Expert Q&A on Health Care Business Bankruptcies

PRACTICAL LAW BANKRUPTCY

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An Expert Q&A with Adam Berkowitz and Burton Weston of Garfunkel Wild, P.C. discussing the unique aspects of health care business bankruptcy cases and providing practical tips for restructuring professionals on addressing the intersection between health care and bankruptcy law.

The Bankruptcy Code and the specialized bankruptcy courts that implement it are uniquely equipped to handle a multitude of debtor-creditor issues. The typical goal of the bankruptcy process is to maximize the value of a limited pool of assets for the benefit of various creditor constituencies, that are ultimately distributed based on a statutory priority scheme. While every bankruptcy case has the potential to raise unique and complicated issues, when a debtor is a health care provider and the safety and welfare of human lives are introduced into the equation, that fundamental rubric is altered.

As many health care cases worked their way through the bankruptcy process over the years, parties were tasked not only with maximizing value for creditors, but also with the practical realities of ensuring the health, safety, and welfare of various patient populations. While these goals sometimes align, often they do not.

As a result, it became necessary to make special accommodations for health care bankruptcies, some through legislative amendments to the Bankruptcy Code, while others resulting from bankruptcy judges, bankruptcy practitioners, and health care providers working out the panoply of issues facing financially distressed health care institutions.

With the current environment of regulatory pressure, financial stress, and reduced reimbursement rates and an ever greater need for institutions to use economies of scale given the changing health care delivery models, bankruptcies involving health care businesses are likely to continue to rise. However, the bankruptcy process has proven particularly adept in accommodating these cases.

Practical Law asked Adam Berkowitz and Burton Weston of Garfunkel Wild, P.C. to explain the unique aspects of health care bankruptcy cases and provide practical tips for restructuring professionals when addressing the intersection between health care and bankruptcy law.

HOW DOES THE BANKRUPTCY CODE SPECIFICALLY ADDRESS HEALTH CARE BUSINESS BANKRUPTCIES?

The 2005 amendments to the Bankruptcy Code addressed several issues facing health care bankruptcy cases. To start, Congress added a new definition for a "health care business" category of debtor (§ 101(27A), Bankruptcy Code). When a health care business debtor files for bankruptcy protection, it triggers other Bankruptcy Code provisions, many of which were also added as part of the 2005 amendments. These provide for, among other things:

- The appointment of a patient care ombudsman (§ 333, Bankruptcy Code).
- Procedures for the disposal of patient records (§ 351, Bankruptcy Code).
- An administrative priority for the expenses associated with the retention of medical records and the transfer of patients from a closing facility to a new facility (§ 503(b)(8), Bankruptcy Code).
- A requirement that a Chapter 7 trustee transfer patients on appointment (§ 704(a)(12), Bankruptcy Code).
- The exemption of certain actions from the applicability of the automatic stay (§ 362(b)(4), (28), Bankruptcy Code).

The 2005 amendments also added provisions requiring not-for-profit health care providers to comply with otherwise applicable non-bankruptcy law in the transfer of their property and assets. In particular, section 363(d) of the Bankruptcy Code requires that a sale of the assets of a not-for-profit corporation must comply with nonbankruptcy law applicable to such a sale. Section 541(f) of the Bankruptcy Code provides that if property or other assets held by "a corporation described in section 501(c)(3) of the Internal Revenue Code" are to be transferred "to an entity that is not such a corporation," the transfer must "occur under the same conditions" that occur under nonbankruptcy law.

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Until recently these provisions had been read to give deference to state attorneys general and state courts in approving these transactions. Recently, however, courts in the Second Circuit have found that a bankruptcy judge may analyze a sale of the assets of a not-for-profit corporation under applicable nonbankruptcy law and approve the sale under both state law and section 363 of the Bankruptcy Code, without the need to seek approval of the sale before both a state court and a bankruptcy court (see, for example, *In re HHH Choices Health Plan, LLC*, 554 B.R. 697 (Bankr. S.D.N.Y. 2016) (approving the sale of substantially all the assets of a not-for-profit corporation under section 511 of the New York Not-For-Profit Corporation law and under section 363 of the Bankruptcy Code)).

WHAT IS A PATIENT CARE OMBUDSMAN, WHEN ARE THEY APPOINTED, AND WHAT ROLE DO THEY PLAY?

