United States Department of Justice
United States Attorney
District of New Jersey
Civil Division

970 Broad Street, Suite 700
Newark, New Jersey 07102

general number: (973) 645-2700
telephone: 973-645-2926
fax: 973-297-2010
e-mail: anthony.labruna@usdoj.gov

Via ECF

September 20, 2011

Hon. Donald H. Steckroth
United States Bankruptcy Court
District of New Jersey
Martin Luther King, Jr. Federal Building
50 Walnut Street 3rd Floor
Newark, New Jersey 07102

Re: Hudson Healthcare, Inc.
Bankr. Case No.11-33014

Dear Judge Steckroth:

This office is writing on behalf of the Secretary of the United States Department of Health and Human Services ("the Secretary") to clarify the Secretary's position with respect to the Sale Motion filed by the Debtor, Hudson Healthcare Inc. ("HHI") for (i) authorization to sell substantially all of its assets, free and clear of all liens, claims, interest, and encumbrances, pursuant to private sale; (ii) approval of form and content of asset purchase agreement (the "APA") between Debtor and HUMC Holdco, LLC and HUMC Opco, LLC (collectively, the "Purchaser"); (iii) authorization to assume and assign certain of its executory contracts and unexpired leases; (iv) authorization to sell "designation rights" in connection with certain of its executory contracts and unexpired leases; (v) authorization to reject all executory contracts and unexpired leases that are not assumed or designated; (vi) authorization to reject collective bargaining agreements and (vii) granting other and related relief .

Pursuant to the APA, the Debtor intends to sell and assign to the Purchaser all of the Debtor's rights and interests under certain contracts and leases needed to operate the Hoboken University Medical Center (the "Hospital"). As described in more detail below, the Secretary does not regard the Sale Motion as objectionable per se since the APA in its current form does not purport to sell the Medicare Provider Agreement. Moreover, the Secretary does not view the provisions of the APA to be binding upon her since the Secretary is not a party to the APA. There are, however, certain provisions in the APA regarding the Purchaser's liability for Medicare overpayments which, in the event the Purchaser decides to accept assignment of the Provider Agreement, are contrary to Medicare principles of successor liability. Accordingly, the Secretary submits this letter in order to apprise the Purchaser and other interested parties of the consequences surrounding the Purchaser's acceptance of the Provider Agreement or, alternatively, the Purchaser's rejection of any such assignment and the Secretary's opposition to any attempt to transfer the Hospital's Medicare Provider Agreement without successor liability. Moreover, because the Hoboken Municipal Hospital Authority (and therefore, not the Debtor) is the holder of the Medicare Provider Agreement and is not in bankruptcy, any transaction regarding the transfer of its

Provider Agreement with the Secretary must take place outside the scope of this court's jurisdiction. Accordingly, in the event the Purchaser does accept assignment of the Medicare Provider Agreement, the Secretary contends this court lacks jurisdiction to grant any limitations upon the Purchaser's liability for pre-Closing Medicare debts.

Requirements Governing Participation in the Medicare Program

The Centers for Medicare and Medicaid Services ("CMS") is an operating component of the U.S. Department of Health and Human Services and is responsible for the administration of the Medicare program established under Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395ccc ("the Medicare Act"). Part A of the Medicare Act provides medical insurance coverage for hospital and skilled nursing care. Part B provides a voluntary program of supplemental medical insurance covering expenses such as physician services, x-rays, outpatient services, and medical supplies. In order for a provider to be eligible to participate in the Medicare program and receive reimbursement for services, a provider must enter into a Provider Agreement with the Secretary of HHS. *See* 42 U.S.C. § 1395cc(a)(1).

The Medicare Act at 42 U.S.C. § 1395g(a) instructs the Secretary to pay a participating provider the amount determined to be due "with necessary adjustments on account of previously made overpayments or underpayments .. . " Under Medicare regulations and policy, when a provider undergoes a change of ownership ("CHOW"), its Medicare provider agreement is automatically assigned to the new owner, subject to all the applicable statutes, regulations and terms and conditions under which it was originally issued (including liability for any overpayments or penalties). *See* 42 C.F.R. § 489.18(c). This policy is also reflected in the Medicare Financial Management Manual and the State Operations Manual which provide that when a provider undergoes a CHOW, the Medicare provider agreement is automatically assigned to the new owner, unless the new owner rejects assignment of the provider agreement. *See* MFM, Chapter 3, Section 130. *See* Exhibit C.

