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Transfer of Medicare Provider Numbers in Bankruptcy: Executory Contract or Saleable Asset?

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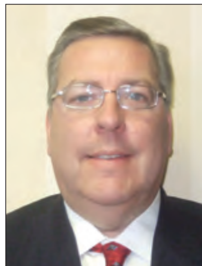
A perfect storm of recent economic factors has led to a large number of hospital and other health care-provider bankruptcies.[2] A significant issue to confront a hospital debtor is the transfer of its Medicare provider number and related provider agreement[3] to a new entity in a sale or merger in bankruptcy.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Courts are split on whether the provider agreement is an executory contract that must be assumed pursuant to §365(a) of the Bankruptcy Code, or if the provider number is a statutory entitlement and transferable, pursuant to §363. Most courts have concluded that a provider agreement is an executory contract, and this is also the government's view. The minority regards the provider number as an asset that can be sold, free and clear of liens and claims, pursuant to §363.

We believe that the analytical framework the minority courts employ to arrive at this conclusion is sound and reflects better policy. As we discuss, because the government is steadfast in adhering to its policy to uphold the executory contractual nature of the provider agreement, unless a prospective purchaser of a hospital in bankruptcy is prepared to litigate through the appellate process, practical considerations suggest that the purchaser will need to reach an agreement with the government, regardless of the law in the particular jurisdiction.

Intensive Care

The Medicare Reimbursement Scheme

A brief overview of the Medicare reimbursement scheme is useful to understand the issue in the bankruptcy context. Medicare is a federally subsidized health insurance program for elderly and disabled people. Medicare Part A[4] authorizes direct payment to a Medicare provider for services, often described as "hospital-covered services." The Medicare program is administered by the Centers for Medicare and Medicaid Services (CMS), a division of the U.S. Department of Health and Human Services (HHS). CMS contracts with fiscal intermediaries to process and pay Medicare claims. Payment to providers is made on an interim basis under a prospective reimbursement system,[5] which results in payments before a determination that the services rendered are covered and costs are reasonable.

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Because the Medicare program mandates that only the reasonable cost of covered services be paid, the fiscal intermediaries audit claims for reimbursement, up to three years from the date of submission, to determine the appropriateness of payments requested and made. If, after completion of the audit, the fiscal intermediary determines that a provider has been overpaid, HHS has the right to recover the overpayments from the provider.[6]

Reimbursement for Medicare services can only be made to an enrolled Medicare provider.[7] The process to become an approved provider can often be lengthy. It is advantageous if an entity purchasing a health care facility can acquire the owner's existing provider number; otherwise, the new owner will not be eligible for Medicare reimbursement during the period between acquisition and approval.

While the Medicare statutes prohibit the sale of a provider number[8] upon a change in ownership, the existing provider agreement is automatically assigned to the new owner,[9] who succeeds to all pre-closing liabilities, whether known or unknown, of the previous owner and can include reimbursement of Medicare

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1 The views expressed in this article are those of the authors and not necessarily the authors' firm.

2 These include declining reimbursements, increasing costs, increased demand for charity care, increased reliance on emergency room physicians as primary health care providers and tightened credit markets. In New York, closures mandated by the state's Commission on Health Care Facilities in the 21st Century, which was charged with identifying hospitals to be closed or merged, also contributed to the increased number of hospital filings.

3 The terms "provider number" and "provider agreement" are used interchangeably as the context requires. It is the provider number that confers enrolled status on a health care provider. The provider agreement does not involve mutual negotiation or an agreed-upon value for the services covered thereunder. It is a uniform document not subject to negotiation or alteration. *See* Centers for Medicare and Medicaid Services, Health Insurance Benefit Agreement, Form CMS-1561 (2001), available at www.cms.hhs.gov/cmsforms/downloads/cms1561.pdf.

4 42 U.S.C. §§1395c-1395i-5.

5 42 C.F.R. §413.60.