A key feature of the bankruptcy process is that all major constituencies are given the opportunity to have representation. For example, unsecured creditors, a largely unaffiliated group of businesses, and individuals that supplied goods, labor, materials, or other services to a debtor before the commencement of a bankruptcy case, are afforded the ability to serve on or be represented by an official creditors' committee that hires counsel paid for by the debtor's estate. This ensures due process for a group that often does not have the means or wherewithal to otherwise protect their rights. With the 2005 amendments to the Bankruptcy Code, a new section 333 was added to mandate the appointment of a patient care ombudsman to act on behalf of patient populations affected by a bankruptcy filing.

The role of a patient care ombudsman is to "monitor the quality of patient care and to represent the interests of patients" in the bankruptcy of a health care business (§ 333(a), Bankruptcy Code). Section 333(a)(1) states that a court must appoint a patient care ombudsman within 30 days following the commencement of a case filed by a health care business. However, there is an exception to this requirement if a court determines "that the appointment of such ombudsman is not necessary for the protection of patients under the specific facts of the case" (§ 333(a), Bankruptcy Code). Further, Federal Rule of Bankruptcy Procedure 2007.2(a) provides that the court must order the appointment of an ombudsman, unless, on motion of the US Trustee or another party in interest filed no later than 21 days after the commencement of the case or within another time fixed by the court, the court finds that the exception applies.

Courts have interpreted this exception to convey considerable discretion to the court "to weigh the facts of each case when determining whether an ombudsman is required" (*In re Smiley Dental Arlington, PLLC*, 503 B.R. 680, 688 (Bankr. N.D. Tex. 2013)). An order finding that an ombudsman is not necessary also does not preclude a later order that an ombudsman should be appointed (Fed. R. Bankr. P. 2007.2(b)).

When evaluating a motion brought under Federal Rule of Bankruptcy Procedure 2007.2(b), bankruptcy courts look to the following non-exclusive factors in evaluating whether or not the appointment of a patient care ombudsman is appropriate in a case:

- The cause of the bankruptcy.
- The presence and role of licensing or supervising entities.
- Debtor's past history of patient care.
- The ability of patients to protect their rights.
- The level of dependency of patients on the facility.
- The likelihood of tension between the interests of patients and the debtor.
- The potential injury to patients if the debtor drastically reduced its level of patient care.
- The presence and sufficiency of internal safeguards to ensure appropriate level of care.
- The impact of the cost of an ombudsman on the likelihood of a successful reorganization.
- The high quality of the debtor's existing patient care.
- The debtor's financial ability to maintain high quality patient care.
- The existence of an internal ombudsman program to protect the rights of patients.
- The level of monitoring and oversight by federal, state, local, or professional association programs which renders the services of an ombudsman redundant.

(*In re North Shore Hematology-Oncology Assocs., P.C.*, 400 B.R. 7, 11 (Bankr. E.D.N.Y. 2008) (citing *In re Alternate Family Care*, 377 B.R. 754, 758 (Bankr. S.D. Fla. 2007)); *In re Valley Health Sys.*, 381 B.R. 756, 761 (Bankr. C.D. Cal. 2008)). The weight given to each factor is discretionary with the reviewing court (*In re North Shore*, 400 B.R. at 11 (citing *Valley Health*, 381 B.R. at 762)).

If appointed, a patient care ombudsman:

- Monitors the quality of care provided to the debtor's patients including, if necessary, interviewing patients and physicians.
- Provides regular reports to the court (at least every 60 days) regarding the quality of patient care.
- Immediately notifies the court if it is determined that the quality of patient care is declining significantly or otherwise being materially compromised.

(11 U.S.C. § 333(b)).

HOW DOES THE BANKRUPTCY CODE ADDRESS HIPAA AND OTHER RULES AND REGULATIONS REGARDING MEDICAL RECORDS?

Before addressing the ways that bankruptcy alters a debtor's obligations regarding medical records, it should be noted that certain non-bankruptcy obligations remain in full force and effect. For example, health care business debtors are often subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Violations of HIPAA can have severe consequences, and there is nothing in the Bankruptcy Code that excuses a health care debtor from continued compliance. Accordingly, debtors that are subject to HIPAA, which includes almost any provider that has, has access to, or otherwise handles protected health information (PHI) about its past and current patients, must take steps to protect it.

PROTECTING PHI

PHI is defined as information, including demographic information, that identifies an individual and relates to the medical condition

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or treatment, including payment for treatment, of the individual (45 CFR § 160.103). Vigilance is important as inadvertent disclosures of PHI can occur in many situations, including in the context of:

- Preparing and filing a debtor's schedules of assets and liabilities.
- Serving notices relating to the case.
- Filing motions or other pleadings.
- Proofs of claims and claim objections.

