THE TREATMENT OF MAAP PAYMENTS IN BANKRUPTCY

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The Medicare Accelerated and Advance Payments Program (MAAP) allows the Centers for Medicare and Medicaid Services (CMS) to accelerate payments to Medicare providers and suppliers to help offset financial losses due to a disruption in claims processing or during a public health emergency such as the COVID-19 pandemic or other national disaster. In the last year, the MAAP Program was amended by the Coronavirus Aid, Relief, and Economic Securities (CARES) Act[1] and the Continuing Appropriations Act, 2021 and Other Extensions Act (CAA)[2] to allow providers, among other things, more flexibility in repayment of MAAP payments.

This article provides a brief review of the guidance issued by CMS in October 2020[3] following the amendments to the MAAP Program as well as a discussion on recoupment of MAAP payments by CMS from a provider in bankruptcy.

On March 28, 2020, CMS implemented the expansion of the existing MAAP Program to a broader group of Medicare Part A providers and Part B suppliers. The MAAP Program is funded through the Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B) trust funds, and CMS has characterized MAAP payments as "a loan that providers must pay back."[4]

As part of the CARES Act, Congress amended the existing MAAP Program to provide additional benefits and flexibilities. The CAA further amended the repayment terms for *all* providers and suppliers who requested and received MAAP payments during the COVID-19 pandemic.

Pursuant to the original MAAP Program, MAAP payments needed to be repaid

with offsetting Medicare claims starting 120 days after payment was made to the provider, and interest began to accrue on any outstanding MAAP payments as soon as 210 days after the payment date. The CAA, however, amended the repayment terms for MAAP payments and extended the starting date of repayment to one year from the date the payment was issued.

Beginning on the one-year anniversary of the MAAP payment issue date until the 23rd month, Medicare will recoup 25 percent of the monthly Medicare reimbursement payments owed to a provider and apply it to the provider's outstanding MAAP payment. Then, for the next six months, Medicare will increase its recoupment percentage to 50 percent. Finally, Medicare will issue a letter notifying the provider of any remaining balance and demanding repayment. If after 30 days from the date the letter was issued Medicare does not receive payment, interest will accrue at 4% and will be assessed for each 30-day period thereafter that the balance remains unpaid. CMS's recoupment began on schedule in April 2021.

If a provider is experiencing financial hardship, however, it may request an extended repayment schedule (ERS) after it receives a demand letter. An ERS is a statutorily authorized installment payment schedule allowing the provider to pay its debts over the course of three years, which may be extended to five years where certain extreme hardship criteria are met.[5]

To be eligible for an ERS, the provider must demonstrate "hardship" or "extreme hardship." Hardship

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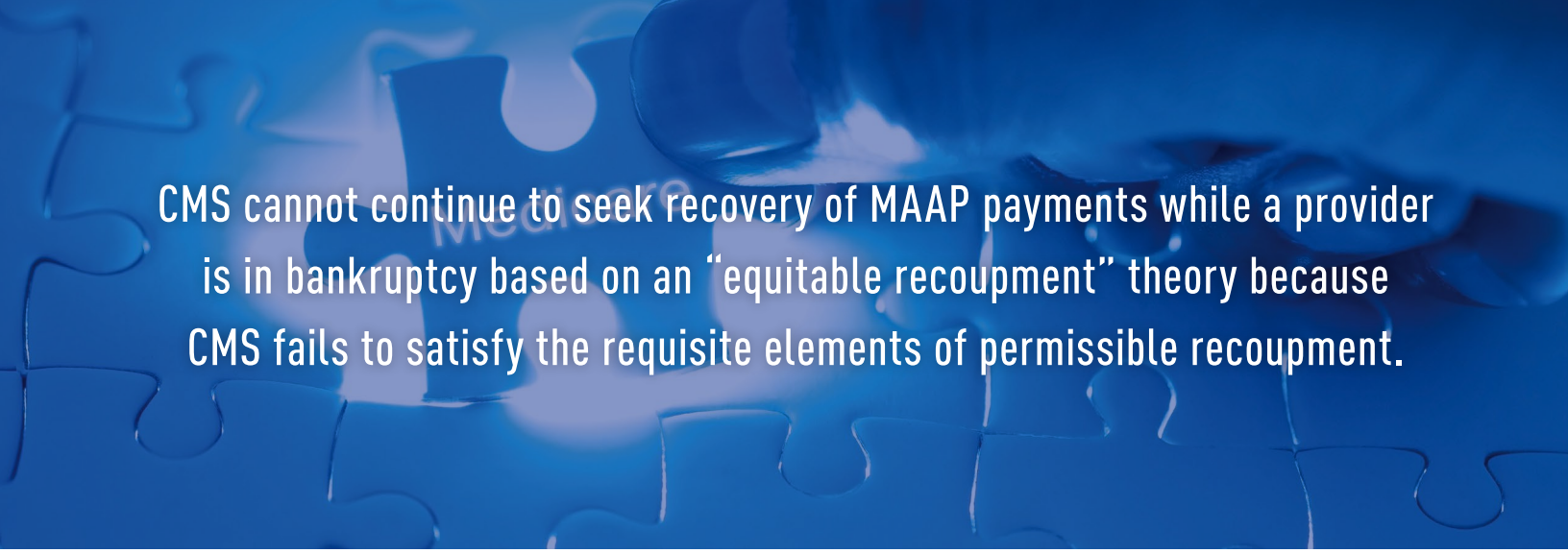