6 42 U.S.C. §1395g(a).

7 42 U.S.C. §1395cc.

8 42 C.F.R. §424.550.

9 42 C.F.R. §489.18(c).

and Medicaid overpayments, duplicate payments or payments made on account of reimbursement claims that are subsequently denied, in whole or in part. In other words, overpayments to the previous owner can be recovered from the new owner.[10]

Asset or Executory Contract?

The executory contract/statutory-entitlement distinction is critical when a hospital debtor wants to transfer its provider number to the purchaser. If the provider agreement is executory, then the new owner will be subject to all government claims, because applicable nonbankruptcy law—the Medicare statutes and regulations—impose this obligation on the new owner.[11] Conversely, if the provider number is a statutory entitlement, then a debtor should be able to transfer the number free and clear pursuant to §363(f). The government will still be able to assert its pretransfer claims against the debtor, but the new owner will not be saddled with the debtor's liabilities and the government's claims for recoupment and false claims. This is the rationale for a "free-and-clear" asset sale.[12]

Outside of bankruptcy, HHS has argued that Medicare is a statutory entitlement, not a contractual relationship—an issue that was addressed in *Harper-Grace Hospitals v. Schweiker*[13] more than 25 years ago. Harper-Grace claimed that one of its hospitals was entitled to reimbursement under the Medicare Act[14] for a percentage of its costs because of certain obligations that it assumed on receiving federal funds under the Hill-Burton Act.[15] Harper-Grace appealed the district court's denial for reimbursement and argued that an amendment to the Medicare Act, which specifically excluded expenses incurred under the Hill-Burton Act from Medicare reimbursement and was retroactively applicable, was unconstitutional since it eviscerated a "vested contractual right" to reimbursement. In rejecting this argument, the Sixth Circuit found the new statute constitutional primarily because Harper-Grace had not shown that the Medicare program established a contractual relationship between the hospital and federal government that covered the hospital's Hill-Burton obligation.[16] Since *Harper-Grace,* nonbankruptcy courts have consistently held that Medicare provider agreements are statutory entitlements.[17]

In bankruptcy, however, courts, with limited exceptions, have concluded that a Medicare contract is executory.[18] The minority view is that provider agreements are assets that can be transferred pursuant to §363 because provider agreements do not create or confer substantive rights and obligations. There are no negotiated elements to the agreement, which mandates that both the provider and the government are bound by the substantive rights and obligations conferred by statutes and regulations.[19] An agreement whereby the provider agrees to comply with federal law is a tautology; it does not create any obligation that did not already exist under the statutory scheme. This is the principle that the Second Circuit recognized in *Hollander v. Brezenoff*,[20] where the court held that signing a provider agreement does not convert statutory mandates to a contract claim. The Second Circuit observed that while the parties' relationship may be effectuated by means of a provider contract, all rights to reimbursement arise from a statutory business relationship and are based on the applicable statutes.[21]

The U.S. Bankruptcy Court for the Southern District of New York, relying in part on *Hollander*, reached the same conclusion under New York state law.[22] The debtor in *Kings Terrace* was a nursing facility that received payments from the Department of Social Services (DSS) under New York's Medicaid program. DSS commenced prepetition audits to determine if it had claims against the debtor based on overpayments. DSS was listed on the debtor's schedules with a contingent and disputed claim. Subsequently, the bankruptcy court set a bar date for filing prepetition claims. DSS was served with actual notice of the bar date but failed to file a claim.

Postconfirmation, DSS advised the debtor that it "may" intend to assert claims arising before the case's commencement. In response, debtor's counsel advised DSS that it was precluded from recovering because the claim had been discharged. DSS asserted that its failure to file a proof of claim did not bar recovery of the overpayments because the debtor had assumed an executory contract, which obligated it to reimburse DSS for overpayments, regardless of when made, discovered by audits.

