Full of Patients But Low on Cash: Managing Conflicts between Health-Care Needs and Budget Woes

Friday, September 30, 2016

Speakers:
William H. Boling, J.D., Owner and Principal, Boling and Co.  
Samantha R. Johnson, Senior Associate General Counsel, Grady Health System  
Samuel R. Maizel, Partner, Dentons

Moderator: Jack F. Williams, Georgia State University College of Law
KILLING THE PATIENT TO CURE THE DISEASE: MEDICARE’S JURISDICTIONAL BAR DOES NOT APPLY TO BANKRUPTCY COURTS

EMORY BANKRUPTCY DEVELOPMENTS JOURNAL (2015)

Samuel R. Maizel

Michael B. Potere

ABSTRACT

- Many of the patients treated by hospitals, and the goods and services related there to, are paid for by the Medicare program.
- However, if the providers of the Medicare Program (hereinafter CMS), decide the hospital owes the government for a prior overpayment, the Medicare Program arguably has the right to recoup the amount it believes it is owed by offsetting it against monies otherwise payable to the hospital.
- The hospital has a right to appeal the decision to the Medicare Program, thus creating an “administrative procedure” that needs to be exhausted before seeking a remedy through the court system.
- The shortage of these necessary funds to pay bills may require a hospital to close its doors until the funds are dispersed and the issue is resolved.
- This Article addresses a unique jurisdictional issue that can shorten the time required to obtain judicial review of a CMS decision by going directly to federal bankruptcy court.
  - Understanding the key issue: the delay associated with exhausting the administrative process could put the at-risk hospital to out of business pending the administrative decision (due to the lengthy process). Thus, the hospital’s only viable option may be to eschew the administrative process by filing for bankruptcy. Giving rise to the jurisdictional issue addressed in this article, as addressed above.
- In re Bayou Shores, SNF, L and In re Nurses’ Registry and Home Health Corp., held that Medicare’s jurisdictional bar under 42 U.S.C. § 405(h), which would otherwise prevent judicial review of CMS decisions prior to exhausting Medicare’s appeals process, does not apply to federal bankruptcy courts.
  - This Article argues that bankruptcy courts should consistently make this finding
• This would allow filing for bankruptcy to become an important option available to health care providers and suppliers to resolve disputes with CMS and the Medicare Program when they would otherwise go out of business absent the speedy resolution of these disputes.

• This Article concludes that debtors in bankruptcy court are exempt from 42 U.S.C. § 405(h)’s exhaustion requirement because its plain language does not bar bankruptcy court jurisdiction prior to exhaustion—thus, bankruptcy courts do not have to wait.

• This Article further analyzes how courts read, understand, and apply 42 U.S.C. § 405(h), by showing a deviation from the plain language of the statute by looking at the legislative history and intent.

**Background on 42 U.S.C. § 405(h) and its analytical framework: Medicare’s jurisdictional bar absent exhaustion of administration remedies**

• Section 405(h) and Its Legislative History
  o Absent a final decision by the applicable administrative body, federal courts cannot take jurisdiction over a disputed issue arising under the Social Security or Medicare Acts. The concept underlying this requirement is that a party is not entitled to federal judicial relief unless and until available administrative remedies have been exhausted. The question then becomes whether such a jurisdictional limitation applies only to those suits brought pursuant to 28 U.S.C. §§ 1331 and 1336, or if § 405(h) applies to other federal jurisdictional grants, including the bankruptcy courts’ jurisdictional grant in 42 U.S.C. § 1334.

• Section 405(h)’s Purpose and Application
  o Section 405(h) serves two primary purposes. First, its rigorous enforcement is said to aid in and benefit from the development of the Secretary of Health and Human Services’s expertise. Second, it is intended to prevent “disgruntled” claimants from bringing actions in federal court instead of exhausting their remedies with the agency.

**Current State of the Medicare Appeals Process**

• Three ways a hospital can get involved in a Medicare dispute:
  o 1. Medicare could deny a hospital’s claim or a group of claims. (5 distinct steps)
    ▪ 1. The hospital could ask the Medicare Administrative
Contractor ("MAC") that actually denied its claims or declared the overpayment to “redetermine” its decision.

