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THE SCRIVENER'S ERROR:

HOW BANKRUPTCY JUDGES OVERRULE HEALTH EXPERTS ON MEDICARE DECISIONS

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I. INTRODUCTION

Who would you rather have decide if your doctor is following the Medicare Act, an expert on the nation's health laws or an expert on the U.S. Bankruptcy Code? In *In re Bayou Shores SNF, LLC*, a skilled nursing facility entered into a Medicare Provider Agreement to receive payments from the Centers for Medicare and Medicaid Services (CMS) (a division of the Department of Health and Human Services) in exchange for medical services if the facility remained compliant with certain federal regulations.[1] Nevertheless, the facility violated those regulations by keeping poor medical records.[2] When CMS followed up to see if the facility had fixed the records, CMS discovered the facility placed a known sexual offender in a disabled patient's room without informing the patient.[3] Finally, CMS revoked its agreement with the facility after finding a mentally impaired man had left the facility undetected on a hot Florida day.[4] Although CMS justifiably revoked the agreement because the facility had placed patients in "immediate jeopardy," the facility immediately filed for bankruptcy, and the bankruptcy court nullified CMS's decision to withdraw the facility's agreement.[5]

1. Fla. Agency for Health Care Admin. v. Bayou Shores SNF, LLC (*In re* Bayou Shores SNF, LLC), 828 F.3d 1297, 1301 (11th Cir. 2016)).
2. *Id.*
3. *Id.*
4. *Id.* at 1302.
5. *Id.* at 1301–03.

The bankruptcy court had jurisdiction over the case due to confusion interpreting the agency exhaustion requirement.[6] Section 405(h) of Title 42 of the U.S. Code compels providers to exhaust their appeals with the agency before proceeding to court.[7] However, several federal appellate courts have held that § 405(h) does not bar bankruptcy court jurisdiction.[8] These rulings have created a split in the circuits regarding bankruptcy court jurisdiction in these types of cases. The split originates from a recodification that omitted several jurisdictional grants from § 405(h), leaving courts to choose whether to continue to interpret the statute as Congress intended or to interpret the plain text of § 405(h). This Note takes the position that Congress should amend the statute to explicitly bar bankruptcy jurisdiction to reflect the Act's original intent since this will ensure uniformity and efficiency in the Medicare law. Furthermore, barring bankruptcy jurisdiction ensures that the agency responsible for health law questions can fully apply its expertise to these questions by facilitating an effective internal agency appeals process.

Part II provides general background by: (1) describing the Department of Health and Human Services and its mission; (2) providing an overview of the Medicare Act and the role of Medicare Provider Agreements; and (3) summarizing the Medicare appeals system and its related issues, along with a brief discussion of the interplay with bankruptcy jurisdiction. Part III explains the current state of the circuit split amongst the four circuits that have stated opinions.

Part IV applies the rules of statutory construction to the statute to determine its proper interpretation. The statute's legislative history, plain text, legislative intent, and statutory evolution are discussed, as well as the application of the recodification canon, to conclude that § 405(h), even as currently drafted, should bar bankruptcy court jurisdiction. Next, Part IV analyzes the policy argument of both sides. Congress intended for HHS to adjudicate Medicare claims and intended bankruptcy courts to adjudicate bankrupt estates, but the bankruptcy jurisdiction is not an ever-expanding jurisdictional grant. Part IV also evaluates the agency's

6. 42 U.S.C. § 405(h) (2020).

7. *Id.*

8. Fla. Agency for Health Care Admin. v. Bayou Shores SNF, LLC (*In re Bayou Shores SNF, LLC*), 828 F.3d 1297, 1300 (11th Cir. 2016) (holding bankruptcy courts do not have jurisdiction over Medicare claims); *In re* Town & Country Home Nursing Servs., Inc., 963 F.2d 1146, 1153–55 (9th Cir. 1991) (holding bankruptcy courts have jurisdiction over Medicare claims); Benjamin v. United States, SSA (*In re* Benjamin), 932 F.3d 293, 302 (5th Cir. 2019) (holding that the claim must arise under Medicare law for § 405(h) to bar bankruptcy jurisdiction over the claim); Univ. Med. Ctr. v. Sullivan, (*In re* Univ. Med. Ctr.), 973 F.2d 1065, 1073 (3d Cir. 1992) (holding that the claim must arise under Medicare law for § 405(h) to bar bankruptcy jurisdiction).

response to the overwhelmed appeal system and how the providers try to evade the appeal system. Lastly, Part V recommends amending the statute back to its original form and passing additional legislation to aid the appeal systems in adjudicating claims.

II. BACKGROUND

A. The Department of Health and Human Services and an Overview of the Medicare Act and its Purpose

The Department of Health and Human Services (HHS) is the federal agency that Congress authorized to implement laws that impact the Medicare and Medicaid programs, in addition to programs that cover public health services.[9] HHS oversees over 300 programs and 11 divisions, including the Centers for Medicare and Medicaid Services (CMS).[10] HHS also oversees an impartial, independent appeals division.[11]

Congress enacted Medicare as part of Title XVIII of the Social Security Act to give health insurance to persons over the age of 65.[12] Over time, the program expanded to cover specific disabilities, services, and diseases.[13] The program's $926 billion expenditure gives care to 62.6

9. *Medicare and Medicaid Guide Explanations and Annotations*, VITAL L. 13,160, (Jan. 22, 2022, 4:31 PM), https://my-vitallaw-com.ezproxy.uakron.edu:2443/#/read/AllContent/09013e2c8734f5c2!csh-da-filter!WKUS-TAL-DOCS-PHC-%7B339287E6-1169-11E6-82AA-74E5434FFA59%7D—WKUS_TAL_444%23teid-1702?searchItemId=851015541!0!09013e2c8734f5c2&da=WKUS_TAL_444#09013e2c8734f5c2-wkhl1 [https://perma.cc/FSQ9-4LNS].

10. *Id.* ("HHS programs are administered by 11 operating divisions, including 8 agencies in the U.S. Public Health Service and three human services agencies (including the Centers for Medicare and Medicaid Services (CMS).").

11. *Id.* ("HHS's Departmental Appeals Board (DAB) provides an impartial, independent review of disputed decisions in a wide range of HHS programs. 'DAB' refers both to the Board members appointed by the HHS Secretary and to the larger staff organization. The DAB has three adjudicatory divisions, each with its own set of judges and staff, as well as its own areas of jurisdiction: the Board itself (supported by the Appellate Division); administrative law judges (supported by the Civil Remedies Division); and the Medicare Appeals Council (supported by the Medicare Operations Division). The DAB also has a leadership role in implementing alternative dispute resolution across HHS.").

12. BARRY R. FURROW, THOMAS L. GREANEY, SANDRA H. JOHNSON, TIMOTHY STOLTZFUS JOST & ROBERT L. SCHWARTZ, HEALTH LAW 401 (3d. ed. 2015).

13. *Id.* ("Medicare eligibility has expanded somewhat since its enactment, and now covers disabled persons who have received Social Security disability for at least 24 months, as well as Social Security disability recipients who have end stage renal disease (ESRD) or Amyotropic Lateral Sclerosis (ALS, also known as Lou Gehrig's disease).").

million vulnerable Americans.[14] Medicare reimbursements[15] account for a significant portion of healthcare organizations' revenue, around 20% for some providers; however, depending on the provider, a combination of Medicare and Medicaid[16] may account for 90% of the revenue.[17] Medicare consists of four different programs, including Parts A and B.[18] Part A is the hospital insurance program and pays for inpatient care, post-hospital skilled nursing, home health, and hospice services.[19] Part A

14. THE BDS OF TRS, FED HOSP. INS. & FED SUPPLEMENTARY MED INS. TRS. FUNDS, 2021 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS 10 (2021), https://www.cms.gov/files/document/2021-medicare-trustees-report.pdf [https://perma.cc/E8DP-FFBU]; *see also* FURROW, *supra* note 12 (indicating Medicare funds generally provide care for the most vulnerable of the American population).

15. *How Do Medicare Reimbursements Work?*, MED. NEWS TODAY (May 21, 2020), https://www.medicalnewstoday.com/articles/medicare-reimbursement [https://perma.cc/7GN2-WFS8]. Patients with Medicare do not pay their bill to the provider directly or submit claims to Medicare. Instead, Medicare and the provider, through their Medicare Provider Agreement, have approved payment amounts for the services that the provider gives the patient and Medicare will pay for those services afterward, through reimbursements.

16. Fla. Agency for Health Care Admin. v. Bayou Shores SNF, LLC (*In re* Bayou Shores SNF, LLC), 828 F.3d 1297, 1300 (11th Cir. 2016) (stating that Medicaid reimbursements are similar to Medicare and that Agreement provisions can often be conditional on compliance with both programs).

17. *Breaking Down U.S. Hospital Payor* Mixes, DEFINITIVE HEALTHCARE (Mar. 10, 2022, 10:44 AM), https://www.definitivehc.com/resources/healthcare-insights/breaking-down-us-hospital-payor-mixes [https://perma.cc/87VQ-BKFR] (finding that Medicare payor mix in hospitals is 20.5% in 2020, but can range higher depending on location and services); Frédéric Michas, *Hospital Revenue Composition in the U.S. as of March 2020, by Payer,* STATISTA (Sept. 13, 2020), https://www.statista.com/statistics/1029719/composition-of-hospital-revenue-by-payer-contribution-in-the-us/ [https://perma.cc/44A9-CLBK]; Bill Meyers, *Share of Medicare, Managed Care Plans In SNF Revenue Falls, Report Finds*, PROVIDER LONG TERM & POST ACUTE CARE (Jan. 13, 2022, 12:45 PM), https://www.providermagazine.com/Breaking-News/Pages/Share-Of-Medicare,-Managed-Care-Plans-In-SNF-Revenues-Fall,-Report-Finds.aspx [https://perma.cc/2FEK-SLG8] (citing a 2016 survey of skilled nursing homes where Medicare generated $497 per patient a day); Alex Spanko, *Medicaid's Share of Nursing Home Revenue, Resident Days Hits Record High as Medicare Drops to Historic Low*, SKILLED NURSING NEWS (Jan. 13, 2022, 12:47 PM), https://skillednursingnews.com/2019/12/medicaids-share-of-nursing-home-revenue-resident-days-hits-record-high-as-medicare-drops-to-historic low/#:~:text=The%20gain%20in%20overall%20day%20share%20translated%20to,for%20financial%20issues%20at%20facilities%20across%20the%20country (citing to a 2019 survey, finding around 20% of skilled nursing facility revenue is Medicare funded, approximately 70% coming from government funding, and Medicare generated $523 per patient revenue); *see also In re Bayou Shores SNF, LLC*, 828 F.3d at 1301 (finding that SNF generated 90% of its revenue from government funding). In other words, Medicare is a significant source of revenue for all providers; thus, providers have a need for speedy adjudication when a problem arises, but also a significant financial reason to stay compliant with their Medicare Provider Agreement.

18. FURROW, *supra* note 12, at 402. Medicare Part C is for Medicare advantage managed care programs, which include all the benefits offered in A and B but have additional supplements. Part D is for prescription outpatient drugs.

19. 42 U.S.C. § 1395d.

receives its funding through a payroll tax on employers, employees, and the self-employed.[20] Part B is for supplemental medical insurance benefits.[21] General revenue funds primarily fund Part B.[22]

B. Medicare Provider Agreement

Providers must meet the Medicare Conditions of Participation for Part A services or Conditions of Coverage for Part B services to receive payment for the services.[23] In addition, all Part A providers and some Part B providers must sign a Medicare Provider Agreement (Agreement) to receive payment.[24] The Agreement is "between CMS and one of the providers specified in 42 C.F.R. § 489.2(b)[25] to provide services to Medicare beneficiaries and to comply with the requirements of section 1866 of the Act."[26]

1. Conditions of Participation, Compliance, and Termination

To participate in the Medicare program, providers must comply with acts such as Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act, the Age Discrimination Act, and federal ownership and control disclosure requirements.[27] Ironically, CMS can refuse to enter into an Agreement with providers who owe them prior Medicare debts.[28]

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20. 42 U.S.C. § 1395i; I.R.C. §§ 1401(b), 1411, 3101(b), 3111(b).