CMS cannot continue to seek recovery of MAAP payments while a provider is in bankruptcy based on an "equitable recoupment" theory because CMS fails to satisfy the requisite elements of permissible recoupment.

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exists when the total amount of all outstanding overpayments (principal and interest) is 10% or greater than the total Medicare payments made for the cost reporting period covered by the most recently submitted cost report for a provider filing a cost report, or for the previous calendar year for a supplier or non-cost-report provider.[6] Extreme hardship exists when a provider or supplier qualifies as being in hardship and the provider's request for an ERS is approved.[7]

Bankruptcy Considerations

CMS cannot continue to recover MAAP payments while a provider is in bankruptcy as a permissible exercise of equitable recoupment. CMS cannot continue to seek recovery of MAAP payments while a provider is in bankruptcy based on an equitable recoupment theory because CMS fails to satisfy the requisite elements of permissible recoupment.

Creditors generally may exercise recoupment rights in bankruptcy only

if both of the following two conditions are satisfied: (i) a debtor's claim against a creditor and the creditor's claim against the debtor arise from a single contract or a series of transactions constituting a single, integrated transaction or contract, and (ii) the creditor has made an accidental or contractual overpayment to the debtor.[8]

MAAP payments do not arise from the same transaction as ordinary course Medicare payments. Courts have developed two approaches for determining when the "same transaction" requirement is satisfied: (a) the logical relationship test, and (b) the single integrated transaction test.

The logical relationship test is a flexible approach under which two claims are part of the same transaction if they are reasonably connected, regardless of the immediacy of their connection.[9] The "same transaction" under the logical relationship test "may comprehend a series of many occurrences, depending not so much upon the immediateness of their connection as upon their logical relationship."[10] Courts typically look to the agreement between the parties.[11]

Under this approach, it is possible for two claims to be logically related, even if they originate from separate contracts.[12] The logical relationship test, however, should not be "so loosely applied that multiple occurrences in any continuous commercial relationship would qualify as one transaction."[13] The logical relationship test has been adopted by the 1st, 9th, and D.C. Circuits.[14]

Under the logical relationship test, MAAP payments and CMS's subsequent adjustment may create one ongoing, integrated transaction that creates a right to recoupment.

In comparison, the single integrated transaction test requires that both claims must arise from a single integrated transaction such that it would be inequitable for the debtor to enjoy the benefits of the transaction without also meeting its obligations.[15] As the 3rd Circuit has held, "a mere logical relationship is not enough: the 'fact that the same two parties are involved, and that a similar subject matter gave rise to both claims . . . does not mean that the two arose from the same transaction.'"[16]

Under the single integrated transaction test, MAAP payments and CMS's subsequent adjustment are likely not part of the same transaction because they relate to different fiscal years and are separate, distinguishable obligations, establishing a right to setoff but not a right to recoupment.

MAAP payments are not an overpayment of Medicare payments. Recoupment requires that the creditor made an accidental or contractual overpayment to the debtor.[17] Overpayments may include advance payments.[18]

MAAP payments likely would not be considered overpayments for purposes of equitable recoupment. These payments are issued as loans, the entirety of which are expected to be repaid. CMS's act of "recouping" the MAAP payments may therefore be more aptly characterized as an attempted setoff of the MAAP payments. Not only would such a setoff violate the automatic stay, but also any attempt by CMS to offset the prepetition MAAP payments against post-petition reimbursement claims would be an example of an impermissible setoff.