Rejecting the government's claim, the bankruptcy court held that "the [d]ebtor's right to reimbursement and the [government's] right to recover payments do not arise from any contract, but rather from statutory and regulatory requirements completely independent of a contract."[23] The bankruptcy court found that DSS's alleged right to payment was a classic example of a dischargeable, contingent "claim" within §101(5)(A),

10 *United States v. Vernon Home Health Inc.*, 21 F.3d 693, 696 (5th Cir. 1994).

11 In one case in the Southern District of New York, *In re Our Lady of Mercy Medical Center*, no. 07-10609 (REG), the government has even attempted to extend the successor liability theory against a new owner to claims arising or asserted under the Federal False Claims Act. 31 U.S.C. §§3729-3731. *See* discussion *infra.*

12 BAPCPA amended §363(d) to restrict the authority of a trustee to use, sell or lease property by a nonprofit corporation or trust. Section 363(d)(1) provides that a trustee may use, sell or lease property under §363(b) or (c) only "in accordance with applicable nonbankruptcy law that governs the transfer of property by a corporation that is not a moneyed, business or commercial corporation or trust." Bankruptcy courts are normally well-equipped to facilitate a debtor's quick sale of distressed assets to maximize the estate, but §363(d)(1) alters the landscape. Compliance with applicable nonbankruptcy law, like Medicare, may impose obligations on a buyer that are incompatible with "free and clear" asset sales. *See* discussion accompanying n.12. It is for this and other reasons that the debtor and purchaser will have little practical choice other than to reach a deal with the government. *See* discussion *infra.*

13 708 F.2d 199 (6th Cir. 1983).

14 42 U.S.C. §1395 *et seq.*

15 *See* 42 U.S.C. §291 *et seq.* The Hill-Burton Act is a federal program that requires "obligated facilities" (health care facilities, including hospitals) that have used federal money for facility reconstruction or modernization to provide free or low-cost services to people living in the facility's area who cannot afford to pay. To be eligible, a person must not be covered by, nor receive services under, a third-party insurer or a governmental program such as Medicaid or Medicare.

16 708 F.2d at 201. The *Germantown Hosp. & Medical Center v. Heckler* court followed a similar line of reasoning when it rejected the hospital's theory that the Hill-Burton Act unconstitutionally abrogated its rights to receive Medicare payments and instead found that there was no contractual obligation requiring HHS to provide Medicare reimbursement. *See* 590 F.Supp. 24 (E.D. Pa. 1983).

17 *See, e.g., Kaye v. Whalen*, 376 N.E.2d 1327, 1328 (N.Y. 1978) ("provider agreement does not establish rights to reimbursement"); *Bezar v. New York State Dept. of Soc. Svcs.*, 151 A.D.2d 44, 49 (N.Y.A.D. 3d Dept. 1989) (no contractual right to participation in Medicaid program); *Rye Psychiatric Hosp. v. State of New York*, 177 A.D.2d 834, 835 (N.Y.A.D. 3d Dept. 1991) ("It is fundamental that a Medicaid provider has no...contract right to reimbursement."). *See also In re Elegant Concepts Ltd.*, 61 B.R. 723 (Bankr. E.D.N.Y. 1986) (debtor could not, as matter of law, reject contract that referred to state statute because obligation was statutory); *In re Saint Joseph's Hosp.*, 103 B.R. 643, 656 (Bankr. E.D. Pa. 1989) (dismissing contract claim based on Medicaid provider agreement on ground that agreement was "merely a form document" and reimbursement calculations are governed by federal and state statutes and regulations), *abrogated on other grounds, In re Sacred Heart Hosp.*, 204 B.R. 132, 142 (E.D. Pa. 1997).