21. 42 U.S.C. §§ 1395k, 1395x; 42 C.F.R. § 410.3 (defining supplemental medical insurance benefits to include: physician's services; outpatient hospital services; renal dialysis; speech and physical therapy; ambulatory surgery; home health services; durable medical equipment and other medical equipment and supplies not covered by part A; partial hospitalization services; services provided by community mental health centers, rural health clinic services, federally qualified health center services; Indian Health Service services; comprehensive outpatient rehabilitation facility services; and some diagnostic tests and preventive services).

22. 42 U.S.C. § 1395r(a).

23. 42 U.S.C. § 1395cc.

24. *Id.* (outlining the enrollment process and agreements with providers of services).

25. 42 C.F.R. § 489.2 (defining providers as hospitals; skilled nursing facilities (SNFs); home health agencies (HHAs); clinics, rehabilitation agencies, and public health agencies; comprehensive outpatient rehabilitation facilities (CORFs); hospices; critical access hospitals (CAHs); community mental health centers; religious nonmedical health care institutions (RNHCIs); opioid treatment programs (OTPs); clinics, rehabilitation agencies, public health agencies only for furnishing outpatient physical therapy, speech pathology services; CMHCs only partial hospitalization services; and OTPs only to provide opioid use disorder treatment services).

26. 42 C.F.R. § 489.3; *see also* FURROW, *supra* note 12, at 419 (defining the Medicare Provider Agreements as a contract between the government and the provider in exchange for medical services or supplies).

27. 42 C.F.R. § 489.10(b); 42 U.S.C. §§ 1320a–3, 1320a–5.

28. 42 C.F.R. § 424.518. The irony of the statute is that it presents scenarios where a provider had an Agreement with CMS and owes a Medicare debt. The statute allows CMS to refuse to enter

The basic terms of the Agreements are set out in 42 U.S.C. § 1395cc and require certain assurances on behalf of the parties.[29]

Additionally, providers must meet other conditions as well. For example, hospitals must continue to qualify as the definition of a hospital.[30] Providers also must stay compliant with the surveying and certification process.[31] CMS may terminate the Agreement with providers that engage in fraud or do not comply with the requirements for participation of the Medicare Act.[32] CMS must give providers a 15-day notice of termination unless they are a Skilled Nursing Facility (SNF) and that SNF places the patient in immediate jeopardy; in such cases, CMS gives a two-day warning.[33]

2. Section 405 (h)

If CMS terminates an Agreement, a provider may appeal the decision but must first exhaust their remedies through the agency's appeal system.[34] 42 U.S.C. § 405(h) is an agency exhaustion requirement that states:

> Findings and decisions of the Commissioner of Social Security after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Commissioner of Social Security shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Commissioner of Social Security, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.[35]

42 § 405(h) applies to HHS and the Medicare Act by 42 U.S.C. § 1395ii.[36]

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into new Agreements with these providers. The factual difference between this scenario and the issue of this Note is that the providers in this Note are not seeking to enter a new Agreement. However, this does raise a significant policy argument that Congress does not want to enter into Agreements with providers who owe congressional Medicare debts.

29. 42 U.S.C. § 1395cc.

30. 42 U.S.C. § 1395x(e); *see* Parkview Adventist Med. Ctr. v. United States *ex rel.*, 842 F.3d 757, 761–65 (1st Cir. 2016) (finding that CMS terminated an Agreement because the provider no longer met the statutory definition of being a provider).

31. 42 C.F.R 488.

32. 42 U.S.C. § 1395cc(b)(2); 42 C.F.R. § 489.53.

33. 42 C.F.R. § 489.53.

34. 42 U.S.C. § 405(h).

35. *Id.*

36. 42 U.S.C. § 1395ii. 42 U.S.C.

C. The Medicare Appeal Process

1. Parts A and B Appeals

The appeals process for Parts A and B generally covers decisions made by Medicare contractors;[37] thus, the appeals process contains two initial steps, redetermination and reconsideration, before a hearing with the agency.[38] This appeal process is not only for individuals; providers may represent an individual and appeal the claim on that individual's behalf.[39] Before the process begins, a contractor makes an initial determination.[40] If the party is unsatisfied with the determination, the party may first appeal the decision for redetermination by the contractor.[41] Redetermination must take place within 120 days.[42] The party must simply state why it disagrees and include evidence on why the contractor should reconsider.[43] The contractor has 60 days for redetermination or dismissal.[44]

The next level is reconsideration by a qualified independent contractor (QIC).[45] Any party to the claim may request the redetermination, and there is no amount-in-controversy requirement.[46]

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37. *What is a MAC*, CMS.GOV, CTRS. FOR MEDICARE AND MEDICAID SERVS. (Oct. 20, 2021, 10:21 PM), https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/What-is-a-MAC#WhatIsAMac [https://perma.cc/KB83-YHQR]. A contractor is a private health care insurer that has jurisdiction to process Part A and B claims. CMS built a network of Medicare Administrative Contractors that function as the primary operational contact between providers and Medicare for the Fee-For-Service claims under Parts A and B.

38. 42 U.S.C. § 1395ff; 42 C.F.R. 405.900. The HHS appeal system is summarized as followed. The DAB appeal process is (1) a hearing with an ALJ, followed by (2) an appeal to the MAC, and then (3) an appeal to the federal court system. A claimant filing a Medicare Part A or Part B claim must first appeal through (1) reconsideration and then (2) redetermination, before they can start the DAB appeal process. A provider appealing termination of its Agreement will immediately start its appeal with an ALJ at the DAB level. A Medicare Advantage claimant will have a similar pathway to a Medicare Part A or Part B claimant, which leads into the DAB appeal process. Finally, PRRB appeal process is separate from the DAB appeal process and has its own appeal mechanisms but is still an appeal system within HHS.

39. 42 U.S.C. § 1395ff(b)(1)(B).

40. 42 U.S.C. § 1395ff(a)(4); C.F.R. §§ 405.920–405.928 (explaining the initial determination explains the reasons for the determination, the procedures for obtaining additional information, and contains a notification of the right to seek a redetermination).

41. 42 U.S.C. § 1395ff(a)(3)(B), (C)(i); *see* 42 C.F.R. §§ 405.940–405.958 (stating that redetermination is made by someone not involved in the initial determination).

42. 42 C.F.R. § 405.942.

43. 42 C.F.R. § 405.946.

44. 42 C.F.R. § 405.950.

45. 42 U.S.C. § 1395ff(c); 42 U.S.C. § 1395ff(c)(3)(A)(B) (stating that qualified independent contractors must have medical, legal, and other expertise to make reconsiderations for coverage).

46. 42 U.S.C. § 1395ff(b)(1)(A), (D); 42 C.F.R. §§ 405.960–405.978.

However, the party must request the reconsideration within 180 days of the redetermination, and reconsideration must occur within 60 days.[47] The QIC's decision is a detailed explanation based on the pertinent facts, regulations, and relevant medical and scientific rationale.[48]

If unsatisfied with the QIC's decision, the party may appeal to an administrative law judge (ALJ) if it meets a certain amount-in-controversy.[49] The ALJ hearing starts the Departmental Appeals Board (DAB) appeal process, and the agency officially hears the claim.[50] The party may not bring new evidence to the ALJ unless it is for a good cause.[51] The ALJ has 90 days to decide on the claim.[52] If the ALJ fails to decide, the party may appeal the claim to the next step in the agency appeal process.[53]

If the party still disagrees with the outcome of the ALJ hearing, the party may appeal it to the Medicare Appeals Council (MAC) of DAB, which also has an amount-in-controversy requirement.[54] Like the ALJ, the MAC has 90 days to review the claim.[55] If the MAC fails to decide, § 405(h) dictates that a court may review the claim.[56] The MAC is the end of the DAB appeals process; thus, the provider exhausted their remedies with HHS.

2. Provider Agreement Termination Appeals

When CMS terminates a Provider Agreement, providers may appeal straight to the agency and have a hearing with an ALJ.[57] Providers will continue to appeal through the DAB appeal process from there.[58]

47. 42 C.F.R. § 405.962.

48. 42 U.S.C. § 1395ff(c)(3)(E); 42 C.F.R. § 405.966.

49. 42 C.F.R. §§ 405.1000–405.1054; 42 U.S.C. § 1395ff(b)(1)(e).

50. *Medicare and Medicaid Guide Explanations and Annotations*, *supra* note 9 (providing that the claim is now inside the agency appeal process, which includes the ALJs that are part of the Office of Medicare Hearings and Appeals). This is the start of the agency appeal process or the DAB process, and the claim is funneled into the overall agency appeal process.

51. 42 U.S.C. § 1395ff(b)(3).

52. 42 U.S.C. § 1395ff(d)(1)(A).

53. 42 U.S.C. § 1395ff(d)(3)(A).

54. 42 C.F.R. §§ 405.1100–405.1140.

55. 42 U.S.C. § 1395ff(d)(2)(A).

56. 42 U.S.C. § 1395ff(d)(2)(B).

57. 42 C.F.R. § 498.5(b), (c), (d), (f) (expressing that these appeals also include prospective providers that wanted to enter into an Agreement with CMS and CMS refused to enter into the Agreement).

58. *Id.* (granting the provider the right to appeal).

3. Medicare Advantage Appeals

The Medicare Advantage Appeals system is another appeal process that feeds into the DAB appeal process; thus, providers will eventually have a hearing with the ALJ and MAC.[59] Initially, the law requires that Medicare Advantage organizations provide a grievance solution mechanism.[60] However, Medicare Advantage coverage may be appealed to an independent review organization and then appealed through the DAB appeal process.[61]

4. The Provider Reimbursement Review Board (Reimbursement Appeals)

An entirely different appeal system in HHS is the Provider Reimbursement Review Board (PRRB).[62] The PRRB does not feed into the DAB but is subject to § 405(h).[63] When providers are dissatisfied with a Medicare contractor's or fiscal intermediary's reimbursement, providers may appeal within 180 days.[64] This review is only available for providers that meet a certain amount in controversy; otherwise, providers may appeal to a hearing officer or a panel designed by the Medicare contractor.[65] The PRRB's decisions are reviewable by the Deputy Administrator of CMS.[66] Providers may seek judicial review of the PRRB or the Administrator's Decision; however, the appeals brought to the hearing officer and panel do not have the option of judicial review.[67] The Administrator can review the Medicare contractor's decision.[68]

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59. 42 U.S.C. § 1395w–22(g)(5) (granting appeal rights to enrollees).

60. 42 U.S.C. § 1395w–22(g) (providing for the required disclosures, in addition to the mandated grievance mechanism, which is a similar process to other appeal mechanisms starting with coverage determinations, reconsideration, and an appeal hearing before the agency); 42 U.S.C. § 1395ff (providing the appeal is further limited by an amount and controversy requirement).

61. 42 C.F.R. §§ 422.592–422.616, 422.624, 422.626.

62. FURROW, *supra* note 12, at 452.

63. *Id.* This appeal system is separate from the prior appeal systems but is still subject to § 405(h). Providers appealing reimbursement amounts still need to exhaust their remedies through the agency.

64. 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835–405.1840.

65. 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1837, 405.1839 (stating that the PRRB review is only for claims between the amount of $10,000 or more, but providers can aggregate claims individually if they reach $10,000 or $50,000 as a group if they face a common issue of fact or law); 42 C.F.R. §§ 405.1809–405.1833 (designating that if the amount in controversy is only $1,000 to less than $10,000 then the provider will have to use the officer or panel alternative). The amount in controversy requirements limit the number of claims that providers can appeal.

66. 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1875.