- 2. the hospital has to compile documents that support its claim and file the appeal within 120 days of the denial.
- 3. If redetermination is denied (the MAC has 60 days to act), the hospital has 180 days to file for reconsideration to the Qualified Independent Contractor ("QIC").
- 4. If this appeal is denied (the QIC has 60 days to decide), the hospital can appeal to an administrative law judge ("ALJ") who operates under the supervision of the Office of Medicare Hearings and Appeals ("OMHA")
- 5. If the ALJ decides against the hospital, the next level of appeal is the Medicare Appeals Council of the Departmental Appeals Board ("DAB"). The DAB decision is the “final decision” referenced in § 405(g)
  - After this final step, the federal courts may have jurisdiction over the claim (because all administrative procedures have been exhausted).

- 2. Medicare could review a hospital’s annual cost report and decide the hospital was overpaid.
  - A MAC or FI reviews the cost report and makes an initial determination of whether the hospital was overpaid or underpaid during the cost year
  - A cost report is a report filed by a hospital at the end of its fiscal year that describes the actual claims submitted during that year.
  - If the hospital was overpaid, the MAC will issue a notice of overpayment, and if payment is not forthcoming, may recover the overpayment through recoupment of outgoing payments.
  - The MAC subsequently performs a full audit of the cost report and issues a Notice of Program Reimbursement ("NPR"), which is the MAC's final determination as to the alleged overpayment.
    - Note: The MAC has seven years to issue the NPR (lengthy time period)
  - The hospital may appeal an adverse NPR to the Provider Reimbursement and Review Board ("PRRB"), and it is only after receiving that decision that a hospital may obtain judicial review of an adverse NPR in federal district court.
3. Medicare could suspend payments due to concerns about a hospital’s billing practices, including allegations of fraud. If a payment suspension is initiated, the hospital can submit a rebuttal that the CMS or the MAC reviews. While generally not appealable, once a determination of an overpayment is made, the same appeals process for denied claims (described above) applies.

Statutes in Conflict:

- Sections 405(g) and (h) of the Social Security Act require an exhaustion of administrative remedies prior to judicial review for any claims brought under the Medicare Act.

v.

- However, 28 U.S.C. § 1334 provides the statutory basis for bankruptcy courts’ jurisdiction and expressly makes that jurisdiction exclusive. Therefore, courts analyzing § 405(h) in the bankruptcy context are nevertheless split on whether is jurisdictional limitation to claims brought under § 1331 or § 13346 of title 28 also bars judicial review absent “exhaustion” under the bankruptcy jurisdictional grant found in § 1334.

The Arguments in Cases on the Issue:

- Reasoning for finding that bankruptcy cases do not fall under §405(h):
  - Bankruptcy cases do not fall under 405(h)’s requirement because §405(h)’s plain language is limited to §§ 1331 and 1346, as well as §1334’s grant of exclusive jurisdictions to the bankruptcy courts over the debtor’s estate.
- Reasoning for finding bankruptcy claims do fall within § 4-5(h)’s jurisdiction bar1:
  - Looking to legislative context, which courts argue implicitly cites to every jurisdictional grant contained in the former 28 U.S.C. § 41, and therefore includes bankruptcy jurisdiction.

---

1 thus requiring presentment and exhaustion to the Secretary before receiving judicial review
What about outside of the bankruptcy realm?

- Less likely to find that parties an escape § 405(h)’s bar.
    - Not Excused from Medicare’s exhaustion requirement
  - Diversity jurisdiction (28 U.S.C. § 1332)
    - Not Excused from Medicare’s exhaustion requirement

LITIGATION IN BANKRUPTCY ON § 406(h)

The Older Cases

- *In re Clawson Medical, Rehabilitation and Pain Care Center*
  - Reasoned: the Bankruptcy Reform Act of 1978 gave the bankruptcy courts “exclusive jurisdiction of the debtor’s property.” Thus authorizing bankruptcy court jurisdiction over a debtor’s estate and claims “irrespective of congressional statements to the contrary in the context of specialized legislation.” This included jurisdiction over issues the resolution of which would “have a considerable impact on the debtor’s estate and on its prospects for effecting a successful reorganization.” Because these were “crucial” to the administration of the debtor’s estate, the Clawson court found it had jurisdiction over the debtor’s claims despite § 405(h).
  - Also reasoned: § 405(h) did not bar because it only applies “in disputes to which it is applicable.”
    - Because § 405(h) did not expressly bar jurisdiction under what was then numbered 28 U.S.C. § 1471, it did not bar review of the debtor's Medicare claims.
    - “in the absence of ‘clear and convincing evidence’ of legislative intent to preclude or condition this Court’s jurisdiction, no further barriers will be erected,” consistent with Congress’ intent to:

2 While the plain language of § 405 (h) makes reading strained (as to mandamus and diversity jurisdiction), the outcome makes more sense because those jurisdictional grants are more susceptible to concealing a Medicare claim under the guise of another claim it improperly avoid going through the Medicare appeals process, while the Medicare appeals process could be a hospital’s “death knell.”
eliminate “frequent, time-consuming and expensive litigation of the question whether the bankruptcy court has jurisdiction of a particular proceeding.”

The Clawson court also analyzed:

1. The harm the debtor would face if it were forced to stop operating because of stopped Medicare payments, and
2. That the Medicare review process took so long as to prevent the debtor from covering its operating expenses.

Clawson further noted that even if the debtor was able to reopen after the appeals process, the “loss of goodwill” the probability that the debtor could revive its business would be low. (An irreparable harm to the debtor).

- Unable to revive due to “loss of goodwill” → liquidation would occur → estate’s value would decrease due to shutdown
- Loss of goodwill would be “difficult if not impossible” to calculate and recover in monetary damages

CONCLUSION: the “best” reading of the statute was that the court had jurisdiction over the debtor’s Medicare claims.

In re St. Johns Home Health Agency

- 15 years later
- Different conclusion, similar facts to Clawson:
  - the St. Johns court declined to take jurisdiction over the debtor’s Medicare claims in the bankruptcy court because:
    - 1. the absence of reference to bankruptcy jurisdiction in § 405(h) was due to a scrivener’s error, basing its conclusion on § 405(h)’s “legislative history,” and thus bankruptcy jurisdiction was incorporated implicitly by reference.
    - 2. the concern that, if it did have jurisdiction, a hospital might use a bankruptcy filing as a “shortcut to judicial review” of a party’s administrative claims, and
    - 3. the court indicated that it did not matter whether, as a result of its ruling, the debtor would be unable to reorganize.

CONCLUSION: the court did not have jurisdiction over the debtor’s Medicare claims.
• **In re Healthback**
  - Holding similar to In re Clawson
  - **CONCLUSION:**
    - 1. the court did have independent bankruptcy jurisdiction over the claim, and
    - 2. § 405 (h)’s plain language does not include § 1346’s bankruptcy jurisdictional grant, and
    - 3. Conclusion was supported by the purpose of the Bankruptcy Code because the debtor might cease to exist without its protection.
  - Also held:
    - § 405 (h)’s legislative history cautioning courts against reading a substantive change into the technical modifications is inapposite because § 405 (h)’s grant is procedural in nature.
    - The bankruptcy court’s administration of the debtor’s estate might frustrate the Secretary’s jurisdiction, but it does not constitute an “illegal interference” with the Secretary’s jurisdiction over the claim.
    - Rejected the Secretary’s “primary jurisdiction doctrine” argument
      - Primary jurisdiction doctrine argument – would require a judicial body to defer the decision-making process to the administrative agency’s “special competence.”
  - Other § 405(h) arguments analyzed in the bankruptcy context:
    - Whether Medicare payments are themselves an asset in the debtor’s estate
    - Whether a debtor going out of business because its Medicare payments stopped and it could not appeal quickly enough to remain open will result in “precluding” review of the debtor’s claims or merely “postpone” it.
    - Whether the government will be harmed if it is not able to be the first to review and decide the debtor’s claims
    - Whether permitted such jurisdiction will encourage bankruptcy filings simply to avoid the agency’s review process.

