous finding.<sup>210</sup> This Note does not advocate allowing egregious violators to remain open.<sup>211</sup> In the second instance, it is highly unlikely a serious abuser would be successful even under the current appeals system and are not likely to be any more successful under the statutory fix herein.<sup>212</sup>

Still, there is a slight, indeed slim, chance that a violator might slip through the cracks. In that instance, the balance still weighs heavily in favor of adopting the statutory solution advocated here. First, continuing to clog

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206. See *supra* note 85–87 and accompanying text (explaining the average number of days it takes before an ALJ releases a decision on Medicare appeals).

207. Pay Rates for “Administrative Law Judge,” FEDERALPAY.ORG, <https://www.federalpay.org/employees/occupations/administrative-law-judge> (last visited Aug. 17, 2018).

208. See *id.* (showing that salaries and related costs would be significant if any meaningful reduction in appeal time is going to be achieved).

209. For a discussion of the investigative process, see *supra* note 46–56 and accompanying text.

210. See *supra* Section II.C.

211. See *supra* Section II.C (“Of course, this does not mean that providers who are breaching regulatory requirements deserve to remain open; certainly, they do not and should be shuttered.”).

212. See *supra* note 92 and accompanying text (noting that to even be granted TRO a provider must show a likelihood of success on the merits, which would not be possible for a serious abuser).

district courts is inefficient and does not adequately protect the appeal rights of providers.<sup>213</sup> Second, it is unfathomable that the law would prefer an appeal structure that forces providers into bankruptcy rather than adequately protecting their rights prior to an appeal decision.<sup>214</sup> Moreover, the risks of losing providers agreements and the funds necessary to remain operational *before an appeal is heard* is fundamentally unfair and may result in an unnecessary closure of a hospital, which likely cannot be undone even if the provider wins on appeal later.<sup>215</sup> The effects of a premature closure are especially detrimental to rural communities and one-provider communities that rely on their only provider for their health care needs.<sup>216</sup> Thus, on balance, it is clear that a slight chance for abuse by providers pales in comparison to the devastating effects of the unjustified, premature closure of hospitals that this Note seeks to remedy.

## V. CONCLUSION

Medicare providers subject to provider agreements with CMS currently face a disproportionate challenge when appealing an adverse decision of CMS. Admittedly, in exercising its regulatory and enforcement power, CMS performs an important oversight function to ensure that Medicare providers are compliant with performance standards.<sup>217</sup> However, providers have an equally compelling interest in preserving their provider agreements and in exercising their due process rights to challenge the merits of a CMS finding on appeal before their provider agreement is terminated.<sup>218</sup> Properly balancing these interests will provide the best solution to the problem presented by the current statute.

The current statutory scheme has not only created a system that threatens the operative future of the health care providers but also creates chaos for the federal district courts<sup>219</sup> and incentivizes companies to attempt to use bankruptcy law for protection.<sup>220</sup> A system that forces providers to run to the nearest courthouse in an attempt to get a TRO against CMS in order to enjoin termination of their provider agreements, or which incentivizes providers to declare bankruptcy to guard their agreements with the automatic stay, cannot be the answer.<sup>221</sup>

The current statute is inadequate. Amending the statute to allow for a stay pending an initial appeals decision better aligns the power balance

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213. See *supra* Section III.A.

214. See *supra* Section III.B.

215. See *supra* notes 82–84 and accompanying text.

216. See *supra* notes 88–91 and accompanying text.

217. See *supra* Section II.B.

218. See *supra* Section II.C.

219. See *supra* Section III.A.

220. See *supra* Section III.B.

221. See *supra* Part IV.

necessary to operate a functional Medicare system. By providing a stay pending appeal, the statute will protect providers from detrimental consequences brought on by the termination of their provider agreement prematurely. And, importantly, adding a stay in no way limits or changes CMS's current authority or ability to enforce its regulations and ensure compliance to protect the public. It is clear that this solution restores the balance between the regulated and regulator while maintaining the integrity of the Medicare system. Therefore, legislatively amending the appeals statute to provide for a stay pending appeal is the best solution to prevent the unfair consequences a provider may face without such a change.