The language of the CARES Act and the CAA further supports the conclusion that MAAP payments are not overpayments. The language of the CARES Act and the CAA likely prevents CMS from recovering MAAP payments through the exercise of equitable recoupment. The applicable Medicare payment regulation, effective March 2020, states that "[r]ecovery of the accelerated payment may be made by *recoupment* as provider bills are processed or by direct payment."[19] Pursuant to the CARES Act amendment, the statutory provisions now state that "the Secretary shall ...: (i) provide up to 120 days before claims are *offset to recoup* the accelerated payment..."[20] In October 2020, Congress again amended Section 1395(g) through the CAA to require the Secretary to "(ii) provide that *any such offset* be an amount equal to [certain specified percentages over time] ...[.]"[21]

Notably, Congress chose to use the term "offset," the same term that appears in Section 553 of the U.S. Bankruptcy

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Code, which governs a creditor's right to setoff, not recoupment.[22] A loan program cannot generate an overpayment because the loan proceeds are not reimbursing the provider for claims for services rendered.

A company's Medicare provider agreements may be sold free and clear of MAAP payments. In certain jurisdictions, a debtor may conduct a sale process pursuant to Section 363 of the Bankruptcy Code and sell its provider agreements free and clear of statutory liabilities. Without a sale process, the debtor will likely have to cure the underlying obligations before assuming and assigning the provider agreements as executory contracts. However, it is unclear whether the MAAP payments will be deemed to be an obligation under the provider agreements that must be paid as part of the cure amount or a loan separate and apart from the provider agreements.

Some courts view provider agreements as statutory entitlements that may be sold free and clear of any underlying interests or claims, while others view them as executory contracts that must be assumed and cured under Section 365 of the Bankruptcy Code.[23] The 3rd, 9th, and 11th Circuits have held that Medicare provider agreements are not executory contracts, but merely statutory entitlements, which are assets of the estate that may be sold free and clear of any underlying interests or claims. [24]

Other courts have held that a provider agreement is an executory contract that must be assumed or rejected during a debtor's bankruptcy case, and all underlying obligations must be cured upon assumption or paid as an administrative claim upon rejection. [25]

If a company files for Chapter 11 protection, particularly in the jurisdictions referenced, and elects to proceed with a Section 363 sale process, it may be able to argue successfully that the provider agreements are not executory contracts and may be sold to a third-party purchaser free and clear of their underlying obligations. In most of the cases where the court reached such a conclusion, however, the parties contemplated or eventually culminated in some type of payment to CMS as part of a global stipulation of its claims, despite the fact that the provider agreements were sold free and clear of any underlying liabilities. J

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[1] Coronavirus Aid, Relief, and Economic Security Act, P.L. 116-136 (Mar. 27, 2020).

[2] Continuing Appropriations Act, 2021 and Other Extensions Act, P.L. 116-159 (Oct. 1, 2020).

[3] See Fact Sheet: Repayment Terms for Accelerated and Advance Payments Issued to Providers and Suppliers During COVID-19 Emergency, cms.gov, Oct. 8, 2020, cms.gov/files/document/accelerated-and-advanced-payments-fact-sheet.pdf (CMS FAQs).

[4] See Press Release, cms.gov, CMS Approves Approximately $34 Billion for Providers with the Accelerated/Advance Payment Program for Medicare Providers in One Week (Apr. 7, 2020), cms.gov/newsroom/press-releases/cms-approves-approximately-34-billion-providers-acceleratedadvance-payment-program-medicare

[5] See generally CMS FAQs.

[6] 42 C.F.R. Section 401.607(c)(2)(i).

[7] *Id.*

[8] *Univ. Med. Ctr. v. Sullivan (In re Univ. Med. Ctr.),* 973 F.2d 1065, 1081 (3d Cir. 1992).

[9] *Moore v. New York Cotton Exch.,* 270 U.S. 593, 610 (1926).

[10] *Id.*

[11] See *In re Health Mgmt. Ltd. P'ship,* 336 B.R. 392, 396–97 (Bankr. C.D. Ill. 2005).

[12] See *In re Silicon Valley Telecom Exch., LLC,* 284 B.R. 700, 709 (Bankr. N.D. Cal. 2002).

[13] *Sims v. United States Dep't of Health & Human Servs. (In re TLC Hosps., Inc.),* 224 F.3d 1008, 1012 (9th Cir. 2000); *In re Gardens Regional Hosp. and Med. Ctr., Inc.,* 975 F.3d 926, 940 (9th Cir. 2020).

[14] See, e.g., *Holyoke Nursing Home, Inc. v. Health Care Fin. Admin (In re Holyoke Nursing Home, Inc.),* 372 F.3d 1, 4 (1st Cir. 2004); *In re Slater Health Center, Inc.,* 398 F.3d 98 (1st Cir. 2005); *In re TLC Hosps., Inc.,* 224 F.3d at 1012; *Consumer Health Servs. of Am.,* 108 F.3d at 395.

[15] See *In re Univ. Med. Ctr.,* 973 F.2d at 1081.

[16] *Id.* (citations omitted).