The Newer Cases (2015)

- **In re Bayou Shores**
• The Facts
  ▪ Bayou Shores involved a skilled nursing facility (“SNF”) that was facing termination from the Medicare program/being forced to close its doors.
  ▪ over 90 percent of the debtor’s revenue was derived from Medicare and Medicaid.
  ▪ between February and July of 2014, the debtor was cited on three separate occasions for noncompliance with Medicare Program, which were immediately cured. The CMS then found the debtor to be in substantial compliance.
  ▪ the debtor also cured the third deficiency and hired an outside consultant to conduct a comprehensive review of these measures.
  ▪ CMS did not visit the facility and terminated the Medicare Provider Agreement.
  ▪ the debtor appealed the decision to terminate, but the CMS continued to deny payments
  ▪ On August 1, 2014, two days before the provider agreements were going to be terminated, the debtor filed a lawsuit in the District Court for the Middle District of Florida seeking an injunction to prohibit the termination of the provider agreement.
  ▪ On the same day, the district court entered a temporary restraining order (“TRO”) prohibiting the termination of the agreements until August 15, 2014.
  ▪ The government brief the district court on the administrative exhaustion requirement, and thus the district court dissolved the TRO.
• Debtor Moves to Bankruptcy Court
  ▪ The debtor filed a chapter 11 and sought an order preventing CMS from terminating the Medicare Provider Agreement
  ▪ The bankruptcy court granted that motion
  ▪ CMS objected the bankruptcy court could not take jurisdiction over the Medicare due to the exhaustion requirement
  ▪ Rejected CMS’ argument and held it had jurisdiction because the plain language of § 405(h) did not restrict jurisdiction under 28 U.S.C. § 1334.
• District Court Appeal
  ▪ Reverses Bankruptcy Court’s finding:
    ▪ Held: Bankruptcy court lacked jurisdiction because debtor had
not exhausted all of its administrative remedies pursuant to § 405(h).

- 11th Circuit Appeal
  - Currently pending at time of publication

- Nurses’ Registry & Home Health Corp. v. Burwell
  - Bankruptcy court granted the debtor’s emergency motion for preliminary injunction and temporary restraining order enjoining the suspension of debtor’s Medicare payments.
  - The government filed a motion to stay pending appeal.
  - The bankruptcy court denied this motion; holding:
    - Based it’s analysis of § 405(h)’s bar by using a “likelihood of success” factor to decide on the injunction.
    - Court found that the government had a very low likelihood of success on the merits on appeal.
    - Rejected the “legislative history” line of cases presented by the government.
      - “Even if the change in § 405(h) from §41 to §§1331 and 1346 was a “scrivener’s error,” the court did not have the power to correct that error and enforce § 405(h) as barring all of § 41’s jurisdictional grants, including bankruptcy.”
    - The debtor fell within an exception to § 405(h)’s jurisdictional bar → waiting for the Medicare review process to finish would have caused the debtor to “become defunct” and resulted in “no judicial review of its claims.”
For § 405(h) to exert a jurisdictional bar over a hospital’s Medicare appeal:

- Three elements must be met:
  - The claims must arise under the Medicare Act
    - When their resolution is “inextricably intertwined” with benefits determinations and
    - When their “standing and substantive bases” are created by the Medicare Act.
  - Analysis changes when a hospital becomes a debtor
    - The party must be seeking a “judicial review” (administrative remedies exhausted) and
    - The action must be brought under 28 U.S.C. §§ 1331 or 1346.

BUT: Bankruptcy Code has its own jurisdictional statute that:

- Confers exclusive jurisdiction to the district and bankruptcy courts over cases “arising under” the Bankruptcy Code’s exclusive jurisdictional grant.
  - Thus, when combined with the fundamental purpose of the Bankruptcy Code (providing debtors with an opportunity to have a “fresh start”), makes it clear that it – and not the Medicare Act – should govern who determines a debtor’s disputes with Medicare.

When a hospital becomes a debtor, analysis changes:

- § 405(h) is designed to prohibit a court’s “judicial review” of Medicare decisions, but:
  - a bankruptcy court exercising jurisdiction over a debtor’s estate is NOT “judicial review” of a Medicare Program decision
  - a bankruptcy court’s exercise of jurisdiction is ensuring creditors are treated fairly under the Bankruptcy Code.
- The Bankruptcy Code’s “arising under” jurisdiction should trump Medicare Act’s jurisdictional grant
  - Ignoring the Bankruptcy Code’s “arising under” jurisdiction when the cessation of Medicare payments is at issue would frustrate the purpose of the Bankruptcy Code.
  - The same frustration does not occur when the Medicare Act’s jurisdiction is superseded by bankruptcy court.
THE ARGUMENTS AGAINST A § 405(H) JURISDICTIONAL BAN IN BANKRUPTCY SETTING

The Plain Language Argument

42 U.S.C. § 405(h) Plain Language

- **Heckler v. Ringer:**
  - “The third sentence of 42 U.S.C. § 405(h), made applicable to the Medicare Act by 42 U.S.C. § 1395ii, provides that § 405(g), to the exclusion of 28 U.S.C. § 1331, is the sole avenue for judicial review for all “claim[s] arising under” the Medicare Act.”