67. 42 C.F.R. § 405.1877; FURROW, *supra* note 12, at 453.

68. 42 C.F.R. § 405.1834.

In the Medicare system, a contractor or fiscal intermediary audits providers.[69] Then, the contractor determines how much to reimburse providers for their services.[70] Consequently, CMS can overpay providers, and the regulations direct that providers must repay these funds to the government.[71]

5. Office of Medicare Hearings and Appeals

The Office of Medicare Hearings and Appeals (OMHA) is the nationwide ALJ hearing program for all claims arising under Medicare.[72] The Medicare Modernization Act of 2003 created OMHA to simplify and streamline the appeals process.[73] The adjudicator conducts a *de novo* review of the appellant's case and decides the issue at this level.[74]

D. The Issue in the Appeals Process

The appeal process is time-consuming and discourages appellants from skipping steps.[75] The HHS appeal system consists of multiple appeal routes that combine into one final appeal route. Thus, it is hard to pinpoint where the problem arises in the system. Nevertheless, HHS is experiencing a significant backlog at the OMHA level.[76] In 2015, this level received more than a year's worth of appeals every 18 weeks.[77] Additionally, in 2015, the MAC received a year's worth of appeals every 11 weeks.[78] In 2021, the average processing time for OMHA appeals was

69. 42 U.S.C. § 1395h(a).

70. 42 C.F.R. § 405.1803.

71. 42 C.F.R. § 413.64(f).

72. *Office of Medicare Hearings and Appeals (OMHA)*, HHS.GOV (Oct. 20, 2021, 10:31 PM), https://www.hhs.gov/about/agencies/omha/index.html [https://perma.cc/8DPM-HGRS].

73. *About OMHA*, HHS.GOV (Oct. 20, 2021, 10:32 PM), https://www.hhs.gov/about/agencies/omha/about/index.html [https://perma.cc/5QY9-HA9G].

74. *Id.* This ALJ is the first agency adjudicator to hear the claim.

75. FURROW, *supra* note 12, at 447; *see also* MEDICARE FEE-FOR-SERVICE OPPORTUNITIES REMAIN TO IMPROVE APPEALS PROCESS, UNITED STATES GOVERNMENT ACCOUNTABILITY OFFICE 17–21 (Oct. 20, 2021, 11:34 PM), https://www.gao.gov/assets/gao-16-366.pdf [https://perma.cc/A8Z2-9PKB] (stating that the total adjudication time for a claim was five years to get through the first four levels of the DAB, although the process was designed to take less than one year).

76. OMHA is the ALJ level and the level at which all the appeals converge together into the final appeal route.

77. MEDICARE APPEALS BACKLOG PRIMER FINAL, HHS.GOV 7 (Jan. 23, 2022, 2:34 PM), https://www.hhs.gov/sites/default/files/dab/medicare-appeals-backlog.pdf [https://perma.cc/ASR8-9ZEN].

78. *Id.* This is level immediately after the ALJ.

1,259.7 days.[79] In 2015, the average claim at the MAC level was 571 days.[80] HHS admits that the number of appeals outpaced the DAB appeal system.[81]

Likewise, the PRRB is not performing any better. In 2016, the PRRB had 10,000 cases on its docket but had only issued 27 decisions that closed 66 cases.[82] The PRRB expedited 147 judicial determinations and 497 jurisdictional determinations but still maintains a backlog at its current rate.[83] The average time to adjudicate an appeal in 2013 was almost 1,095 days.[84]

1. Options Available After Termination

When CMS terminates a Provider Agreement or withholds a significant portion of its revenue, providers have few options to deal with their financial condition. The first option is to appeal to the DAB or PRRB and start the agency appeal process.[85] However, this may be financially unfeasible; as demonstrated, this could take years to reach a decision.

79. *Average Processing Time by Fiscal Year*, HHS.GOV (Mar. 12, 2022, 10: 25 AM), https://www.hhs.gov/about/agencies/omha/about/current-workload/average-processing-time-by-fiscal-year/index.html [https://perma.cc/7X6N-SST6].

80. MEDICARE FEE-FOR-SERVICE OPPORTUNITIES REMAIN TO IMPROVE APPEALS PROCESS, *supra* note 75, at 18 (citing that average processing time for the OMHA level was 689 days in 2015, indicating the problem occurs to be growing).

81. *Workload Information and Statistic*, HHS.GOV (Oct. 20, 2021, 10:50 PM), https://www.hhs.gov/about/agencies/omha/about/current-workload/index.html [https://perma.cc/7PNN-2RR4].

82. *HHS Developing New System to Speed PRRB and Other Appeal Processes*, WOLTERS KLUWER (Jan. 10, 2022, 9:52 AM), http://health.wolterskluwerlb.com/2017/04/hhs-developing-new-system-to-speed-prrb-other-appeal-processes/ [https://perma.cc/62MT-JJM6].

83. *Id.*

84. *HHSOPRRB0005 - Hearing Level – Procedures*, ADJUDICATION RES. JOINT PROJECT OF ACUS AND STANFORD L. SCH. (Jan. 11, 2022, 9:13 AM), https://acus.law.stanford.edu/hearing-level/hhsoprrb0005-hearing-level-procedures-0 [https://perma.cc/5889-Y3B4].

85. 42 C.F.R. § 498.5.

Thus, after losing a significant part of its revenue, a healthcare organization's best option[86] is to file bankruptcy.[87]

2. The Role of Bankruptcy Jurisdiction

Federal courts may hear bankruptcy cases through 28 U.S.C. § 1334, and bankruptcy courts may hear bankruptcy cases for federal courts through 28 U.S.C. § 157.[88] Federal courts have original and exclusive jurisdiction over bankruptcy cases.[89] One form of bankruptcy is Chapter 11 bankruptcy, which allows an organization to continue operating its business while formulating a reorganization plan with its creditors.[90] The bankruptcy code uses automatic stay to aid the organization in its effort to continue to operate its business.[91] An automatic stay is an injunction that goes into effect after the organization files its petition and generally stops all prepetition acts by the creditors against the organization.[92]

III. STATEMENT OF THE CASE

A. The Circuits Split on Interpreting the Meaning of § 405(h)

A circuit split exists between the Ninth, Fifth, Third, and Eleventh Circuits regarding whether § 405(h) bars bankruptcy jurisdiction. If the bankruptcy court has an independent basis for jurisdiction over the Medicare claim, the Ninth, Fifth, and Third Circuits held that the bankruptcy court may exercise jurisdiction.[93] On the other hand, if the claim is primarily about the entitlement to benefits under the Medicare

86. Fla. Agency for Health Care Admin. v. Bayou Shores SNF, LLC (*In re* Bayou Shores SNF, LLC), 525 B.R. 160, 165 (Bankr. M.D. Fla. 2014) (finding that if the court does have jurisdiction over the claim, then it may be possible to get a temporary restraining order on CMS to not terminate the Agreement); *see also* Emma Trivax, *The Collateral-Claim Exception: A Unique Solution to the Harmful Backlog of Medicare Appeals*, 65 WAYNE L. REV. 687, 688 (2020) (explaining the collateral-claim exception). Another possible way to avoid § 405(h) is the collateral-claim exception. If the provider can show that a constitutional violation occurred and is entirely collateral to the backlog in the appeals, the provider does not have to exhaust their administrative remedies. Yet, this exception cannot interfere with the underlying merits of the Medicare claim. Thus, depending on the jurisdiction and the circumstances of the provider, it is possible for the provider to avoid the agency appeal process.

87. *In re* Town & Country Home Nursing Servs., Inc., 963 F.2d 1146, 1148 (9th Cir. 1991).

88. 28 U.S.C. § 1334; 28 U.S.C. § 157.

89. 28 U.S.C. § 1334(a).

90. CHARLES JORDAN TABB, LAW OF BANKRUPTCY 1032–33 (5th ed. 2020).

91. 11 U.S.C. § 362.

92. 11 U.S.C. § 362(a)(1).

93. Leslie A. Berkoff, *Circuit Splits Over Medicare Claims*, 38 AM. BANKR. INST. J., 24, 25 (2019).

Act, then the Third and Fifth Circuits bar bankruptcy jurisdiction until the claimant exhausts its remedies with the agency.[94] Therefore, the Ninth and Eleventh Circuits stand opposed to each other, the Ninth always allowing bankruptcy jurisdiction, the Eleventh never allowing bankruptcy jurisdiction, and the Third and Fifth Circuits look to whether the claim arose under bankruptcy law or the Medicare Act.[95]

B. Ninth Circuit's Analysis

In *Town & Country*, a contractor[96] responsible for paying Medicare reimbursements to the healthcare organization overpaid the organization significantly.[97] To fix the overpayment, the contractor withheld future payments until the balance was due; however, the contractor miscalculated the overpayment.[98] As a result, the organization did not owe nearly the amount the contractor withheld, and the organization filed for bankruptcy.[99]

The U.S. Secretary of Health and Human Services (Secretary) argued that the organization did not exhaust its remedies within the agency.[100] The court disagreed, relying heavily on the court's jurisdiction on bankruptcy cases and cases related to bankruptcy.[101] The court stated, "Section 405(h) only bars actions under 28 U.S.C. §§ 1331 and 1346; it in no way prohibits an assertion of jurisdiction under section 1334."[102] As long as the bankruptcy court has an independent basis for jurisdiction, the claimant does not need to exhaust his remedies with the agency.[103]

In another Ninth Circuit case, the court ruled the exhaustion requirement applies to diversity jurisdiction, which seems at odds with its reasoning in *Town & Country,* considering both diversity jurisdiction and bankruptcy jurisdiction are not listed in § 405(h).[104] However, in a case after both, the court clarified that bankruptcy jurisdiction is unique from other jurisdictional grants; bankruptcy jurisdiction affords the court broad

94. *Id.*
95. *Id.*
96. 42 U.S.C. § 1395g; 42 C.F.R. § 413.60 (explaining that the Medicare program reimburses providers through fiscal intermediaries or contractors).
97. *In re* Town & Country Home Nursing Servs., Inc., 963 F.2d 1146, 1148 (9th Cir. 1991).
98. *Id.*
99. *Id.*
100. *Id.* at 1153–54.
101. *Id.* at 1155.
102. *Id.*
103. *Id.* at 1154.
104. Kaiser v. Blue Cross of Cal., 347 F.3d 1107 (9th Cir. 2003).

power over all the bankruptcy estate.[105] Thus, the Ninth Circuit takes a firm stance that § 405(h) does not bar bankruptcy jurisdiction.[106]

C. Fifth Circuit's Analysis

In *In re Benjamin,* the Social Security Administration (SSA) notified the claimant that the beneficiary's benefits expired and that the SSA would recover the overpayments that the beneficiary collected.[107] While the claimant appealed through the agency, the SSA collected the overpayment, compelling him to file for bankruptcy.[108]

The court pointed out that the Third, Seventh, and Eighth Circuits barred 28 U.S.C. § 1332 jurisdiction using the Act's legislative history for hearing claims under the Medicare Act, regardless of the statute's text.[109] Ultimately, the court rejected the non-textual approach and adopted the plain language approach, thereby discarding the recodification and legislative history arguments.[110] The court also rejected the policy argument raised by the SSA and restricted the SSA to the plain language of the statute, quoting from *Utility Air Regulatory Group*, "We reaffirm the core administrative-law principle that an agency may not rewrite clear statutory terms to suit its own sense of how the statute should operate."[111] The court clarified that § 405(h) does not apply to every claim related to the agency but only those associated with the entitlement of benefits.[112]

D. Third Circuit's Analysis

In *In re Univ. Med. Ctr.*, the contractor overpaid the healthcare organization and subsequently withheld a portion of future payments to balance out the total payments.[113] However, after attempting a repayment plan, the healthcare organization did not comply with the contractor's

105. Do Sung Uhm v. Humana, Inc., 620 F.3d 1134 (9th Cir. 2010).

106. *In re Town & Country Home Nursing Servs., Inc.*, 963 F.2d at 1155.