Other areas where debtors and their professionals should be aware of the disclosure of PHI include, for example, the sharing of documents and other information with a creditors' committee or a patient care ombudsman. In those situations, it is important for a debtor to enter into a business associates agreement, which allows parties to share PHI for certain limited purposes. Another situation that often poses a risk for inadvertent disclosure is during the discovery stage of litigation where it is often impossible to ensure with complete certainty that PHI is not inadvertently produced. In regard to responding to civil subpoenas, HIPAA provides that PHI may be disclosed on receipt of a patient authorization, a qualified protective order issued by a court, or satisfactory assurance together with the subpoena (45 CFR §164.512(e)(1)(ii)). As obtaining authorizations from each current and former patient is often impractical, if not impossible, parties should seek a qualified protective order from the bankruptcy court before producing documents. A qualified protective order, which is similar to a non-disclosure agreement, prohibits the parties from using or disclosing the PHI for any purpose other than the litigation or proceeding for which this PHI was requested and requires the return or destruction of the PHI at the end of the litigation or proceeding (45 CFR §164.512(e)(1)(v)).

RECORD RETENTION AND DISPOSAL

With the overlay of HIPAA, it is not surprising that health care businesses expend significant resources on the retention, protection, and ultimate disposal of medical records to comply with various requirements under federal and state law. In addition to HIPAA, under many state laws, medical providers must retain medical records for seven years or more. The related costs can run into the hundreds of thousands, if not millions, of dollars.

In a financially distressed situation, where limited resources are being expended to address issues of current patient safety and to try and maximize recoveries to creditors, many of which continue to provide ongoing support to the debtor, funds and other resources for the long-term maintenance of patient records are often not available. Over the years, this has been addressed in several ways.

The 2005 amendments to the Bankruptcy Code added a new section 351, which provides a mechanism for a trustee or debtor-in-possession to dispose of patient records if there are not sufficient funds to store the records according to applicable federal or state law, or both. To do so, the trustee or debtor-in-possession must first publish notice, in one or more appropriate newspapers, which states that the records in question are to be destroyed if unclaimed by the patient or, if applicable law allows, by an insurance provider within 365 days from the date of publication. Under Federal Rule of Bankruptcy Procedure 6001(a), as well as HIPAA, the published notice must not contain patient names or any other information that may identify a patient.

The trustee or debtor-in-possession then must, during the first 180 days of the 365-day period, attempt to directly notify each patient or insurance provider regarding the claiming or disposing of the records (§ 351(1)(B), Bankruptcy Code). Proof of compliance with this requirement should be retained for a reasonable time and must not be filed unless the court orders this filing under seal (Fed. R. Bankr. P. 6001(c)).

Following the expiration of the 365-day period, the trustee or debtor-in-possession must then mail, by certified mail, a written request to each appropriate federal agency requesting to store the records with that federal agency and federal agencies are not required to approve this request (11 U.S.C. § 351(2)). If the requests are denied, the trustee or debtor-in-possession may destroy the records in an appropriate manner. For written records, an appropriate manner is burning or shredding and for electronic information, an appropriate manner is any manner that ensures the records cannot be retrieved (§ 351(3), Bankruptcy Code). Within 30 days following the destruction, the trustee must file a report with the court certifying that the records were destroyed and specifying the method of the destruction. Further, the report must not contain patient names or any other information that may identify a patient (Fed. R. Bankr. P. 6011(d).)

Where immediate destruction is not a viable alternative, a debtor often finds itself in need of obtaining the services of a third-party records storage facility with the ability to remove, index, store, retrieve (on request of former patients), and ultimately destroy the medical records in compliance with HIPAA and other relevant federal and state laws. The chosen third party becomes the official custodian of the records and takes over full responsibility relating to those records, including compliance with record requests for ongoing patient care as well as litigation.

While this is far from an inexpensive process and often times costs a debtor hundreds of thousands of dollars, it is a necessary step where the funds are available. It does, however, require bankruptcy court approval on notice to former patients.

WHAT CHALLENGES DO HEALTH CARE BUSINESSES FACE IN A SALE OF SUBSTANTIALLY ALL THE DEBTOR'S ASSETS AS A GOING CONCERN UNDER SECTION 363 OF THE BANKRUPTCY CODE?