- **Shalala v. Illinois Council on Long Term Care, Inc.:**
  - “The statute [§ 405(h)] plainly bars § 1331 review . . . .” The plain meaning of § 405(h)’s jurisdictional limitations has been adopted by both the Third and Ninth Circuits, as well as by numerous district and bankruptcy courts, and has gone unchanged by Congress for over twenty years. Although § 405(h) and § 1334 are “incongruous,” it is not “absurd” to have a bankruptcy exception to Medicare’s exhaustion requirement, particularly in light of the harm that can arise to the debtor due to stopped Medicare payments during the lengthy Medicare review process. Thus, courts should not “allow ambiguous legislative history to muddy clear statutory language.”

- **King v. Burwell:**
  - The Court’s analytical framework strongly supports applying § 405(h) based on its plain language. In King, the Court was charged with interpreting the short phrase, “established by the State,” in the Affordable Care Act, and the outcome of which would either preserve or undermine the entire statutory scheme.
  - The Court chose preservation because it was “implausible” that Congress would have written the term such that it would cause a “death spiral” and undermine the entire Affordable Care Act.
  - Although the words appear clear on the surface, they became ambiguous when viewed in light of the entire statute.
  - “the words of a statute must be read in their context and with a view to their place in the overall statutory scheme,” and only then can they be deemed non-ambiguous and subject to enforcement based on their plain meaning.
28 U.S.C. § 1334 Plain Language

- The statute reads:
  - (a) Except as provided in subsection (b) of this section, the district courts shall have original and exclusive jurisdiction of all cases under title 11.

  ***

  - (e) The district court in which a case under title 11 is commenced or is pending shall have exclusive jurisdiction of all of the property, wherever located, of the debtor as of the commencement of such case, and of property of the estate . . .

- This structure creates no ambiguity, and nothing suggests that this exclusive jurisdictional grant cedes to the Medicare Act.

- Courts have stated § 1334’s plain meaning as independent grounds for permitting bankruptcy jurisdiction over Medicare disputes.

- See Do Sung Uhm v. Humana Inc.:
  - concluded that bankruptcy, consistent with the BC’s plain language and purpose, is special.
  - Neither the plain language or purpose is in dispute in this case which is based on diversity jurisdiction where neither party is insolvent.
  - “when two statutes are capable of coexistence, it is the duty of the courts, absent a clearly expressed Congressional intention to the contrary, to regard each as effective”
  - Because the Medicare Act and Bankruptcy Code “coexist” due to Medicare’s jurisdictional carve-out for bankruptcy courts in § 405(h), this outcome makes sense.

- Plain Language of § 405(h) is consistent with the Bankruptcy Code’s purpose
  - The purpose of the Bankruptcy Code is stated as:
    - “The purpose of Chapter 11 reorganization is to assist financially distressed business enterprises by providing them with breathing space in which to return to a viable state.”
    - Absent such breathing space, a debtor may be forced to cease its operations, rendering virtually impossible a return to a viable state. The problem is particularly acute for hospital-debtors that rely on Medicare payments and cannot have their Medicare disputes appealed quickly enough to keep operating.
The “Legislative History” Argument

1. **Jurisdiction Under § 405(h) is Procedural, Not Substantive**
   a. § 2664(b) of the Deficit Reduction Act – can be read as applying only to preclude substantive changes (a conclusion not supported by the statutes language), jurisdictional statutes are procedural, not substantive, and are therefore not covered by § 2664(b)’s directive

2. **Federal Jurisdiction: Claims Against the United States**
   a. 1948 re-codification of 28 U.S.C. § 41 did include substantive changes, and applying § 405(h) in 2015 to a jurisdictional statute dating back nearly a century (i.e., slavery) leads to absurd results.

3. **Federal Jurisdiction: Bankruptcy Jurisdiction**
   a. § 1334 (bankruptcy jurisdiction) has been amended and expanded several times as part of significant revisions to the entire Bankruptcy Code. Ignoring this presumes Congress meant to preclude certain individuals and businesses from bankruptcy protection.