18 *See, e.g., In re Univ. Med. Ctr.*, 973 F.2d 1065, 1076 (3d Cir. 1992); *Lee v. Monsour Med. Ctr.*, 8 B.R. 606, 616 (Bankr. W.D. Pa.), *aff'd*, 11 B.R. 1014 (W.D. Pa. 1981); *In re Advanced Prof'l Home Health Care Inc.*, 94 B.R. 95, 97 (E.D. Mich. 1988); *In re Tidewater Mem'l Hosp.*, 106 B.R. 876, 883-84 (Bankr. E.D. Va. 1989); *In re Mem'l Hosp.*, 82 B.R. 478, 480 (W.D. Wis. 1988). *See also Vernon Home Health Inc.*, 21 F.3d at 696 (A nonbankruptcy case where Fifth Circuit affirmed that purchaser of Medicare provider's assets was liable to government for overpayments).

19 Two commentators have concluded that a Medicare provider agreement does not stand up to traditional contract scrutiny because it lacks at least two of the basic *indicia* of contracts—negotiated price and remedies upon breach. First, HHS has substantial control over the amount it is obligated to pay providers for services, and therefore controls the scope of its obligation under the provider agreement. Second, the remedies available to the parties upon breach are not contractual remedies. Sarah Robinson Borders and Rebecca Cole Moore, "Purchasing Medicare Provider Agreements in Bankruptcy: The Case Against Successor Liability for Prepetition Overpayments," 24 *Cal. Bankr. J.* 253, 264-69 (1998). "Although both *Kings Terrace* and *Hollander*…involve the Medicaid program, their reasoning is applicable in the Medicare context as well." *Id.* at 262, n.60. *See also Maximum Care Home Health Agency v. HCFA*, No. 3-97-CV-1451-R, 1998 WL 901642, at *5 (N.D. Tex. April 14, 1998) ("[A] Medicare service provider agreement is not a contract in the traditional sense. It is a statutory entitlement created by the Medicare Act."); *In re BDK Health Mgmt Inc.*, No. 98-00609-6B1, 1998 WL 34188241 (Bankr. M.D. Fla. Nov. 6, 1998) (holding that Medicare payments are statutory entitlements, provider could sell its provider number in §363 sale without assumption and cure). *See also United States ex rel. Roberts v. Aging Care Home Health Inc.*, 474 F.Supp.2d 810, 820 (W.D. La. 2007) ("Breach of contract is not an available remedy because Medicare provider agreements create statutory, not contractual rights"); *United States v. Medica-Rents Co.*, 285 F.Supp.2d 742, 777 (N.D. Tex. 2003) (same).

20 787 F.2d 834, 839 (2d Cir. 1986).

21 *Id.* at 838-39. *See also Case v. Weinberg*, 523 F.2d 602, 607 (2d Cir. 1975).

22 *Kings Terrace Nursing Home and Health Related Facility v. N.Y.S. Dep't of Soc. Serv. (In re Kings Terrace Nursing Home Health Related Facility)*, No. 91 B 11478, 1995 WL 65531, at *8 (Bankr. S.D.N.Y. Jan. 27, 1997), *aff'd*, 184 B.R. 200 (S.D.N.Y. 1995).

23 *In re Kings Terrace Nursing Home Health Related Facility,* 1995 WL 65531, at *9.

and that failure to file a timely claim resulted in its claim for overpayments being deemed discharged under the confirmation order.

Reimbursement is a statutory right that does not depend on a confirming agreement for its efficacy. As a statutory obligation, the provider agreement constitutes property of the estate, which, under §363(f), may be transferred "free and clear" of any governmental interest in recouping prepetition overpayments from such property. Courts have regularly held that the free-and-clear sale power under §363(f) can cut off federal and state statutory liabilities, including government claims against the buyer.[24] Courts have also recognized that a free-and-clear sale may cut off successor liability claims against the buyer with respect to claims that arose before the sale,[25] even if they are unknown at the time of sale.[26]

Permitting successor liability claims to survive a free-and-clear sale would undermine the fundamental purpose of §363(f): to permit the maximization of the estate's assets without the overhang of the debtor's existing liabilities. To the extent that the purchaser continues using the debtor's existing provider number, potential overpayments for Medicare should not be recoverable from a purchaser in bankruptcy.