107. Benjamin v. United States, SSA (*In re* Benjamin), 932 F.3d 293, 294–95 (5th Cir. 2019).

108. *Id.* at 295.

109. Bodimetric Health Servs. Inc. v. Aetna Life & Casualty, 903 F.2d 480, 488–90 (7th Cir. 1990); Nichole Med. Equip. & Supply, Inc. v. TriCenturion, Inc., 694 F.3d 340, 346–47 (3d Cir. 2012); Midland Psychiatric Assocs., Inc. v. United States, 145 F.3d 1000, 1004 (8th Cir. 1998).

110. *In re Benjamin*, 932 F.3d at 298 ("With respect to the majority of our sister circuits, we reject the non-textual approach exemplified by the Eleventh Circuit and join the Ninth Circuit in applying the third sentence's plain meaning—a meaning that, everyone agrees, does not bar § 1334 jurisdiction.").

111. *Id.* at 300 (quoting Utility Air Regulatory Group v. EPA, 573 U.S. 302 (2014)).

112. *Id.* at 301.

113. Univ. Med. Ctr. v. Sullivan, (*In re* Univ. Med. Ctr.), 973 F.2d 1065, 1070 (3d Cir. 1992).

terms, prompting HHS to withhold all payments.[114] As a result, the healthcare organization closed its doors and filed for bankruptcy.[115] However, during the bankruptcy proceedings, HHS violated the automatic stay provision of the bankruptcy code by demanding the pre-petition overpayments and withholding the post-petition.[116]

On appeal, the Secretary argued that the provider did not exhaust its claim through the agency.[117] The provider argued its claim was not a Medicare claim; however, the Supreme Court construes the "claim arising under" language in § 405(h), defining it "to encompass any claims in which 'both the standing and substantive basis for the presentation' of the claims is the Medicare Act."[118] However, in this case, the court determined that the claim arose under the bankruptcy code as a violation of the automatic stay provision and did not arise under the Medicare Act; therefore, the healthcare organization did not have to exhaust its remedies in the agency.[119]

The court recognized the importance of the agency deciding claims related to Medicare, but also stated, "[W]here there is an independent basis for bankruptcy court jurisdiction, exhaustion of administrative remedies pursuant to other jurisdictional statutes is not required."[120] Thereby, the Third Circuit preserved the Ninth Circuit's certainty that bankruptcy courts have jurisdiction over bankruptcy claims, while emphasizing that HHS has jurisdiction over Medicare claims; essentially, holding the channel of review depends on where the claim arises.

E. Eleventh Circuit's Analysis

A healthcare facility lost its Agreement after failing to comply with Medicare regulations.[121] When CMS terminated the organization's Agreement, the organization filed for bankruptcy to have the court protect its Agreement via the automatic stay.[122] However, on appeal from the

114. *Id.* at 1070–71.
115. *Id.* at 1071.
116. *Id.*
117. *Id.* at 1072–73.
118. *Id.* at 1073 (quoting Heckler v. Ringer, 466 U.S. 602, 615 (1984); Weinberger v. Salfi, 422 U.S. 749, 760–61 (1975)).
119. *Id.*
120. *Id.* at 1073-74 (quoting *In re* Town & Country Home Nursing Servs. Inc., 963 F.2d 1146, 1154 (9th Cir. 1991)).
121. Fla. Agency for Health Care Admin. v. Bayou Shores SNF, LLC (*In re* Bayou Shores SNF, LLC), 828 F.3d 1297, 1299–300 (11th Cir. 2016); *see infra* Part I for the facts of *In re* Bayou Shores SNF, LLC.
122. *Id.* at 1300, 1303.

bankruptcy court, the circuit court found that the bankruptcy court did not have jurisdiction over the claim.[123]

The court relied on the Act's legislative history, which barred bankruptcy jurisdiction if not for a recodification error that omitted § 1334.[124] Moreover, the court also established that barring bankruptcy jurisdiction is consistent with congressional policy.[125] Essentially, the best adjudicator in healthcare decisions is HHS, not a bankruptcy court.[126] In this case, the bankruptcy court made decisions that HHS would normally be making, such as reinstating the Agreement or ensuring the organization's compliance with Medicare regulations.[127] Ultimately, the claim arose under the Medicare Act and should proceed through the agency before the claim can proceed to the district court.[128] Therefore, § 405(h) bars bankruptcy courts from hearing Medicare claims.[129]

F. Other Circuits

Two other circuits recognized the issue but did not express their opinion in the split. In the Seventh Circuit, a bankruptcy court issued a preliminary injunction barring CMS from terminating a healthcare Provider Agreement; however, the issue was moot upon appeal, so the court did not contribute to the split.[130] The other circuit to examine the issue was the First Circuit, and it assumed hypothetical jurisdiction to decide the claim.[131] The court found no violation of the automatic stay or other parts of the bankruptcy code by CMS but did find that the healthcare organization no longer complied with regulations and rightfully lost its Agreement.[132]

123. *Id.* at 1303–04.
124. *Id.* at 1304–10.
125. *Id.* at 1324.
126. *Id.* at 1324–25.
127. *Id.*
128. *Id.* at 1326, 1329–31.
129. *Id.* at 1331.
130. Home Care Providers, Inc. v. Hemmelgarn, 861 F.3d 615, 623 (7th Cir. 2017).
131. Parkview Adventist Med. Ctr. v. United States *ex rel.*, 842 F.3d 757, 760 (1st Cir. 2016).
132. *Id.* at 761–65.

IV. ANALYSIS

A. The Legislators' Intended to Bar Bankruptcy Jurisdiction

1. The Legislative History Supports Barring Bankruptcy Jurisdiction

Congress should amend the statute to explicitly bar bankruptcy jurisdiction to reflect the Act's original intent. As initially written, the statute intended to bar bankruptcy courts from hearing Medicare claims.[133] After a recodification, Congress omitted several jurisdictional grants from the statute, leaving the plain text to support judicial adjudication of Medicare claims.[134] Nonetheless, the legislators' intent is evident, and the recodification canon of statutory construction allows courts to continue using the pre-amended meaning of § 405(h).[135]

a) The Original Congress Intended to Bar Bankruptcy Courts from Adjudicating Medicare Claims

The legislative history of § 405(h) reveals Congress did not intend to change the substantive law of § 405(h) when it recodified the laws.[136] As currently written,[137] the language of § 405(h) appears not to bar bankruptcy courts from hearing Medicare claims; however, before Congress recodified § 405(h), Congress intended to bar bankruptcy courts from hearing Medicare claims without prior agency exhaustion.[138]

The original text of the statute stated:

> (h) The findings and decision of the Board after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Board shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Board, or any officer or employee thereof shall be brought under *section 24 of the Judicial Code of the United*

133. *In re Bayou Shores SNF, LLC*, 828 F.3d at 1304–10.

134. 42 U.S.C. § 405 (1982).

135. *In re Bayou Shores SNF, LLC*, 828 F.3d at 1318 (quoting Muniz v. Hoffman, 422 U.S. 454, 472 (1975)).

136. *Id.* at 1304–10.

137. 42 U.S.C. § 405(h) (2020). The language currently lacks the bankruptcy jurisdiction grant; thus, bankruptcy courts are not subject to the exhaustion requirement. Therefore, as currently written, it appears that a provider would not have to appeal a claim with the agency before proceeding to bankruptcy court.

138. *In re Bayou Shores SNF, LLC*, 828 F.3d at 1304–10.

> *States* to recover on any claim arising under this title. (Emphasis added).[139]

In 1939, section 24 of the Judicial Code granted federal district courts original jurisdiction over bankruptcy proceedings, diversity actions, federal questions, and claims against the United States.[140] Therefore, the statute initially barred all federal courts from hearing Medicare claims until agency exhaustion, including bankruptcy courts.[141]

b) A Recodification of the Judicial Code into Title 28

In 1948, Congress recodified section 24 of the Judicial Code into Title 28 in the U.S. Code and split the jurisdictional grants into multiple sections within Title 28.[142] For example, 28 U.S.C. § 1331 grants federal question jurisdiction, 28 U.S.C. § 1332 grants diversity jurisdiction, and 28 U.S.C. § 1334 grants bankruptcy jurisdiction.[143] Despite this recodification, for nearly 30 years after section 24 of the Judicial Code no longer existed, the text of § 405(h) improperly read "section 24 of the Judicial Code."[144]

c) The Office of the Law Revision Counsel Revises the Statute

To fix this mistake in the U.S. Code, the Office of the Law Revision Counsel (Revisers) switched "Section 24 of the Judicial Code of the United States" with the current two jurisdictional grants "section 1331 or 1346 of title 28", thus omitting the remaining jurisdictional grants.[145] *However, the Revisers do not have the power to make laws or change jurisdictional grants; they can only make editorial adjustments.*[146] The Revisers expanded on their 1976 codification notes in the 1982 U.S. Code by clarifying the jurisdictional provisions that were not encompassed

139. 42 U.S.C. § (1939), Pub. L. No. 76-379, 53 Stat. 1360, 76 Cong. Ch. 666.

140. *See* Judicial Code, Pub. L. No. 61-475, 36 Stat. 1087, 61 Cong. Ch. 231, § 24(19), 24(1), 24(20) (1911).

141. *In re Bayou Shores SNF, LLC*, 828 F.3d at 1305 (quoting Weinberger v. Salfi, 422 U.S. 749, 756 n. 3 (1975)).

142. *Id.* at 1305; *see generally* U.S. Code Title 28, Pub. L. No. 80-773, 62 Stat. 869 (1948).

143. 28 U.S.C. §§ 1331–32, 1334.

144. *In re Bayou Shores SNF, LLC*, 828 F.3d at 1305 (citing Weinberger v. *Salfi,* 422 U.S. 749, 756 (1975). A footnote in the *Weinberger* opinion pointed out the error created by the 1948 Judicial Code recodification. The footnote merely pointed out that the text was never changed; thus the U.S. Code had a mistake in the text for 30 years.

145. *See* 42 U.S.C. § 405 (1976).

146. *See North Dakota v. United States,* 460 U.S. 300, 311 n.13 (1983).

under the new text, including bankruptcy jurisdiction.[147] The codification notes to the 1982 U.S. Code read:

> In subsec. (h), "sections 1331 or 1346 of title 28" was substituted for "section 24 of the Judicial Code of the United States" on the authority of Act June 25, 1948, ch. 646, 62 Stat. 869, section 1 of which enacted Title 28, Judiciary and Judicial Procedure. Prior to the enactment of Title 28, section 24 of the Judicial Code was classified to section 41 of Title 28. *Jurisdictional provisions previously covered by section 41 of Title 28 are covered by sections 1331 to 1348, 1350 to 1357, 1359, 1397, 1399, 2361, 2401, and 2402 of Title 28*. (Emphasis added).[148]

Thus, after the Revisers's editorial adjustments and notes, the text unofficially appeared to allow bankruptcy courts to have jurisdiction over Medicare claims before prior exhaustion with HHS.

d) Technical Correction Act of 1983

To make the Revisers's adjustments official, Congress introduced the "Technical Corrections Act of 1983" to describe the origin and purpose of the changes but ultimately merged with another bill before it passed.[149] A report of the bill for the "Technical Corrections Act of 1983" describes it as "technical in nature" and intended to clarify and confirm various provisions adopted by the acts. . . ."[150] The bill proposed enacting the prior codification into positive law.[151] Yet, following this section of the bill was the effective dates section, which preserved the substance of the law.[152] The section stated:

> (b)(1) Except to the extent otherwise specifically provided in this title, the amendments made by section 403 shall be effective on the date of enactment of this Act; *but none of such amendments shall be construed as changing or affecting any right, liability, status, or*

147. 42 U.S.C. § 405 (1982).

148. *Id.* (indicating that revisers removed 28 U.S.C. § 1334, but not providing any justification for their removal).