[17] See *Kosadnar v. Metropolitan Life Ins. Co. (In re Kosadnar),* 157 F.3d 1011, 1014 (5th Cir. 1998); see also *Photo Mech. Servs., Inc. v. E.I. DuPont De Nemours & Co., Inc. (In re Photo Mech. Servs., Inc.),* 179 B.R. 604, 614 (Bankr. D. Minn. 1995).

[18] See, *e.g., In re Public Serv. Co. of N.H.,* 107 B.R. 441, 445 (Bankr. D. N.H. 1989) (permitting repayment of utility security deposits as recoupment); *Mohawk Indus., Inc. v. United States (In re Mohawk Indus., Inc.),* 82 B.R. 174, 177–78 (Bankr. D. Mass. 1987); *In re CDM Mgmt Servs., Inc.,* 226 B.R. 195, 197 (Bankr. S.D. Ind. 1997).

[19] 42 C.F.R. Section 413.64(g) (emphasis added).

[20] CARES Act (emphasis added).

[21] CAA (emphasis added) (amending, among other provisions, Section 1395(g) of Title 42 of the United States Code).

[22] See 11 U.S.C. Section 553.

[23] See 11 U.S.C. Section 365(b)(1)(A)

[24] See, *e.g., PAMC, Ltd. v. Sebelius,* 747 F.3d 1214, 1221 (9th Cir. 2014); see also *Hollander v. Brezenoff,* 787 F.2d 834, 839 (2d Cir. 1986); *Germantown Hosp. and Med. Ctr. v. Heckler,* 590 F. Supp. 24, 30-31 (E.D. Pa. 1983), *aff'd sub nom. Germantown Hosp. & Med. Ctr. v. Schweiker,* 738 F.2d 631 (3d Cir. 1984); *U.S. ex rel. Roberts v. Aging Care Home Health, Inc.,* 474 F. Supp. 2d 810, 820 (W.D. La. 2007);

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Greater Dallas Homecare Alliance v. United States, 10 F. Supp. 2d 638, 647 (N.D. Tex. 1998); *U.S. ex rel. Acad. Health Ctr., Inc. v. Hyperion Foundation, Inc.,* 2014 WL 3385189 (S.D. Miss. July 9, 2014); *Maximum Care Home Health Agency v. HCFA,* 1998 WL 901642, at *5 (N.D. Tex. Apr. 14, 1998); Hr'g Tr., *In re Center City Healthcare, LLC,* No. 19-11466 (KG) (Bankr. D. Del. Sept. 5, 2019) [Docket No. 664]; *In re Verity Health Sys. of Cal., Inc.,* 606 B.R. 843, 851-52 (Bankr. C.D. Cal. 2019) *vacated by In re Health Sys. of Ca., Inc.* 2019 WL 7288754 (Banrk. C.D. Cal. Dec. 9, 2019) (subsequently vacated by stipulation); *In re BDK Health Mgmt., Inc.,* 1998 WL 34188241, at *6 (Bankr. M.D. Fla. Nov. 16, 1998); *In re Kings Terrace Nursing Home and Health Related Facility,* 1995 WL 65531, at *9 (Bankr. S.D.N.Y. Jan. 27, 1995). Notably, as exhibited by *Center City, Verity, and True Health,* CMS's typical approach following the issuance of an unfavorable opinion is to engage in a lengthy appellate process which typically culminates in a settlement through which the unfavorable Bankruptcy Court opinion is vacated. For example, Verity and DHCS entered into a stipulation regarding assumption and assignment of the provider agreements in the underlying sale, which involved the Bankruptcy Court vacating its previous opinion and sale order. See *In re Verity Health Sys. of Cal., Inc.,* 2019 WL 7288754, at *1 (Bankr. C.D. Cal. Dec. 9, 2019). Similarly, the parties in *True Health* reached a comprehensive settlement, which included vacating the Bankruptcy Court and District Court opinions involved in those issues. See *In re THG Holdings, Inc.,* Adv. Proc. No. 19-50280 [Docket No. 99].

[25] See, *e.g., In re Univ. Med. Ctr.,* 973 F.2d at 1075 n.13; *In re Advanced Prof. Home Health Care,* 94 B.R. 95 (E.D. Mich. 1988); *In re Memorial Hosp. of Iowa,* 82 B.R. 478, 480 (W.D. Wis. 1988); *In re Heffernan Memorial Hosp. District,* 192 B.R. 228, 231 n.4 (Bankr. S.D. Cal. 1996); *In re St. Johns Home Health Agency, Inc.,* 173 B.R. 238, 242 n.1 (Bankr. S.D. Fla. 1994); *Tidewater Memorial Hospital,* 106 B.R. 876, 880 (Bankr. E.D. Va. 1989).