Recent Cases Involving Transfer of Provider Numbers

As a practical matter, parties and the courts can and should find ways to facilitate the transfer of provider numbers that do not impinge the government's rights under the Medicare statutes nor undercut the policy of §363 sales to maximize the value for creditors, particularly where the choice is to reach an agreement with the government or risk the hospital's closure and the loss of a vital (and often only) community medical center. Flexibility and pragmatism should be the mindset of debtors, purchasers and the government. Two recent cases illustrate how to achieve practical results given the legal and regulatory framework.

In a case of first impression in the First Circuit, the U.S. Bankruptcy Court for the District of Massachusetts considered whether a chapter 7 trustee could sell the debtor's Medicare provider number free and clear of the government's right to recoup from the buyer any prior overpayment of Medicare benefits to the debtor.[27] The Massachusetts court sidestepped a direct answer to arrive at what it considered to be a "practical" solution that balanced the trustee's interest in maximizing the debtor's assets with the government's statutory rights.

The debtor in *Vitalsigns* operated a home health care agency, and after its case was converted to chapter 7, the trustee moved for the authority to sell the debtor's Medicare provider number and "any and all rights, privileges and entitlements associated therewith" to ABC Home & Healthcare Inc. (ABC), free and clear of liens, claims and encumbrances under §363(f), including HHS's right to recoup overpayments from future Medicare payments. ABC was not an approved Medicare provider and needed the debtor's provider number. The government objected to the trustee's attempt to terminate the government's right to recoup overpayments to the debtor from ABC, and alleged that the provider agreement was an executory contract.

The bankruptcy court found that the transaction between the trustee and ABC did not involve any transfer that would bring the sale of the Medicare provider number within the definitions of change of ownership set forth in the regulations.[28] The court then considered whether a provider number, standing alone, could be sold by the debtor. The court concluded that if the First Circuit were confronted with the question, it would follow the reasoning of those courts, which have held that the provider number and agreement are part of a comprehensive statutory scheme that imposes benefits and burdens on the provider, and that the provider could not accept the benefits without the attendant burdens; that is, the provider agreement is an executory contract.[29]

Having reached this conclusion, the court backed away from following it to the logical conclusion, namely that ABC would be wholly liable to HHS for recoupment. The court, cautioning that it was not "rewriting the Bankruptcy Code or ignoring HHS' charge under the Medicare program," approved the sale, but then ruled that HHS could recoup any overpayments from ABC, as assignee of the provider number, only after recouping first from any payments due to the debtor's estate from HHS, next against funds held by the trustee if the funds were generated by past interim Medicare payments and then against any sale proceeds generated by the sale of the provider number.[30] This result, while pragmatic, doesn't follow from the legal analysis that underpins it and, at least in the First Circuit, leaves the question unresolved.

The U.S. Bankruptcy Court for the Southern District of New York confronted the same question in *Our Lady of Mercy Medical Center* (OLM).[31] In January 2006, a special purpose entity (SPE) acquired 100 percent of the membership interests in OLM. Before the acquisition, SPE engaged in extensive due diligence, and the parties were affiliated for a year before OLM filed for chapter 11 relief in March 2007. Simultaneously with its filing, OLM filed a motion to sell substantially all of its assets to another hospital wholly owned by SPE (the buyer), free and clear pursuant to §363(f) and subject to (1) higher and better offers, (2) bankruptcy court approval and (3) applicable regulatory approvals. The court approved the sale free and clear, without any objection by the government.