Bankruptcy sales, often referred to as section 363 sales (named after the section of the Bankruptcy Code which authorizes these sales) are often viewed as a quick, efficient, and safe method of acquiring the assets of a distressed entity. Among other things, the order approving the sale often provides that the sale is free and clear of liens and other encumbrances, provides protection from successor liability, and the entire process can be completed in as little as 60 to 90 days from the commencement of a bankruptcy case. However, health care businesses face many challenges in implementing and executing a sale of the businesses' assets as a going concern. Three major issues that arise are:

- The need for state regulatory approvals.
- Continuation of Medicare provider agreements.
- Potential for a purchaser to incur successor liability for Medicare overpayments that were previously paid to the debtor.

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STATE REGULATORY APPROVAL PROCESS

While section 363 sales can usually proceed to closing shortly after the bankruptcy court enters an order approving the sale, the purchaser of the assets of a health care business, such as a hospital or nursing home, must also obtain the proper licensing and approvals from applicable state regulators. Bankruptcy courts cannot simply authorize or order the transfer of the requisite licenses as it can with a contract for the ongoing provision of supplies or use of equipment. As a result, in addition to obtaining bankruptcy court approval, the parties must also seek approval from the relevant state department of health, usually in a process known as obtaining a "certificate of need." State departments of health have as their primary concern the welfare of patients and the preservation and integrity of the health care delivery system for the state. They are not accustomed to and, in many instances, are simply not in a position to work with the same speed as the bankruptcy courts.

Therefore, there can be a significant delay between entry of a sale order by a bankruptcy court and the granting of the necessary regulatory approvals, which then holds up a sale for an extended period of time. For example, we served as debtor's counsel in a case involving the sale of a nursing home where it took about two years after entry of the sale order before the purchaser, which was approved by the bankruptcy court, acquired the necessary regulatory approvals to close on the sale.

These delays pose a significant risk to the continued viability of the debtor as it may not be able to continue sustaining the losses that drove the estate into bankruptcy in the first instance. Over the years, practitioners have devised innovative solutions to this problem which have been used to varying degrees of success.

A solution, where available under the relevant state statutory and regulatory framework, is to seek to have the proposed purchaser appointed as a receiver for the entity. Once appointed, the receiver operates the health care business pending final approvals by state regulators, on its own account, assuming both profits and losses for the interim period. Other options may include entering into a management services agreement with the proposed buyer or some other permitted arrangement whereby the proposed purchaser begins to assume the liability of continuing losses pending final approvals and closing.

SUCCESSOR LIABILITY FOR MEDICARE OVERPAYMENTS

One of the driving forces behind a section 363 sale, as opposed to an out of court transaction, is to ensure that the purchaser does not inadvertently take on successor liability. This becomes all the more important when the seller is in financial distress.

However, when dealing with a health care provider that receives reimbursement for services from Medicare, there is one potentially large liability that a purchaser cannot likely avoid. Health care providers are liable, often for many years after services have been provided, for the reimbursement of Medicare overpayments they receive. Those liabilities can amount to millions of dollars and, based on the way participation in the Medicare program is structured, these liabilities flow through to a purchaser, even in the context of bankruptcy.

Each institution that participates in Medicare is party to a Medicare provider agreement and is assigned a unique Medicare provider number. If a purchaser does not acquire the debtor's provider number, it cannot seek reimbursement for Medicare services until it obtains approval to participate in these programs and receives its own Medicare provider number. The process can take several months, during which time the provider may be required to continue providing services for continuity of care purposes, without payment. This has the potential to create staggering losses which the provider may not be able to sustain.

If, however, the purchaser acquires the debtor's provider number subject to successor liability for past overpayments, the purchaser is potentially exposed to significant liability for overpayments as Medicare audits can look back to recapture overpayments from years before the purchase occurred.

The determination of whether successor liability flows with the acquisition of a debtor's provider number turns on the characterization of whether the debtor's Medicare agreement is an executory contract subject to section 365 of the Bankruptcy Code or a statutory entitlement subject to being sold free and clear under section 363(f) of the Code.

For the most part, bankruptcy courts examining Medicare provider agreements have concluded that they constitute executory contracts subject to section 365 of the Bankruptcy Code (see *Univ. Med. Ctr. v. Sullivan (In re Univ. Med. Ctr.)*, 973 F.2d 1065 (3d Cir. 1992); *Advanced Prof'l Home Health Care Inc v. Bowen (In re Advanced Prof'l Home Health Care Inc.)*, 94 B.R. 95 (E.D. Mich. 1988)). Therefore, the assuming purchaser is subject to successor liability for overpayments under applicable nonbankruptcy law, namely the statutes and regulations governing the Medicare program.