Effects of Accepting Assignment of the Medicare Provider Agreement

By accepting assignment of the provider agreement of the previous owner, an organization will enjoy continued, uninterrupted participation in the Medicare program (Title XVIII of the Social Security Act), will be reimbursed by CMS, through approved contractors, at the same rates as the previous owner, and any Medicare Inpatient Prospective Payment System (IPPS)-excluded status enjoyed by the previous owner will continue. The new owner will also be held responsible for all liabilities and payments due to or from Medicare. Acceptance of the assignment of the Medicare provider agreement also ensures that the assigned CMS Certification Number (CCN) is retained.

Effects of Rejection of Assignment of Medicare Provider Agreement

A new owner may decline to accept assignment of the provider agreement; however, doing so has many implications. CMS recognizes a purchaser's refusal to accept assignment of the previous owner's provider agreement as a voluntary termination of that provider agreement. *See* 42 C.F.R. § 489.52. The Medicare provider ceases to exist; therefore, the facility's Medicare provider agreement is terminated along with the CCN that tracks that agreement, effective with the date of the CHOW transaction. If the

provider was accredited and deemed to meet Medicare requirements, the deemed status of the accredited provider also ceases. In order for the hospital to once again participate in the Medicare program after the termination, the new owner has to apply for participation. The new owner needs to complete the appropriate Form CMS-855A and undergo a review for initial enrollment by the Fiscal Intermediary, as well as submit to CMS, via the State Survey Agency, the Medicare certification application package, including the documents required by the Office of Civil Rights.

Notably, SOM section 3210.5A states that, in such a circumstance, the new owner is treated as a new applicant, the facility is subject to an initial survey and the facility cannot participate until the CMS Regional Office determines all federal requirements are met, including the Medicare Hospital Conditions of Participation. This section also states that the new owner must put in writing its refusal to accept assignment and notify CMS 45 calendar days prior to the CHOW date to allow for the orderly transfer of any beneficiaries that are patients of the provider and the survey must be done after the CHOW since the provider agreement of the former owner terminates on the CHOW date. Furthermore, the effective date of participation for the hospital's provider agreement, which is also the date the hospital will be eligible for Medicare payment for covered services, may not be sooner than the date the hospital meets all Federal requirements. *See* 42 C.F.R. § 489.13 (a)-(c). The hospital is not eligible for Medicare payment from the date of the termination of the prior owner's agreement until the effective date of the new provider agreement. Further guidance on such transactions may be found in CMS' Survey and Certification Letter 09-08, dated October 17, 2008, which is available on CMS's website. [1]

Relevant Facts

The provider in this case, Hoboken University Medical Center (the "Hospital"), participates in the Medicare program pursuant to the terms of a Provider Agreement established between the Secretary and the Hoboken Municipal Hospital Authority, as the owner of the Hospital. See Medicare Provider Agreement dated July 23, 2007, attached hereto as Exhibit A. In August of 2006, the City of Hoboken adopted an ordinance pursuant to the Municipal Hospital Authority Law, and created the Authority for the purpose of acquiring St. Mary Hospital and saving it from closure. As described in the "Provider Tie-In Notice" issued by CMS, effective February 1, 2007, the Hoboken Municipal Hospital Authority became the new owner of the Hospital, formerly known as St. Mary Hospital, and was assigned the

[1] In addition, in general, where assignment of a provider agreement is rejected, the data used to calculate a hospital's IPPS payments does not transfer to the CCN associated with the new provider agreement. As such, data used to calculate a hospital's Medicare Disproportionate Share Hospital (DSH) payment, charge-to-cost ratios (CCRs) for outlier payments, and wage index reclassification under the CCN associated with old provider agreement would not be used to determine those IPPS hospital payments under the new CCN associated with the new provider agreement. Furthermore, if the provider has a Graduate Medical Education (GME) residency program, the residency slots associated with the CCN under the old provider agreement do not necessarily transfer to the new CCN associated with new provider agreement.

provider number 31-0040 previously used by St. Mary Hospital.[2] *See* Tie-In Notice attached hereto as Exhibit B.

The Debtor operates and manages the daily operations of the Hospital pursuant to a Master Manager and Operator Agreement dated February 1, 2007 between itself and the Hoboken Municipal Hospital Authority. The Secretary is not a party to this Management Agreement. Moreover, as the Debtor acknowledges in its Verified Application in support of the Sale Motion, the Authority is not a debtor in this or any other bankruptcy case. Because the Authority has not filed for bankruptcy, it is not subject to the automatic stay protections afforded by section 362 of the Bankruptcy Code and the Secretary may reimburse the Authority as it does other providers in the ordinary course of business. As the holder of the Provider Agreement, the Authority is the sole entity liable for the payment of any debts owed to the Medicare program and is the sole entity entitled to the receipt of any underpayments owed by the Medicare program. In short, the Secretary's contractual relationship here is with the Authority, not the Debtor, and the Secretary consequently is not a creditor in this case.