149. 129 CONG. REC. 23,439 (daily ed. Jan. 3, 1983) (statement of Rep. Rostenkowski); Technical Corrections Act of 1983, H.R. 3805, 98th Cong. (1983); *In re Bayou Shores SNF, LLC*, 828 F.3d at 1307.

150. *See* STAFF OF J. COMM. ON TAXATION, 98TH CONG., DESCRIPTION OF H.R. 3805 (TECHNICAL CORRECTIONS ACT OF 1983) 1 (J. Comm. Print 1983).

151. *See Technical Corrections Act of 1983: Hearing on H.R. 3805 Before the H. Comm. on Ways and Means*, 98th Cong. 79 (1984) (draft text of H.R. 3805).

152. *Id. at* 89–90.

> *interpretation which existed (under the provisions of law involved) before that date*. (Emphasis added).[153]

Moreover, the legislative history characterizes the changes and the "technical corrections" to the Act as correcting spelling, punctuation, and cross-references to other codes and acts.[154] The Bill's sponsor, Representative Dan Rostenkowski, said, "I would like to emphasize that this bill intends simply to correct technical errors and to better reflect the policies established by the Congress in enacting the original legislation."[155]

e) The Deficit Reduction Act of 1984

The "*Technical Corrections Act of 1983" did not pass independently but* merged with the Deficit Reduction Act of 1984.[156] The corrections were under a "Technical Corrections" heading. The provision was consistent with the 1976 and 1982 codifications, as the amendment proposed in H.R. 3805.[157] The Act officially modified § 405(h) to contain the current language.[158] The Deficit Reduction Act of 1984 went on to explain that ". . . such amendments shall [not] be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) . . . ."[159] Again, the House Committee Report on the Deficit Reduction Act of 1984 explained that the reason for the House of Representative's corrections was to make general corrections of spelling, punctuation, and cross-references to other acts and codes.[160]

153. *Id.*

154. 129 CONG. REC. 23321, 23440 (1983) (statement of Rep. Rotenkowski).

155. *Id.*

156. The Deficit Reduction Act of 1984, Pub. L. No. 98–369, 98 Stat. 494 (1984) ("The purpose of the Act was to provide for tax reform, and for deficit reduction."); *see also* H.R. 3805, 98th Cong. (1983) (failing to make any refence to bankruptcy jurisdiction). The Deficit Reduction Act of 1984 did not contain any references to bankruptcy jurisdiction.

157. The Deficit Reduction Act of 1984, Pub. L. No. 98–369, 98 Stat. 494, 1162 (1984). The statute kept the same text as the prior Revisers's notes and editorial adjustments.

158. *Id.*

159. *Id.* at 1171–72.

160. *See* H.R. Rep. No. 98-432, pt. 2, at 1663 (1984); *see also* Fla. Agency for Health Care Admin. v. Bayou Shores SNF, LLC (*In re* Bayou Shores SNF, LLC), 828 F.3d 1297, 1308 (11th Cir. 2016). Nothing else in the report or legislative history of the Deficit Reduction Act suggests that Congress intended to change the jurisdictional grant or that bankruptcy courts should have parallel authority with HHS over Medicare claims.

f) The Deficit Reduction Act of 1984's Amendment to 42 U.S.C. § 405(h) Was a Technical Amendment and Did Not Change the Substantive Law

The recodification canon of statutory construction proposes that "[a] change of language in a revised statute will not change the law from what it was before, unless it be apparent that such was the intention of the legislature."[161] Essentially, after a recodification, courts will not infer that the legislature intended to change its policy without a clear expression to do so.[162] Other cases from the 1948 recodification of the Judicial Code used the recodification canon to retain their prior meaning.[163] In *Fourco Glass Co. v. Transmirra Prods. Corp.*,[164] the Court stated that nothing in the legislative history indicated a substantive change and that any change of arrangement of the statute could not be regarded as altering the scope and "[t]he change of arrangement, which placed portions of what was originally a single section in two separate sections cannot be regarded as altering the scope and purpose of the enactment. For it will not be inferred that Congress, in revising and consolidating the laws, intended to change their effect, unless such intention is clearly expressed."[165]

Likewise, in *Tidewater Oil Co. v. the United States,* the Court rejected the notion that a recodification could substantially modify the law.[166] Under the recodification, a new interpretation of the statute was plausible; thus, the Court relied upon the absence of a "clearly expressed

161. *In re Bayou Shores SNF, LLC*, 828 F.3d at 1315 (citing Stewart v. Kahn, 78 U.S. 493, 502 (1870)).

162. *Id.* (citing United States v. Ryder, 110 U.S. 729, 740 (1884)).

163. *Id.* (citing McDonald v. Hovey, 110 U.S. 619, 629 (1884); Logan v. United States, 144 U.S. 263, 302 (1892); Witherspoon v. Illinois, 391 U.S. 510 (1968); Holmgren v. United States, 217 U.S. 509, 520 (1910); Anderson v. Pac. Coast S.S. Co., 225 U.S. 187, 199 (1912); United States v. Sischo, 262 U.S. 165, 168–69 (1923); Hale v. Iowa State Bd. of Assessment & Review, 302 U.S. 95, 102 (1937); Fourco Glass Co. v. Transmirra Prods. Corp., 353 U.S. 222, 227 (1957); United States v. FMC Corp., 84 S. Ct. 4, 7 (Goldberg, Circuit Justice 1963); United States v. Welden, 377 U.S. 95, 98 n.4 (1964); Tidewater Oil Co. v. United States, 409 U.S. 151, 162 (1972); Cass v. United States, 417 U.S. 72, 82 (1974); Aberdeen & Rockfish R. Co. v. Students Challenging Regulatory Agency Procedures (S.C.R.A.P.), 422 U.S. 289, 309 n.12 (1975); Muniz v. Hoffman, 422 U.S. 454, 470 (1975); Fulman v. United States, 434 U.S. 528, 538 (1978); Walters v. Nat'l Ass'n of Radiation Survivors, 473 U.S. 305, 318 (1985); Finley v. United States, 490 U.S. 545, 554 (1989); Ankenbrandt v. Richards, 504 U.S. 689, 700 (1992); Keene Corp. v. United States, 508 U.S. 200, 209 (1993); Scheidler v. Nat'l Org. for Women, Inc., 547 U.S. 9, 20 (2006); John R. Sand & Gravel Co. v. United States, 552 U.S. 130, 136 (2008)).

164. *Id.* (citing *Fourco Glass Co. v. Transmirra Prods. Corp.*, 353 U.S. 222 (1957) (answering the question if the 1948 recodification, which recodified § 48 of the Judicial Code to 28 U.S.C. § 1400(b) substantively changed the patent venue statute)).

165. *Id.* (quoting Fourco Glass Co. v. Transmirra Prods. Corp., 353 U.S. 222 (1957)).

166. *Tidewater Oil Co. v. United States*, 409 U.S. 151, 162 (1972) (finding the 1948 judicial recodification changed the appellate jurisdiction for civil interlocutory appeals in antitrust cases).

intent" by Congress to change the law in the recodifications to retain the meaning of the law as it was before the recodification.[167] This reasoning was further reinforced in *Muniz v. Hoffman*, where before the recodification, there was "no right to a jury trial in contempt actions to enforce injunctions issued under the Wagner and Taft-Hartley Acts"; however, after the 1948 recodification, it appeared that the party had a right to a jury trial.[168] The Court looked to the Revisers's notes, which expressed that there was no substantive change intended in the revisions to the law; accordingly, the Court maintained the original meaning.[169] Finally, in *Finley v. the United States, the Court* considered whether the recodification of the law created a "new pendent" party jurisdiction.[170] Justice Scalia wrote, "Under established canons of statutory construction, it will not be inferred that Congress, in revising and consolidating the laws, intended to change their effect unless such intention is clearly expressed."[171]

g) Applying the Statutory Canon to 42 U.S.C. § 405(h)

The recodification canon of statutory construction shows that the Revisers's made an error when it failed to include bankruptcy jurisdiction in 42 U.S.C. § 405(h).[172] After recodifying the laws, Congress must clearly express intent to change the substantive law. Here, the legislative history shows no intent to change the law.

For instance, the adjustments suggested in the "Technical Corrections Act of 1983" were to "clarify and conform various provisions" and were merely "technical in nature."[173] Later in the "Technical Corrections Act of 1983" and the "Deficit Reduction Act of 1984," the Acts expressly state that the amendments will not be construed to change the substantive meaning of the law.[174] Both Acts indicate that

167. *Id.* at 162–63.

168. Muniz v. Hoffman, 422 U.S. 454, 461–63, 67 (1975).

169. *Id.* at 468–69.

170. *Finley v. United States*, 490 U.S. 545, 553–54 (1989) (quoting from *Anderson v. Pac. Coast S.S. Co.*, 225 U.S. 187, 199 (1912); *United States v. Ryder*, 110 U.S. 729, 740 (1884)) (allowing the pre-amended interpretation of the statute to continue being used).

171. *Id.* (quoting from *Anderson v. Pac. Coast S.S. Co.*, 225 U.S. 187, 199 (1912); *United States v. Ryder*, 110 U.S. 729, 740 (1884)) (allowing the pre-amended interpretation of the statute to continue being used).

172. Fla. Agency for Health Care Admin. v. Bayou Shores SNF, LLC (*In re* Bayou Shores SNF, LLC), 828 F.3d 1297, 1319 (11th Cir. 2016).

173. *See* STAFF OF J. COMM. ON TAXATION, 98TH CONG., DESCRIPTION OF H.R. 3805 (TECHNICAL CORRECTIONS ACT OF 1983) 1 (J. Comm. Print 1983).

174. *See Technical Corrections Act of 1983: Hearing on H.R. 3805 Before the H. Comm. on Ways and Means*, 98th Cong. 79 (1984) (draft text of H.R. 3805). *98 Stat. 494, 1171–72.*

the corrections fix the cross-references and other technical issues.[175] Finally, the "Technical Corrections Act of 1983's" sponsor said that this was not to change the law but was to align the recodification with the original congressional intent.[176] Therefore, the recodification canon shows that the Revisers and Congress made an error when amending 42 U.S.C. § 405(h), and it should be interpreted with the same jurisdictional grants that "Section 24 of the Judicial Code" granted it. In other words, § 405(h) bars bankruptcy courts from hearing Medicare claims.

2. The Plain Language of the Current Text Permits Bankruptcy Jurisdiction

Advocates of allowing providers to use the bankruptcy courts argue that the plain language does not bar the adjudication of Medicare claims in the bankruptcy courts. The plain language of § 405(h) "only bars actions under 28 U.S.C. §§ 1331 and 1346; it in no way prohibits an assertion of jurisdiction under § 1334."[177] The recodification canon requires that there must be a clear indication of Congress's intent to change the law, but the "most obvious source of congressional intent" is the words of the statute itself.[178] Moreover, "The new text is the law, and where it clearly makes a change, that governs. This is so even when the legislative history . . . expresses the intent to make no change."[179] Accordingly, the statutory canon of *expressio unius* is also violated because Congress expressly selected to bar §§ 1331 and 1346, implicitly permitting the remaining jurisdictional grants to hear Medicare claims.[180]

a) The Clear-Indication Exception Issue

To use the recodification canon, courts suggest that the provision must be ambiguous.[181] In other words, the ambiguity indicates why courts

175. *See* 129 CONG. REC. 23321, 23440 (1983); *see* H.R. REP. NO. 98-432, pt. 2, at 1663 (1984).

176. 129 CONG. REC. 23321, 23440 (1983) (statement of Rep. Rotenkowski); Technical Corrections Act of 1983, H.R. 3805, 98th Cong. (1983).