The buyer's intention was to bring the OLM beds and Graduate Medical Education (GME) program under its own provider number. Thus, while the contract provided that OLM's provider agreement was not being transferred to the buyer, the contract also condi-

24 *In re Leckie Smokeless Coal Co.*, 99 F.3d 573, 582 (4th Cir. 1996) (permitting sale free and clear of federal Coal Act successor liabilities); *Forde v. Kee-Lox Mfg. Co. Inc.*, 437 F.Supp. 631, 633-34 (W.D.N.Y. 1977) (holding that civil rights claims did not survive sale free and clear), *aff'd*, 584 F.2d 4 (2d Cir. 1978); *P.K.R. Convalescent Ctrs. Inc. v. Va. Dep't of Med. Assistance (In re P.K.R. Convalescent Ctrs. Inc.)*, 189 B.R. 90, 93-94 (Bankr. E.D. Va. 1995) (permitting free and clear sale notwithstanding state law permitting Virginia Department of Medical Assistance Services to recapture overpayments from purchaser of provider's assets); *WBQ P'ship v. Va. Dep't of Med. Assistance (In re WBQ P'ship)*, 189 B.R. 97, 102-03 (Bankr. E.D. Va. 1995) (granting injunction to enforce free and clear sale against attempt by Virginia Department of Medical Assistance Services to recapture overpayments from purchaser). *See also In re Kings Terrace Nursing Home Health Related Facility*, 1995 WL 65531, at *5-6 (Bankr. S.D.N.Y. Jan. 27, 1997) (holding that overpayment claims were discharged under confirmation order).

25 *See, e.g., Forde*, 437 F.Supp. at 633-34 (holding that plaintiff could not pursue successor-liability civil rights claim against assignee that purchased debtor's assets in free-and-clear sale); *In re Leckie Smokeless Coal Co.*, 99 F.3d at 581-82; *Am. Living Sys. v. Bonapfel (In re All Am. of Ashburn Inc.)*, 56 B.R. 186, 191 (Bankr. N.D. Ga. 1986) ("[T]he [o]rders authorizing the [t]rustee's sale of assets [free and clear] preclude the [plaintiffs in a products liability suit] from recovering…under the successor doctrine."); *In re P.K.R. Convalescent Ctrs. Inc.*, 189 B.R. at 95-96 (holding that state could not pursue its claim against purchaser of debtor's assets sold free and clear under §363(f)); *In re WBQ P'ship*, 189 B.R. at 103 (holding that debtors could sell free and clear of state's right to recapture Medicaid payments); *Rubinstein v. Ak. Pac. Consort. (In re New England Fish Co.)*, 19 B.R. 323, 328-29 (Bankr. W.D. Wash. 1982) (permitting sale free-and-clear of federal employment discrimination successor liabilities). *See also In re White Motor Credit Corp.*, 75 B.R. 944, 948 (Bankr. N.D. Ohio 1987) (holding that court had equitable power under §105 to conduct sale free and clear of successor liabilities for general unsecured claims such as tort claimants, but that §363(f) did not give court that power). *But cf. R.C.M. Executive Gallery Corp. v. Rols Capital Co.*, 901 F.Supp. 630, 637 (S.D.N.Y. 1995) (holding that successor liability is not precluded by bankruptcy court order where plaintiffs were not provided notice of bankruptcy).

26 *See In re Kings Terrace Nursing Home Health Related Facility*, 1995 WL 65531, at*9 ("It is well settled Second Circuit law, *government agencies which fail to file a timely proof of claim waive that claim—even if its amount or existence is contingent and unknown* and even if another statutory scheme appears to conflict with the Code's provisions.") (emphasis added).

27 *In re Vitalsigns Homecare Inc.*, 396 B.R. 232 (Bankr. D. Mass 2008).

28 *See* discussion *supra* at n.8-10.

29 *In re Vitalsigns Homecare Inc.*, 396 B.R. at 240.

30 *Id.* at 241.