However, a few courts have found that Medicare provider agreements are capable of being sold free and clear under section 363(f)(5) of the Bankruptcy Code (see *WBQ P'ship v. Commonwealth of Va. Dept. of Med. Assistance Servs. (In re WBQ P'ship*), 189 B.R. 97 (Bankr. E.D. Va. 1995); *In re B.D.K. Health Mgmt., Inc.*, No. 98-00609-6B1, 1998 WL 34188241 (Bankr. M.D. Fla. Nov. 16, 1998)). Section 363(f)(5) provides that:

> "[t]he trustee may sell property under subsection (b) or (c) of this section free and clear of any interest in such property of an entity other than the estate, only if such entity could be compelled, in a legal or equitable proceeding, to accept a money satisfaction of such interest."

The *WBQ* and *B.D.K.* courts found that the overpayment claims of the Department of Health and Human Services (HHS) (in *B.D.K.*) and the Virginia state Medicaid administrator (in WBQ) may be reduced to a claim and were therefore capable of being satisfied by a monetary payment, allowing a sale free and clear under section 363(f)(5).

Another case, with a more peculiar result, was *In re Vitalsigns Homecare, Inc.*, 396 B.R. 232 (Bankr. D. Mass. 2008). In *Vitalsigns*, a Chapter 7 trustee moved to sell the debtor's provider number free and clear. The court granted the motion but also stated that it believed that HHS may recoup overpayments from the purchaser if liability remained after HHS had recovered:

- First, against any payments due by HHS to the estate.
- Second, against estate funds that were generated by past interim Medicare payments.
- Third, against the proceeds of the sale.

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TERMINATION OF MEDICARE AGREEMENTS POSTPETITION

Another issue that debtors face when filing for bankruptcy is whether or not HHS can terminate a debtor's Medicare provider agreement postpetition. In *Parkview Adventist Medical Center v. United States on behalf of Department of Health & Human Services*, a debtor's Medicare provider agreement was terminated postpetition because the debtor no longer qualified to receive Medicare reimbursements under the Medicare statute (842 F.3d 757, 764 (1st Cir. 2016)). The court found that the decision to terminate was exempt from the automatic stay as an exercise of the police and regulatory power under section 362(b)(4) of the Bankruptcy Code.

Similarly, in *Florida Agency for Health Care Administration v. Bayou Shores SNF, LLC (In re Bayou Shores SNF, LLC)*, the Eleventh Circuit held that, where a debtor had failed to exhaust its administrative remedies prepetition, a bankruptcy court lacked jurisdiction to prevent termination of a debtor's Medicare provider agreement postpetition (see 828 F.3d 1297 (11th Cir. 2016), cert. denied sub nom. *Bayou Shores SNF, LLC v. Florida Agency for Health Care Admin.*, 137 S. Ct. 2214 (2017)).

DO BANKRUPTCY COURTS LACK JURISDICTION TO ADJUDICATE CERTAIN TYPES OF DISPUTES INVOLVED IN CASES FILED BY HEALTH CARE BUSINESSES?

One of the major areas in which a bankruptcy court lacks jurisdiction relates to personal injury tort and wrongful death claims (for example, medical malpractice claims). Section 157(b)(5) of Title 28 of the US Code states that:

> "[t]he district court shall order that personal injury tort and wrongful death claims shall be tried in the district court in which the bankruptcy case is pending, or in the district court in the district in which the claim arose, as determined by the district court in which the bankruptcy case is pending."

This restriction prevents a bankruptcy court from trying medical malpractice cases, which are common occurrences in health care business bankruptcies. Conducting full or even modified trials on medical malpractice cases in the district court is never a debtor's preferred method of resolving these claims.

Often there is applicable medical malpractice insurance which is available not only to satisfy the claims, to the extent they are ultimately adjudicated as meritorious, but also to provide for the defense of these actions. In those circumstances, it is typical to enter into a stipulation, subject to approval of the bankruptcy court, that modifies the automatic stay to allow the claimant to proceed in a medical malpractice action in state court if the recovery on this action, if any, is limited to any available insurance. These stipulations contain full and explicit waivers of any and all claims against the debtor's bankruptcy estate. Plaintiffs typically prefer this route as well because they have the potential to obtain full recovery on their claims from an insurance provider as opposed to being paid potentially pennies on the dollar by obtaining an allowed claim against the estate.