4. **Section 2663 Contains Numerous Sections that Change Parties’ Rights**

5. **“Before That Date” Language**
   a. Section 2664(b) of the “technical” amendments in the DRA states that, “but none of such amendments shall be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date.”
   b. However, the Bankruptcy Reform Act of 1984, which granted bankruptcy courts broad jurisdictional authority over a debtor’s estate, was passed eight days before the DRA.
   c. So, § 2664(b) actually preserves the jurisdictional rights granted to bankruptcy courts as they existed before the passage of the DRA, which would be based on the Bankruptcy Reform Act.
   d. Section 2664(b)’s plain language therefore requires § 1334 to be read out of § 405(h) because § 1334 was passed eight days earlier and grants significant procedural and substantive rights to bankruptcy courts over the debtor’s estate.

   * Indeed, it is implausible that Congress enacted the Bankruptcy Code and its jurisdictional grant and then, just over a week later, abrogated parts of it in the Medicare Act without any explicit intent to do so.

   e. § 2664(b) is labeled “Effective Dates” and ends with the limitation,
“before that date.”

i. Just eight days “before that date” of the DRA’s enactment, the Bankruptcy Reform Act of 1984 was passed, reaffirming the bankruptcy court’s exclusive jurisdiction over a debtor’s case and estate.

1. The plain language of § 2664(b) therefore prohibits courts from ignoring the rights created in the Bankruptcy Reform Act.

6. Courts Lack Power to Correct Technical Errors

a. Even if the Office of Revision Counsel’s change, which was then codified by Congress, was a “scrivener’s error,” courts are not permitted to correct technical legislative errors.
Important Citations, Case Notes and Commentary

- In re Bayou Shores, 525 B.R. 160, 166 (Bankr. M.D. Fla. 2014)
- In 1984, § 405(h) was amended by the Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2663(a)(4)(D), 98 Stat. 1162. The language cited to by courts to read beyond § 405(h)’s plain language is contained in the Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2664(b), 98 Stat. 1162. Because § 2664(b) is itself legislation, it cannot be “legislative history.” The analysis courts must employ when considering § 2663 in conjunction with § 2664 is that of statutory construction, and not legislative intent. Be that as it may, this Article uses the “legislative history” label to refer to arguments based on § 2664(b) to mirror the language, however imprecise, used by the courts.
- Generally, the concept of requiring exhaustion of administrative remedies provides that a party is not entitled to judicial relief unless and until available administrative remedies have been exhausted. Myers v. Bethlehem Shipbuilding Corp., 303 U.S. 50–51 (1938). The doctrine of exhaustion of administrative remedies is applicable in bankruptcy cases. See, e.g., In re Cottrell, 213 B.R. 33 (M.D. Ala. 1997) (discussing statutory and non-statutory exhaustion).
- In this discussion, we address an instance where the exhaustion requirement is based on a statute. There are cases, however, where courts have required parties to exhaust their administrative remedies based on the court’s discretion, rather than a statute. In such cases requiring the exhaustion of administrative remedies, it is generally thought to encourage more economical and less formal means of dispute resolution, as well as to promote efficiency. See generally Stephens v. Pension Benefit Guar. Corp., 755 F.3d 959, 964–66 (D.C. Cir. 2014) (discussing ERISA).


• Courts have not allowed suits against these private contractors to proceed as a way to avoid the jurisdictional bar to suing the federal agency (CMS) itself. See, e.g., Bodimetric Health Services, Inc. v. Aetna Life & Cas., 903 F.2d 480, 487–88 (7th Cir. 1990). This is because Medicare contractors are merely conduits for payment and have no vested interest in the Medicare funds they administer. 42 U.S.C. § 1395kk-1(a)(4)(A), (B) (2015).

• In re Consol. Med. Transp., Inc., 300 B.R. 435, 445 (Bankr. N.D. Ill. 2003);
• In re Rusnak, 184 B.R. 459, 462–63 (Bankr. E.D. Pa. 1995);
• In re Univ. Med. Ctr., Inc., 973 F.2d 1065, 1072 (3d Cir. 1992);
• In re Town & Country Home Nursing Servs., Inc., 963 F.2d 1146, 1155 (9th Cir. 1991);
• In re Shelby Cty. Healthcare Servs. of Ala., Inc., 80 B.R. 555, 559–60 (Bankr. N.D. Ga. 1987);