With respect to the assets being sold by the Debtor, the Debtor appropriately does not identify the Medicare Provider Agreement as among the contracts it is Assuming and Assigning to the Purchaser (Schedule 2.1(d)) nor among the Designated Contracts which could be assumed and assigned to the Purchaser upon the filing of a notice by the Purchaser (Schedule 2.6) nor is the Provider Agreement listed among the contracts it is rejecting (respectively, Exhibits C, D and F to the Verified Application in Support of the Sale Motion). (APA, p. 12-14). Indeed, as the Debtor explains in its Verified Application in support of the Debtor's Sale Motion, the Authority owns most of the real property upon which the Hospital is situated, as well as the majority of the personal property connected with the Hospital, including the accounts receivable, and the Authority has executed an APA with the Purchaser for the sale of these assets (the Authority Sale Agreement). The Debtor states that its Sale Motion is an essential component of the larger goal of selling the entire Hospital to Purchaser, both the parts owned by the Authority and the parts owned by Debtor. Further, since the Debtor is not a signatory to the Authority APA, and the Debtor's assets are not being sold pursuant to the Authority APA, the Debtor acknowledges bankruptcy court approval of the Authority APA is not being sought. The Debtor states that, upon the closing of the Authority's sale of the Authority Assets to Purchaser, the Debtor's management agreement with the Authority will terminate, the Debtor will liquidate and Purchaser will immediately begin operating the Hospital. However, as discussed above, in the event the Purchaser declines assignment of the Provider Agreement, under Medicare policies and procedures, the Purchaser will **not** be able to immediately begin operating the hospital.

However, the APA does contain provisions which conflict with Medicare law. Notably, the Debtor's APA lists as among its assets which are excluded from the sale "Excluded Contracts" which is

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[2] The Debtor erroneously states under section 5.10(a) of the APA that "HHI and/or the Authority are eligible to receive payment without restriction under Medicare and are 'providers' with valid and current provider agreements with one or more provider numbers with Medical Reimbursement Programs administered by a Governmental Body . . ." APA at p. 30. The only entity with which the Secretary has a Medicare Provider Agreement, and consequently the only entity which is eligible to receive Medicare payments, is the Authority.

defined as every contract that is *not* a Medicare provider agreement of the type described in Section 8.12 of the Authority Sale Agreement or Section 8.12 of the Debtor's APA. (APA, p. 5, p.14). Section 8.12, in turn, states with respect to the Medicare Provider Agreement, that after September 7, 2011, the Purchaser shall apply to CMS for the assignment of the Hospital's existing Medicare Provider Agreement and all corresponding Medicare provider numbers for the Hospital *or* shall apply to CMS for a new Medicare Provider Agreement and corresponding provider numbers for the Hospital. (APA, p. 46). These two provisions, read together, seem to suggest that the Purchaser may decide to include the Medicare Provider Agreement among the contracts it decides to purchase, despite the fact that the Debtor is not a party to this Agreement and therefore cannot assign it.

Further, with respect to the Assumption of Liabilities, of relevance here, section 2.3 states that the Purchaser shall assume, effective as of the Closing, "only the Liabilities accruing from and after the Closing with respect to the Purchased Assets, liabilities under the Medicare and Medicaid programs . . ." (APA, p. 15). Further, section 2.4 states, in relevant part, that the Purchaser shall not assume or become liable for the following: (g) all Healthcare Program Liabilities (other than those Medicare and Medicaid program liabilities assumed under section 2.3) incurred prior to or relating to a period prior to the Closing Date, whether assessed or demanded before or after the Closing Date . . . .; (i) any Liability related to Cost Report settlement payables arising from Cost Report periods ending on or before the Closing Date . ..;(k) any Liability related to penalties, fines, settlements, interest, costs and expenses to the extent arising out of or incurred as a result of any violation by HHI prior to the Closing Date of any Law or Order, . . .; and (m) except as otherwise specifically agreed by Purchaser, all Liabilities under HHI's or the Authority's Medicare and Medicaid provider number(s) and related provider agreements, whether assessed or demanded before or after the Closing Date pertaining to services rendered by or on behalf of HHI prior to Closing. . . . (APA, p. 16-17).