There are times, however, when a health care provider is either self-insured or under-insured, where stipulating to a stay modification with recovery limited to insurance proceeds is not an option. In those circumstances, debtors have obtained approval of mandatory mediation procedures designed to foster efficient settlements of claims that the bankruptcy court otherwise lacks jurisdiction to adjudicate.

Despite the bankruptcy court's lack of jurisdiction to adjudicate the underlying action, it is well settled that bankruptcy courts have jurisdiction to require claimants to participate in some type of central claims resolution process (see *In re New York Med. Grp., P.C.*, 265 B.R. 408, 414 (Bankr. S.D.N.Y. 2001) (noting that a bankruptcy court "may deny stay relief in favor of mediation where the time and expense of litigating a substantial number of personal injury claims would seriously threaten the reorganization")).

Consistent with that basic premise, numerous courts have approved claims resolution procedures involving medical malpractice claims (see *In re Sound Shore Med. Ctr. of Westchester, et al.*, Case No 13-22840, Docket No. 402 (Bankr. S.D.N.Y. 2013) (RDD); *In re Cabrini Med. Ctr.*, Case No. 09-14398, Docket No. 497 (Bankr. S.D.N.Y 2009) (AJG); *In re Caritas Health Care, Inc.*, jointly administered under Case No. 09-40901, Docket No. 751 (Bankr. E.D.N.Y. 2009); *In re Our Lady of Mercy Med. Ctr., et al.*, jointly administered under Case No. 07-10609 (Bankr. S.D.N.Y. 2007) (REG); *In re New York Westchester Square Med. Ctr.*, Case No. 06-13050, Docket No. 255 (Bankr. S.D.N.Y. 06-13050) (SMB); *In re Victory Mem'l Hosp., et al.*, jointly administered under Case No. 06-44387, Docket No. 732 (Bankr. E.D.N.Y. 2006); *In re The Brooklyn Hosp. Ctr. & Caledonian Health Ctr., Inc.*, jointly administered under Case No. 05-26990, Docket No. 380 (Bankr. E.D.N.Y. 2005); *In re Flushing Hosp. & Med. Ctr.*, Case No. 198-17475-260, Docket. No. 444 (Bankr. E.D.N.Y. 1998); see also *In re Penn Traffic Co., et al.*, jointly administered under Case No. 03-22945, Docket No. 911 (Bankr. S.D.N.Y. 2003); *In re Kmart Corp., et al.*, jointly administered under Case No. 02-B02474, Docket No. 4970 (Bankr. N.D. Ill. 2002); *In re Union Hosp. Ass'n of the Bronx (d/b/a Union Hosp.)*, Case No. 97-45032, Docket No. 184 (Bankr. S.D.N.Y. 1997)).

ARE CERTAIN TYPES OF DISPUTES THAT AFFECT HEALTH CARE BUSINESSES EXEMPTED FROM THE AUTOMATIC STAY?

There are two exemptions to the automatic stay that affect health care businesses in bankruptcy. The police and regulatory powers exception, found in section 362(b)(4) of the Bankruptcy Code, exempts from the automatic stay "the commencement or continuation of an action or proceeding by a governmental unit... to enforce such governmental unit's or organization's police and regulatory power, including the enforcement of a judgment other than a money judgment, obtained in an action or proceeding by the governmental unit to enforce such governmental unit's or organization's police or regulatory power."

This section has been used to allow the postpetition termination of a debtor's Medicare provider agreement (see *Parkview*, 842 F.3d 759) and to allow the continuation of an investigation into a debtor's Medicare billing practices (see *Medicar Ambulance Co. v. Kramer (In re Medicar Ambulance Co., Inc.)*, 174 B.R. 804 (N.D. Cal. 1994)). Alternatively, the court in *In re University Medical Center* found that section 362(b)(4) did not permit the withholding of interim Medicare payments postpetition (see 973 F.2d 1065 (3d Cir. 1992)). It is also

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the basis for states' continuing ability to regulate and determine licensure issues for a postpetition debtor.

The second exemption, under section 362(b)(28) of the Bankruptcy Code, exempts a debtor from the automatic stay for "the exclusion by the Secretary of Health and Human Services of the debtor from participation in the Medicare program or any other Federal health care program." However, as noted by one court, which declined to decide the issue of the applicability of section 362(b)(28), "[c]ase law regarding the application of section 362(b)(28) is scant" (*MMM Healthcare, Inc. v. Santiago* (*In re Santiago)*, 563 B.R. 457, 475 (Bankr. D.P.R. 2017)).

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