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

178. Fla. Agency for Health Care Admin. v. Bayou Shores SNF, LLC (*In re* Bayou Shores SNF, LLC), 828 F.3d 1297, 1314 (11th Cir. 2016); Benjamin v. United States, SSA (*In re* Benjamin), 932 F.3d 293, 298 (5th Cir. 2019) (citing Hotze v. Burwell, 784 F.3d 984, 997 (5th Cir. 2015); United Motorcoach Ass'n v. City of Austin, 851 F.3d 489, 492 (5th Cir. 2017)).

179. *In re Benjamin*, 932 F.3d at 298 (quoting ANTONIN SCALIA & BRYAN A. GARNER, READING LAW: THE INTERPRETATION OF LEGAL TEXTS 257 (2012)).

180. *Id.* (quoting ANTONIN SCALIA & BRYAN A. GARNER, READING LAW: THE INTERPRETATION OF LEGAL TEXTS 107 (2012)).

181. *Id.*

should read into the legislative history.[182] The clear-indication exception is only needed when the provision is clearly ambiguous; thus, courts should only refer to the legislative history to decide Congress's intent because there is an exception to look beyond the plain text.[183] *United v. Wells* is an example of the clear-indication exception.[184] In this case, the Revisers's omitted a "materiality" requirement, but the Revisers's Note stated no substantive change to the law.[185] However, the Court found the current provision of the statute was unambiguous; hence, there is no reason to infer from the legislative history that Congress intended it to continue to keep the materiality requirement.[186]

In *Tidewater Oil Co. v. United States*, the Court only used the recodification canon after finding two possible meanings for the statute.[187] In *Southern Pacific Transportation Co. v. San Antonio*, a deleted portion of the statute created an ambiguity in the remaining language.[188] The court relied on the recodification canon to infer Congress's intent.[189] In § 405(h), there are not two ways to interpret the statute or an ambiguity; thus, it cannot bar bankruptcy jurisdiction.[190]

Another example is in *American Bankers Insurance Co. of Florida v. United States*, in which the court adopted an alternative meaning for the statute because the court believed the statute to be ambiguous and unaligned with Congress's intentions.[191] Here, § 405(h)'s plain meaning remains unambiguous without including bankruptcy jurisdiction.[192] Again in *Ankenbrandt v. Richards*, the Revisers changed the text of the statute that granted diversity jurisdiction, which appeared to expand the jurisdiction of the federal courts.[193] The Court disregarded the plain text and used the recodification canon to keep the jurisdictions before the recodification.[194] Applying the recodification in § 405(h) would require giving approximately 30 jurisdictional grants originally included in the statute; in contrast to *Akenbradnt*, the court removed jurisdiction to match

182. *Id.*
183. *Id.*
184. *Id.* (citing United States v. Wells, 519 U.S. 482 (1997)).
185. *Id.* (citing United States v. Wells, 519 U.S. 482, 490–98 (1997)).
186. *Id.* (citing United States v. Wells, 519 U.S. 482, 497 (1997)).
187. *Id.* (citing Tidewater Oil Co. v. United States, 409 U.S. 151, 162–63, (1972)).
188. *Id.* (citing S. Pac. Transp. Co. v. San Antonio, 748 F.2d 266, 271 (5th Cir. 1984)).
189. *Id.* (citing S. Pac. Transp. Co. v. San Antonio, 748 F.2d 266, 271 (5th Cir. 1984)).
190. *Id.* at 299.
191. *Id.* at 298 (citing Am. Bankers Ins. Co. of Fla. v. United States, 388 F.2d 304, 305 (5th Cir. 1968); Am. Bankers Ins. Co. of Fla. v. United States, 265 F. Supp. 67, 74–75 (S.D. Fla. 1967)).
192. *Id.* at 299.
193. Ankenbrandt v. Richards, 504 U.S. 689, 698 (1992).
194. *Id.* at 700–01.

the jurisdiction that the federal courts already had.[195] Consequently, the recodification canon is likely not applicable here because the statute's language lacks ambiguity.

b) Expressio Unius Application

Providers advocating for the use of bankruptcy courts to adjudicate their Medicare claims argue that Congress deliberately left out the other jurisdictional grants from § 405(h).[196] The statutory canon "*expressio unius est exclusio alterius*" means "expressing one item of an associated group or series excludes another left unmentioned."[197] Courts can use the exclusion of other statutes to determine legislative intent.[198] Therefore, Congress intended to narrow § 405(h) after the recodification by leaving out bankruptcy jurisdiction.[199]

3. The Recodification Canon Still Applies to § 405(h)

As noted, many cases use the recodification canon for interpretive purposes, including clarifying ambiguous terms, provisions subject to multiple interpretations, and provisions found after deleted phrases; however, courts have also used the canon in circumstances similar to § 405(h).[200] For instance, in *Holmgren v. United States*, the recodification appeared to remove jurisdiction from certain courts.[201] Nevertheless, even though the statute's text supported the argument that some courts would not have jurisdiction over certain cases, the Court retained the original meaning.[202] The Court stated that it "will not infer that Congress in revising and consolidating the laws intended to change their policy in the absence of a clear expression of such purpose."[203]

195. *In re Benjamin*, 932 F.3d at 300.

196. *Id.* at 298.

197. Barbara J. Van Arsdale, Tracy Bateman Farrell, & Tom Muskus, *Rule That Expression of Particular Matters Implies Exclusion of Others*, 73 AM. JUR. 120 (citing N.L.R.B. v. SW General, Inc., 137 S. Ct. 929 (2017)).

198. *Id.* (citing Patterson v. Beall, 2000 OK 92, 19 P.3d 839 (Okla. 2000)).

199. *In re Benjamin*, 932 F.3d at 298.

200. *See* Tidewater Oil Co. v. United States, 409 U.S. 151 (1972); S. Pac. Transp. Co. v. San Antonio, 748 F.2d 266, 271 (5th Cir. 1984); Am. Bankers Ins. Co. of Fla. v. United States, 388 F.2d 304, 305 (5th Cir. 1968); Ankenbrandt v. Richards, 504 U.S. 689, 698 (1992).

201. Holmgren v. United States, 217 U.S. 509, 519 (1910). The legislators suggested no reason for the change in the statute and the purpose of the law was still the same.

202. *Id.* (quoting United States v. Ryder, 110 U.S. 729, 740).

203. *Id.* (quoting United States v. Ryder, 110 U.S. 729, 740).

Moreover, significant policy changes cannot occur without mentioning it in the legislative history of Revisers's notes.[204] In *Muniz*, the Court stated the pre-amendment meaning will still apply to the statute if the Revisers do not explain why they made the policy changes.[205] The Court said, ". . . it would seem difficult at best to argue that a change in the substantive law could nevertheless be effected by a change in the language of a statute without any indication in the Revisers's Note of that change."[206] Accordingly, the use of the recodification canon varies;[207] in general, courts should not infer that Congress intended to change policies when it recodified the laws without expressly stating so in the legislative history.[208]

a) Expressio Unius is Not Applicable to Accidental Omissions

Espressio unius only applies when Congress deliberately chooses to exclude specific terms, not when Congress accidentally omits terms.[209] The legislative history indicates that Revisers omitted the statutes by accident. For instance, both the *Technical Corrections Act of 1983 and the* Deficit Reduction Act of 1984 contained advisory language that the substantive law would not change regardless of the textual form of the provision, in addition to its supporters advising that the law would not change in substantive form.[210] The canon cannot defeat clear evidence of

204. Fla. Agency for Health Care Admin. v. Bayou Shores SNF, LLC (*In re* Bayou Shores SNF, LLC), 828 F.3d 1297, 1318 (11th Cir. 2016) (quoting Muniz v. Hoffman, 422 U.S. 454, 472 (1975)).

205. Muniz v. Hoffman, 422 U.S. 454, 472 (1975).

206. *Id.*

207. *In re Bayou Shores SNF, LLC*, 828 F.3d at 1315 (citing McDonald v. Hovey, 110 U.S. 619, 629 (1884); Logan v. United States, 144 U.S. 263, 302 (1892); Witherspoon v. Illinois, 391 U.S. 510 (1968); Holmgren v. United States, 217 U.S. 509, 520 (1910); Anderson v. Pac. Coast S.S. Co., 225 U.S. 187, 199 (1912); United States v. Sischo, 262 U.S. 165, 168–69 (1923); Hale v. Iowa State Bd. of Assessment & Review, 302 U.S. 95, 102 (1937); Fourco Glass Co. v. Transmirra Prods. Corp., 353 U.S. 222, 227 (1957); United States v. FMC Corp., 84 S. Ct. 4, 7 (Goldberg, Circuit Justice 1963); United States v. Welden, 377 U.S. 95, 98 n.4 (1964); Tidewater Oil Co. v. United States, 409 U.S. 151, 162 (1972); Cass v. United States, 417 U.S. 72, 82 (1974); Aberdeen & Rockfish R. Co. v. Students Challenging Regulatory Agency Procedures (S.C.R.A.P.), 422 U.S. 289, 309 n.12 (1975); Muniz v. Hoffman, 422 U.S. 454, 470 (1975); Fulman v. United States, 434 U.S. 528, 538 (1978); Walters v. Nat'l Ass'n of Radiation Survivors, 473 U.S. 305, 318 (1985); Finley v. United States, 490 U.S. 545, 554 (1989); Ankenbrandt v. Richards, 504 U.S. 689, 700 (1992); Keene Corp. v. United States, 508 U.S. 200, 209 (1993); Scheidler v. Nat'l Org. for Women, Inc., 547 U.S. 9, 20 (2006); John R. Sand & Gravel Co. v. United States, 552 U.S. 130, 136 (2008)).

208. United States v. Ryder, 110 U.S. 729, 740 (1884).

209. Barbara J. Van Arsdale, Tracy Bateman Farrell, & Tom Muskus, *Rule That Expression of Particular Matters Implies Exclusion of Others—Limitations of Rule,* 73 AM. JUR. 121 (citing Barnhart v. Peabody Coal Co., 537 U.S. 149 (2003)).

210. *See* H.R. REP. NO. 98-432, pt. 2, at 1663 (1984); *see In re Bayou Shores SNF, LLC*, 828 F.3d at 1308; *Technical Corrections Act of 1983: Hearing on H.R. 3805 Before the H. Comm. on*

legislative intent; in this case, Congress was clear that this was purely technical and did not affect the substantive law.[211]

b) Congress Intended to Bar Bankruptcy Jurisdiction

Regardless of the application of statutory canons of interpretation, Congress intended to bar bankruptcy courts from hearing Medicare claims until the claimant exhausted its remedies through the agency.[212] Moreover, "[I]t has long been a 'familiar rule that a thing may be within the letter of the statute and yet not within the statute, because [its] not within its spirit nor within the intention of its makers.'"[213] The recodifying of the law was not intended to change the jurisdictional grants but to reflect the policy of the Congress that established § 405(h).[214] Therefore, regardless of the statute's current text, Congress envisioned HHS to adjudicate all disputes prior to the court system.

Ways and Means, 98th Cong. 79 (1984) (draft text of H.R. 3805); 129 CONG. REC. 23321, 23440 (1983) (statement of Rep. Rotenkowski); Technical Corrections Act of 1983, H.R. 3805, 98th Cong. (1983); The Deficit Reduction Act of 1984, Pub. L. No. 98-369, 98 Stat. 494, 1162, 1171–72 (1984). Nothing else in the report or legislative history of the Deficit Reduction Act or Technical Corrections Act suggests that Congress intended to change the jurisdictional grant or that bankruptcy courts should have parallel authority with HHS over Medicare claims.