31 *In re Our Lady of Mercy Medical Center*, No. 07-10609 (REG) (Bankr. S.D.N.Y.). The authors, together with special health care and regulatory counsel at Garfunkel, Wild & Travis PC, were counsel to the debtors.

tioned the sale on the buyer obtaining an increase in its GME reimbursement cap by the amount of OLM's cap. Following bankruptcy court approval of the sale, the government advised that it would not allow the buyer to obtain the GME increase utilizing its own provider number. The government insisted that the buyer either apply for and obtain a new provider number, or take OLM's number by assumption and assignment while remaining potentially liable for pre-assignment known and unknown claims under a successor-liability theory. Since there would have been an interruption in the reimbursement stream of millions of dollars per week if the buyer applied for a new provider number, option one was not feasible. The buyer concluded that if it wanted to consummate the transaction, it had no choice but to take an assignment of OLM's provider agreement and number, albeit on negotiated terms. Without the sale, there was no dispute that the hospital would have closed, forcing 2,300 employees out of work and eliminating a health care facility in an already underserved community. Moreover, a closure would have significantly increased claims against the estate while decreasing recoveries for creditors.

After months of negotiations, during which the buyer was never able to reach a satisfactory agreement with the government on GME reimbursement rates, OLM filed a second motion in the bankruptcy court for authority to transfer the provider number to the buyer as an asset free and clear of all government claims pursuant to §363(f), including claims for successor liability and unknown claims. The government objected to OLM's motion and asserted that the provider agreement was an executory contract that OLM had to assume before it could be assigned to the buyer. The government also contended that the buyer would be liable as a successor for all presale OLM-related claims, known and unknown, that the government might assert in the future, including claims for overpayment of Medicare reimbursement and fraud claims arising under the Federal False Claims Act (FCA).[32]

While the court did not issue a decision to facilitate settlement discussions, the parties stipulated that for purposes of the sale, OLM and the buyer would agree to treat the provider agreement as an executory contract that OLM would assume before assigning it to the buyer. The government agreed that all amounts that OLM owed for overpayments through the filing date would be considered "cure" payments. To resolve the government's issues relating to the buyer's potential liability for unknown OLM FCA-related claims and foreclose litigation, the buyer negotiated an annual cap on any payment it might be responsible for related to such presale claims, if any. The parties also agreed that the buyer would not be released from any claim that the government might later assert on account of the buyer's own knowledge, conduct or participation with OLM.

An important factor underpinning the *OLM* settlement was the government's national policy, which treats provider agreements as executory contracts within §365. The government takes the position in every health care bankruptcy case that a provider agreement must be assumed before it can be transferred to a new owner. The government made it clear that it would appeal an adverse ruling in light of its national policy. Faced with a liquidity crisis, OLM was in no position for lengthy and expensive litigation and appeals; while the fight wound its way through the courts, the hospital would have run out of money and been forced to close.

In light of the government's fundamental policy interests, it would hardly make practical sense for a debtor to litigate to conclusion the government's objection to a §363 sale unless the debtor and purchaser were prepared to wait years for the government's claims to be resolved, or unless the parties were willing and able to establish a reserve sufficient to satisfy the government's potential claims. The *Our Lady of Mercy* and *Vitalsigns* cases illustrate ways that courts and parties in interest can navigate through the dual Medicare/Medicaid and bankruptcy statutory schemes to reach pragmatic results that facilitate a health care debtor's sale of its assets to the benefit of creditors and the community, while respecting the government's strong policy concerns. In these difficult economic times, it is certain that many hospitals and other health care providers will need to seek the relief afforded in chapter 11 and thus there will be a continuing need to harmonize the Bankruptcy Code and practice with the applicable federal, state and local health care regulations and policies. ■

32 The government asserted these claims against OLM under the FCA for approximately $29 million, which, when trebled as authorized by nonbankruptcy law, resulted in a principal claim of $87 million. The government contended that it was allowed civil monetary penalties of up to $11,000 for each false claim submitted for Medicare or Medicaid reimbursement by OLM, further multiplying the principal claim several-fold.

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