The Authority's Provider Agreement Cannot Be Assigned "Free and Clear" of Successor Liability.

The above-quoted provisions are directly contrary to Medicare principles on successor liability. To the extent the Purchaser may decide to seek an assignment of the Medicare Provider Agreement, any such assignment must come from the Authority by operation of law, not the Debtor, and any such assignment is subject to successor liability for pre-closing Medicare overpayments.[3] Upon assignment of the Provider Agreement, the new owner assumes all penalties and sanctions under the Medicare program, including the repayment of any accrued overpayments, regardless of who had ownership of the Medicare agreement at the time the overpayments were discovered. Under Medicare regulations, it is the continuity of the provider agreement that governs, not the continuity of the entity participating under the agreement. *See* Derville Memorandum ("The assignment or non-assignment of the [provider] agreement is the controlling factor" in determining liability for overpayments.") *See* Exhibit D. CMS policy, as expressed in the Derville Memorandum of January 6, 1999, and the Pelovitz Memorandum of October 1, 1999 (Exhibit E), explains that all assets (*i.e.*, underpayments) and liabilities, including overpayments made to a

[3] The Medicare Provider Agreement has been recognized as an executory contract subject to assumption or rejection under section 365 of the Bankruptcy Code. *See In re University Medical Center*, 973 F.2d 1065, 1075 (3d Cir. 1992); *U.S. v. Consumer Health Services*, 108 F.3d 390, 394 (D.C. Cir. 1997)(and cases cited therein). Since the Authority, as holder of the Provider Agreement, is not in bankruptcy, the requirements of section 365 are not applicable here.

former owner, are transferred to the new owner when the new owner accepts assignment of the Provider Agreement.

Federal caselaw supports the Secretary's interpretation of the Medicare regulations with respect to liability for Medicare overpayments and penalties before and after assignment of the provider agreement. *See United States v. Vernon Home Health, Inc.*, 21 F.3d 693 (5th Cir. 1994), (corporate entity purchased the assets of another corporation that provided home health care and, according to the terms of the purchase sale agreement, assumed none of the seller's liabilities; the Fifth Circuit held that the purchaser was liable to the Medicare program for Medicare overpayments that had been incurred by the seller, despite the terms of the sale agreement). Similarly, in *Deerbrook Pavilion, LLC v. Shalala*, 235 F.3d 1100 (8th Cir. 2000), the Eighth Circuit held that, under the Medicare regulations, the new owner of a skilled nursing facility is liable for civil monetary penalties assessed on the basis of the former owner's actions, where a CHOW had occurred and the new owner had agreed to accept assignment of the existing provider agreement pursuant. *Deerbrook*, 235 F.3d at 1104. Although in an unpublished and non-precedential opinion, the Third Circuit has also, in the bankruptcy context, endorsed the construction of the Medicare regulations adopted by the Fifth and Eighth Circuits. The Third Circuit has noted that if a new owner "elects to take an assignment of the existing Medicare Provider Agreement, it receives an uninterrupted stream of Medicare payments but assumes successor liability for overpayments . . . asserted by the Government against the previous owner." *In re Charter Behavioral Health Sys., Inc.* 45 Fed. Appx. 150, 151 n.1 (3d Cir. 2002). Indeed, this is based on the fundamental principle that where a debtor assumes an executory contract, it assumes the contract *cum onere*, *i.e.*, the obligations must be accepted along with its benefits. *Adventure Resources, Inc. v. Holland*, 137 F.3d 786, 798 (4th Cir. 1998), cert. denied, 525 U.S. 962 (1998), *citing NLRB v. Bildisco & Bildisco*, 465 U.S. 513, 531 (1984).

Accordingly, the Secretary opposes any sale entailing the transfer of the Provider Agreement without successor liability. Furthermore, successor liability cannot be limited if the purchaser accepts assignment of the provider agreement; indeed, there should not even be any provisions in the APA with respect to the provider agreement inasmuch as neither the debtor nor the purchaser are parties to that agreement at this point in time. Finally, we reiterate that because the debtor is not a party to the provider agreement and the entity which currently holds the provider agreement is not in bankruptcy, HHS/CMS cannot be bound by the automatic stay.

Respectfully submitted,

PAUL J. FISHMAN
United States Attorney

By: */S/ Anthony J. LaBruna*
ANTHONY J. LABRUNA, JR.
Assistant United States Attorney