211. Van Arsdale, *supra* note 209 (citing Holland v. Florida, 130 S. Ct. 2549, 177 L. Ed. 2d 130 (2010); Neuberger v. Comm'r of Internal Revenue, 311 U.S. 83 (1940); Burnett v. Stewart Title, Inc., 431 B.R. 894 (S.D. Tex. 2010), judgment aff'd, 635 F.3d 169 (5th Cir. 2011); Silverbrand v. Los Angeles, 205 P.3d 1047 (2009). *See* H.R. REP. NO. 98-432, pt. 2, at 1663 (1984). Again, nothing else in the report or legislative history of the Deficit Reduction Act or Technical Corrections Act suggests that Congress intended to change the jurisdictional grant or that bankruptcy courts should have parallel authority with HHS over Medicare claims. *See In re Bayou Shores SNF, LLC*, 828 F.3d at 1308; *Technical Corrections Act of 1983: Hearing on H.R. 3805 Before the H. Comm. on Ways and Means*, 98th Cong. 79 (1984) (draft text of H.R. 3805) (draft text of H.R. 3805) (emphasis added); 129 CONG. REC. 23321, 23440 (1983) (statement of Rep. Rotenkowski); Technical Corrections Act of 1983, H.R. 3805, 98th Cong. (1983); The Deficit Reduction Act of 1984, Pub. L. No. 98-369, 98 Stat. 494, 1162, 1171–72 (1984).

212. *See In re Bayou Shores SNF, LLC*, 828 F.3d at 1305 (quoting Weinberger v. Salfi, 422 U.S. 749, 756 n.3 (1975)).

213. Muniz v. Hoffman, 422 U.S. 454, 469 (1975) (citing Holy Trinity Church v. United States, 143 U.S. 457, 459 (1892)).

214. *See Technical Corrections Act of 1983: Hearing on H.R. 3805 Before the H. Comm. on Ways and Means*, 98th Cong. 79 (1984) (draft text of H.R. 3805); 129 CONG. REC. 23321, 23440 (1983); Technical Corrections Act of 1983, H.R. 3805, 98th Cong. (1983); H.R. REP. NO. 98-432, pt. 2, at 1663 (1984); The Deficit Reduction Act of 1984, Pub. L. No. 98-369, 98 Stat. 494, 1162, 1171–72 (1984).

B. Congressional Policy Promotes Agency Adjudication Over Bankruptcy Court Adjudication for Medicare Claims

Congress should amend the statute to explicitly bar bankruptcy jurisdiction to ensure uniformity and efficiency in Medicare law. Congressional Medicare policy leans towards barring bankruptcy courts and allowing the HHS to adjudicate these claims first.[215] This Medicare policy supports a uniform and efficient Medicare law.[216] On the contrary, congressional bankruptcy policy supports the court having jurisdiction over the entire bankruptcy estate, including Medicare claims.[217] Nevertheless, bankruptcy jurisdiction is not expansive enough to cover claims clearly under HHS's jurisdiction.[218]

1. The Congressional Policy Promotes Prior Agency Adjudication Before Final Review by Courts for Uniformity and Efficiency in Medicare LAW

Congressional policy supports barring bankruptcy jurisdiction to ensure uniformity and efficiency in Medicare law.[219] To achieve this policy, § 405(h) prevents the courts from making premature interferences until the agency fully reviews the claim.[220] Providers filing for bankruptcy argue that if bankruptcy courts do not have jurisdiction over Medicare claims, then the providers will go out of business before the appeals process is complete.[221] Yet, the choice of the adjudicator for Medicare claims is a policy decision for Congress, and the administrative exhaustion requirement reveals that Congress explicitly passed § 405(h) to ensure uniformity and efficiency in the Medicare Act.[222]

The Supreme Court endorsed this view in *Illinois Council* when reviewing § 405(h).[223] The Court acknowledged this congressional policy by recognizing the importance of "channeling" claims through the

215. *In re Bayou Shores SNF, LLC*, 828 F.3d at 1324–26.
216. *Id.* at 1324–25.
217. *In re* Town & Country Home Nursing Servs., Inc., 963 F.2d 1146, 1155 (9th Cir. 1991).
218. *In re Bayou Shores SNF, LLC*, 828 F.3d at 1322–23.
219. *Id.* at 1324–25.
220. *Id.* at 1326 (citing Shalala v. Ill. Council on Long Term Care, Inc., 529 U.S. 1, 13 (2000)).
221. *Id.* at 1324.
222. *Id.* at 1324–25.
223. Shalala v. Ill. Council on Long Term Care, 529 U.S. 1, 5 (2000). In *Ill. Council* a provider sued over the constitutionality of Medicare Regulations; the Court discussed § 405(h) and its unwritten bar of 28 § 1331 claims. Thus, the Court barred federal question jurisdiction without § 405(h) expressly barring the jurisdictional grant. Therefore, the same reasoning ought to apply to 28 § 1334 claims as well.

agency.[224] The Court held that § 405(h) allows the agency a "greater opportunity to apply, interpret, or revise policies, regulations, or statutes without [the possibility of] premature interference by different individual courts applying 'ripeness' and 'exhaustion' exceptions case by case."[225] The Court noted that this comes at a price—a slower appeal process—but due to the complexity of the Medicare program, which anyone could challenge in any court system in the country, it is a necessary burden.[226]

Moreover, like *Illinois Council*, § 405(h) should still apply to bankruptcy courts because bankruptcy courts make "premature inferences" as the federal questions claims do in *Illinois Council*.[227] When a bankruptcy court has jurisdiction over a Medicare claim, the court finds itself reviewing decisions and findings of HHS before complete agency exhaustion.[228] For example, by reinstating Provider Agreements[229] or usurping the PRRB's role in reviewing provider reimbursements.[230]

Providers must comply with regulations to enter and maintain a Provider Agreement with Medicare; their regulations serve "strong public policy" purposes.[231] For example, regarding regulations that protect patient health and safety, when a bankruptcy court preemptively reviews the surveys that measure health and safety, that court impedes the policies and decisions of HHS.[232] Moreover, when a court prematurely reviews Medicare claims, that court interferes with CMS's policy interest in making sure Medicare Program Dollars are spent appropriately and with compliant providers.[233] This financial policy is further supported and foreseeable to providers by regulations stating that providers cannot keep the overpayments.[234] Therefore, for § 405(h) to function as an effective administrative-exhaustion requirement and promote Congress's policy goals, § 405(h) should bar bankruptcy courts from hearing claims until the claimant exhausts their remedies with HHS.

224. *Id.* at 13.
225. *Id.*
226. *Id.* In other words, without a uniform exhaustion requirement, every court could interpret Medicare law differently, creating inconsistent Medicare law across the country.
227. Fla. Agency for Health Care Admin. v. Bayou Shores SNF, LLC (*In re* Bayou Shores SNF, LLC), 828 F.3d 1297, 1325 (11th Cir. 2016).
228. *Id.*
229. *Id.*
230. *In re* Town & Country Home Nursing Servs., Inc., 963 F.2d 1146, 1154 (9th Cir. 1991).
231. Parkview Adventist Med. Ctr. v. United States *ex rel.*, 842 F.3d 757, 764 (1st Cir. 2016).
232. *In re Bayou Shores SNF, LLC*, 828 F.3d at 1326.
233. *Parkview Adventist Med. Ctr.*, 842 F.3d at 764.
234. 42 C.F.R. § 413.64(f).

2. The Congressional Policy Promotes Bankruptcy Courts Having Complete Jurisdiction Over the Bankruptcy Estate

Contrary to Congress's Medicare Act policy, congressional bankruptcy policy promotes bankruptcy courts having complete jurisdiction over the bankruptcy estate. The Ninth Circuit stated, "[W]here there is an independent basis for bankruptcy court jurisdiction, exhaustion of administrative remedies pursuant to other jurisdictional statutes is not required."[235] In addition, 28 U.S.C. §§ 157 and 1334 give "original and exclusive jurisdiction over actions related to bankruptcy for which they otherwise would not have jurisdiction . . ."[236] Therefore, if the bankruptcy court has jurisdiction over any part of the claim, the court will take jurisdiction over the case.

Accordingly, the test for determining if a case is related to bankruptcy "is whether the outcome of that proceeding could conceivably have any effect on the estate being administered in bankruptcy."[237] Moreover, "an action is related to bankruptcy if the outcome could alter the debtor's rights, liabilities, options, or freedom of action (either positively or negatively) and which in any way impacts upon handling and administration of the bankrupt estate."[238] Thus, the policy for the broad grant of jurisdiction is clear; bankruptcy jurisdiction allows for a single court to manage the affairs of a bankrupt estate.[239] This single-court policy promotes "the efficient and expeditious resolution of all matters connected to the bankruptcy estate."[240] Congress intended to establish a policy that brought all matters related to the bankruptcy under a single court.[241] This gives bankruptcy courts a "special status" compared to other jurisdictional grants.[242] Therefore, if bankruptcy courts have an

235. *In re Town & Country Home Nursing Servs., Inc.*, 963 F.2d at 1154 (quoting *In re* Town & Country Home Nursing Servs., Inc., 112 B.R. 329, 334 (B.A.P. 9th Cir. 1990), aff'd, 963 F.2d 1146 (9th Cir. 1991)).

236. *Id.* at 1155.

237. *Id.* (quoting Kaonohi Ohana, Ltd. v. Sutherland, 873 F.2d 1302 (9th Cir. 1989)).

238. *Id.* (quoting Kaonohi Ohana, Ltd. v. Sutherland, 873 F.2d 1302 (9th Cir. 1989)).

239. *Id.* (citing *In re* Fietz, 852 F.2d 455, 457 (9th Cir. 1988); H.R. REP. NO. 595, at 43–48 (1977), *as reprinted in* 1978 U.S.C.C.A.N. 5963, 6004–08; S. REP. NO. 989 (1978), at 29–30, *as reprinted in* 1978 U.S.C.C.A.N. 5787, 5815-160).

240. *Id.* (citing *In re* Fietz, 852 F.2d 455, 457 (9th Cir. 1988) (H.R. REP. NO. 595, at 43–48 (1977), *as reprinted in* 1978 U.S.C.C.A.N. 5963, 6004–08; S. REP. NO. 989 (1978), at 29–30, *as reprinted in* 1978 U.S.C.C.A.N. 5787, 5815-16)).

241. *Id.* (citing RICHARD LEVIN, & HENRY J. SOMMER, COLLIER ON BANKRUPTCY §3.01[1][c]ii 3–22 (16th ed. 1991)).

242. Fla. Agency for Health Care Admin. v. Bayou Shores SNF, LLC (*In re* Bayou Shores SNF, LLC), 828 F.3d 1297, 1322 (11th Cir. 2016) (citing Do Sung Uhm v. Humana, Inc., 620 F.3d 1134 (9th Cir. 2010)).

independent basis for hearing claims, it seems equally correct to suggest Congress intended a policy for bankruptcy courts to adjudicate Medicare claims.

3. Congress Did Not Intend to Give Bankruptcy Courts Ever-Expanding Jurisdiction

Nevertheless, bankruptcy courts do not really have this "special status" or ever-expanding jurisdictional grant compared to other jurisdictional grants.[243] The Supreme Court rejected this "special status" jurisdictional argument in *Bd. of Governors of Fed. Reserve Sys. v. MCorp Fin., Inc.*, holding that an automatic stay provision could not stay an administrative proceeding.[244] Administrative hearings fall into the "governmental unit's police or regulatory power" exception of the automatic stay provision.[245]

The Court stated that this "would require bankruptcy courts to scrutinize the validity of every administrative or enforcement action brought against a bankrupt entity."[246] The Court went on to describe that "[s]uch a reading is problematic, both because it conflicts with the broad discretion Congress has expressly granted many administrative entities and because it is inconsistent with the limited authority Congress has vested in bankruptcy courts."[247] Therefore, Congress did not give bankruptcy courts ever-expanding jurisdiction that allows them to second guess the findings of regulatory agencies and take precedence over Congress's Medicare policy.

C. HHS's Initiatives for the Appeal Systems Backlog and Providers' Attempt to Evade the Agency Appeal Systems

Congress should amend the statute to explicitly bar bankruptcy jurisdiction to ensure HHS may fully apply its expertise by facilitating an effective internal agency appeals process. Due to the backlog in the appeal systems, providers claim they need bankruptcy courts as an alternative to agency adjudication.[248] Subsequently, the agency is proactively speeding

243. *Id.* at 1322–23.

244. Bd. of Governors of Fed. Rsrv. Sys. v. MCorp Fin., Inc., 502 U.S. 32 (1991).

245. *Id.* at 39–40.

246. *Id.* at 40.

247. *Id.*

248. Fla. Agency for Health Care Admin. v. Bayou Shores SNF, LLC (*In re* Bayou Shores SNF, LLC), 828 F.3d 1297, 1300 (11th Cir. 2016); *see also* Samuel R. Maizel & Michael B. Potere, *Killing the Patient to Cure the Disease: Medicare's Jurisdictional Bar Does Not Apply to Bankruptcy Courts*,

up the appeal process.[249] Though providers may try to avoid the appeal system by asserting that their claim does not arise under Medicare law, § 405(h) encompasses the claims that providers are trying to file in bankruptcy court.[250] Consequently, providers must appeal to the agency first.

1. HHS's Initiatives to Deal with Appeal System Backlog

The primary reasons providers claim they need to file for bankruptcy are the DAB appeal system backlog, the PRRB appeal system backlog, and the general need for a quick adjudication of their claims.[251] Recognizing these backlogs, HHS approved a three-pronged strategy to reduce the overflow in the DAB appeal system.[252] The first strategy is to "invest new resources at all levels of appeal to increase adjudication capacity and implement new strategies to alleviate the current backlog."[253] The second is to "take administrative actions to reduce the number of pending appeals and encourage resolution of cases earlier in the process."[254] The last is to "propose legislative reforms that provide additional funding and new authorities to address the appeals volume."[255]

The HHS developed a series of administrative actions to reduce the Medicare appeals backlog through these strategies.[256] First, the HHS created an administrative settlement for certain hospitals to resolve appeals of patient status denials with CMS.[257] These settlements allow eligible hospitals to submit settlement requests to CMS for partial settlements on claims in exchange for withdrawing appeals.[258]

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32 EMORY BANKR. DEV. J. 19, 20, 29 (2015) (discussing providers' need for bankruptcy courts as an alternative to agency adjudication).

249. MEDICARE APPEALS BACKLOG PRIMER FINAL, HHS.GOV 7 (Jan. 23, 2022, 1:20 PM), https://www.hhs.gov/sites/default/files/dab/medicare-appeals-backlog.pdf [https://perma.cc/FEJ3-JUHF].

250. Brief for Respondent at 8, Shalala v. Ill. Council on Long Term Care, Inc., 529 U.S. 1 (2000) (No.98-1109), 1999 WL 651607 (U.S.); *see also* Shalala v. Ill. Council on Long Term Care, Inc., 529 U.S. 1, 14 (2000).

251. MEDICARE APPEALS BACKLOG PRIMER FINAL, *supra* note 249.

252. *Id.*

253. *Id.*; *see* Am. Hosp. Ass'n v. Azar, No. CV 14-851 (JEB), 2018 WL 5723141, at *4 (D.D.C. Nov. 1, 2018) (holding that since Congress appropriate funds HHS since 2018, the timetable of reducing the backlog by 2022 was possible).

254. MEDICARE APPEALS BACKLOG PRIMER FINAL, *supra* note 249.

255. *Id.* To aid in these strategies, HHS asked for funding requests in 2017 to establish more field offices and employees to increase adjudication capacity.

256. *Id.* at 8.

257. *Id.*

258. *Id.*

HHS also created OMHA Settlement Conference Facilitation, allowing an alternative dispute resolution process.[259] OMHA trained mediators bring the appellants and CMS together and revolve the pending appeal.[260] HHS is finding this process to be an effective tool for clearing the backlog.[261]

Prior authorization is another effective administrative action.[262] This agency tool is when Medicare and its contractors review the request before authorizing certain medical care.[263] Prior authorizations notify providers that Medicare will not reimburse improperly recorded or authorized care.[264]

The Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Discussion Demonstration focuses on education on the QIC level to create more accurate Medicare claims on initial submission.[265] DMEPOS Discussion Demonstration allows suppliers to talk with QIC regarding their appeals, send in more documentation for their current appeals, and receive feedback on their past appeals.[266] It may even allow suppliers to reopen past appeals.[267]

HHS also implemented on-the-record adjudication.[268] This OMHA program allows the appellants to waive their rights to an oral hearing, allowing a senior OMHA attorney to review the record, draft a recommendation, and let the ALJ review the attorney's work to see if the ALJ concurs.[269] Additionally, CMS also changed its auditing technique to decrease the number of recovery audit-identified claims that enter the appeal system.[270] Finally, after 2017, HHS also recommended several other legislative proposals to Congress that could help reduce the backlog.[271]

The backlog in the PRRB appeal system may seem like another issue, but it is not. The system is not a problem because 90 to 95% of issues are

259. *Id.*
260. *Id.*
261. *Id.* (reporting in 2016, that this method has facilitated 4,245 appeals which is equivalent to four ALJ teams' annual workload).
262. *Id.*
263. *Id.*
264. *Id.*
265. *Id.*
266. *Id.*
267. *Id.*
268. *Id.* at 7–9.
269. *Id.*
270. *Id.* at 9.
271. *Id.*

settled at mediation or after and do not need a hearing.[272] Alternative dispute resolution is just one tool that PRRB uses; PRRB has also made its appeal system more efficient.[273] Even as of November 2021, PRRB was still finding ways to simplify the process, for instance, by requiring all appeals to be electronically submitted in one place.[274] In addition, the HHS made several changes to the appeal system that improved the backlog and proposed several other pieces of legislation to continue the improvement.[275] As a result, HHS can handle the appeal backlog without bankruptcy courts' interference.

2. § 405(h) Cannot Bar Claims that Do Not Arise Under the Medicare Act

Even with changes to the appeal systems, providers can still avoid filing their claims with the Medicare appeal system in favor of the bankruptcy courts. To do this, a provider asserts that their claim is not an action arising under the Medicare Act, and thus § 405(h) cannot bar their claim.[276] The Supreme Court defined the "claim arising under" language to broadly encompass any claims in which "both the standing and the substantive basis for the presentation of the claims is the Medicare Act."[277]

Accordingly, HHS needs both requirements to bar providers from going to bankruptcy court; however, if one of the elements is not present, providers may proceed to court.[278] For example, if HHS and a provider disagree regarding reimbursements, the provider would have to proceed through the administrative channel.[279] On the contrary, if HHS were to violate a provision such as the automatic stay, the bankruptcy court would

272. *Adjudication Research Joint Project of ACUS and Stanford Law School*, STANFORD U. (last visited Jan. 22, 2022, 3:21 PM), https://acus.law.stanford.edu/hearing-level/hhsoprrb0005-hearing-level-procedures-0 [https://perma.cc/EDX2-4Z8U].

273. *See HHS Developing New System to Speed PRRB and Other Appeal Processes*, *supra* note 82.

274. *United States Department of Health and Human Services Provider Reimbursement Review Board: Order No. 2: Supplemental Order on Mandatory Electronic Filing*, CMS.GOV 47 (Jan. 22, 2022, 3:25 PM), https://www.cms.gov/files/document/current-prrb-rules-v-31-cover-order-2-november-1-2021.pdf [https://perma.cc/CR2S-CBM8].

275. MEDICARE APPEALS BACKLOG PRIMER FINAL, *supra* note 249, at 7.

276. Brief for Respondent at 8, Shalala v. Ill. Council on Long Term Care, Inc., 529 U.S 1 (2000) (No.98-1109), 1999 WL 651607 (U.S.).

277. Univ. Med. Ctr. v. Sullivan, (*In re* Univ. Med. Ctr.), 973 F.2d 1065, 1073 (3d Cir. 1992) (quoting Heckler v. Ringer, 466 U.S. 602, 615 (1984); Weinberger v. Salfi, 422 U.S. 749, 760–61 (1975)).

278. *Id.*

279. *Id.*

have jurisdiction over the claim.[280] On its face, a provider just needs to ensure their claim does not arise under Medicare law, and they can avoid filing with the agency.

3. The Claims the Providers Raise Really Do Arise Under the Medicare Act

This evasion tactic is not as extensive as it seems. For example, the Supreme Court in *Illinois Council* spoke on the scope of § 405(h), stating:

> Nor can we accept a distinction that limits the scope of § 405(h) to claims for monetary benefits. Claims for money, claims for other benefits, claims of program eligibility, and claims that contest a sanction or remedy may all similarly rest upon individual fact-related circumstances, may all similarly dispute agency policy determinations, or may all similarly involve the application, interpretation, or constitutionality of interrelated regulations or statutory provisions. There is no reason to distinguish among them in terms of the language or in terms of the purposes of § 405(h)... Nor for similar reasons can we here limit those provisions to claims that involve "amounts."[281]

Allowing bankruptcy courts to interfere with the agency's decisions because the claim is not characterized as "substantive" is a fictitious argument. When providers bring a bankruptcy claim, they essentially appeal HHS's decision. For instance, when a provider appeals its Agreement termination through a bankruptcy court, they appeal the program eligibility, a sanction, or a remedy.[282] The same reasoning applies when a provider appeals recoupment to claims for money and other benefits even though the provider claimed it arose under the bankruptcy code.[283] Moreover, Medicare law clearly states that if a provider is overpaid, then the provider has to pay back the government through repayments.[284] The underlying claim does not change regardless of whether the provider files an appeal with HHS or the bankruptcy court, as the provider is still appealing a claim that is under HHS's jurisdiction.[285] Therefore, HHS can increase its adjudicatory capacity to handle the demands, and these claims fall under HHS's jurisdiction, precluding the providers' attempts to evade agency adjudication.

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280. *Id.*

281. Shalala v. Ill. Council on Long Term Care, Inc., 529 U.S. 1, 14 (2000).

282. Fla. Agency for Health Care Admin. v. Bayou Shores SNF, LLC (*In re* Bayou Shores SNF, LLC), 828 F.3d 1297, 1329 (11th Cir. 2016).

283. *Id.*

284. 42 C.F.R. § 413.64(f).

285. *In re Bayou Shores SNF, LLC*, 828 F.3d at 1329.

V. RECOMMENDATION AND CONCLUSION

As this Note expressed, several circuits disagree if § 405(h) bars bankruptcy jurisdiction; however, Congress should amend the statute to explicitly bar bankruptcy jurisdiction to reflect the Act's original intent since this will ensure uniformity and efficiency in Medicare law. Amending the statute to bar bankruptcy jurisdiction ensures that the agency responsible for Medicare law questions can fully apply its expertise to these questions by facilitating an effective internal agency appeals process. The following model statute represents how Congress could amend § 405(h) to bar bankruptcy jurisdiction explicitly:

> Findings and decisions of the Commissioner of Social Security after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Commissioner of Social Security shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Commissioner of Social Security, or any officer or employee thereof shall be brought under section 1331, *1334*, or 1346 of Title 28 to recover on any claim arising under this subchapter.

Congress may amend the statute to its original form in the interim, which barred many other jurisdictional grants, but this amendment would solve the current bankruptcy dispute.

Amending § 405(h) will answer the question of what Congress's intent was when it omitted the missing jurisdictions. Under this amendment, the experts on the nation's health laws will be responsible for enforcing Medicare laws; thus, no provider will get away with placing patients in "immediate jeopardy." Passing this amendment will promote a uniform and efficient Medicare law, while ensuring that courts cannot second guess HHS's decisions. With this amendment, in addition to HHS's current initiatives to speed up the adjudication process, Congress can also allocate additional resources to HHS to ensure that providers receive a quick adjudication. In conclusion, Congress should amend § 405(h) to bar bankruptcy jurisdiction to reflect the Act's original intent since this will ensure uniformity and efficiency in Medicare law. By amending § 405(h) to bar bankruptcy jurisdiction, Congress will allow HHS to fully apply its expertise to health and Medicare law by facilitating an effective internal agency appeals process.