IN THE UNITED STATES BANKRUPTCY COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

In re: MODIVCARE, INC., *et al.,* Debtors.	Chapter 11 Case No. 25-90309 (ARP) (Jointly Administered)

HEALTHSPRING, INC.'S POST-HEARING BRIEF OPPOSING DEBTORS' MOTION TO REJECT CONTRACT
(Relates to Docket Nos. 1133, 1188, and 1213)

TO THE HONORABLE ALFREDO R. PÉREZ,
UNITED STATES BANKRUPTCY JUDGE:

At the Court's invitation, HealthSpring, Inc. submits its post-hearing brief opposing the motion by the Reorganized Debtors ("ModivCare") to reject a certain executory contract.

The February 13, 2026, evidentiary hearing confirmed what prior briefing had already indicated: ModivCare is not seeking to escape a burdensome contract. There has been no evidence that the contract terms that apply today, at the time of proposed rejection, are truly burdensome. Instead, ModivCare is weaponizing § 365 to extort payment of disputed funds it could not otherwise secure. After lulling HealthSpring into reliance with months of assurances that services would continue, ModivCare suddenly pivoted to threats: pay what we demand for past services, or we cut off transportation for tens of thousands of elderly and disabled patients who depend on it to reach dialysis and chemotherapy appointments. This gambit conflicts with federal regulations designed to protect those very patients, and rests on no legitimate business judgment at all. The Court should reject it.

I. The Court Should Apply a Higher Standard for Rejection Because It Conflicts with Federal Law and the Public Interest in Patient Health and Safety.

At the February 9 status conference, the Court questioned whether the heightened standard for rejection under § 365, described in *In re Mirant Corp.*, 378 F.3d 511 (5th Cir. 2004) and related cases, should apply instead of the standard business judgment test. The hearing has confirmed that it should.

The main cases HealthSpring has cited on this point—*Mirant*; *Midlantic Nat'l Bank v. New Jersey Dep't of Environmental Protection (In re Quanta Resources Corp.)*, 474 U.S. 494 (1986); *N.L.R.B. v. Bildisco & Bildisco*, 465 U.S. 513 (1984); and *In re Ultra Petroleum Corp.*, 621 B.R. 188 (S.D. Tex. 2020)—are consistent as to when the heighted standard applies. In each case, rejection or abandonment under § 365 conflicted with a statutory or regulatory scheme designed to protect the public interest—that is, to prevent harm to some broad group of third parties. In *Midlantic*, it was state and local environmental laws meant to prevent release of toxic substances; in *Bildisco*, the National Labor Relations Act scheme that protected the collective bargaining process; and in *Mirant* and *Ultra* Petroleum, the Federal Power Act's regulatory scheme designed to protect energy consumers. As the Supreme Court put it in *Midlantic*, "Congress has repeatedly expressed its legislative determination that the trustee is not to have *carte blanche* to ignore nonbankruptcy law . . . Congress has expressly provided that the efforts of the trustee to marshal and distribute the assets of the estate must yield to governmental interest in public health and safety." 474 U.S. at 502.

This case is similar. The Medicare Advantage program—under which HealthSpring's plan operates—was created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and is regulated by 42 CFR Part 422. Under § 422.112, a Medicare Advantage organization like HealthSpring that offers supplemental benefits in its plan (like NEMT services)

"must . . . [m]aintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served," and also "[a]rrange for and cover any medically necessary covered benefit outside of the plan provider network . . . when an in-network provider or benefit is unavailable or inadequate to meet an enrollee's medical needs." And under § 422.111(e), when a contracted provider is terminated, the organization must "provide written notice, at least 30 calendar days before the termination effective date, and to all enrollees who are patients seen on a regular basis by the provider whose contract is terminating." These federal regulatory requirements are designed to protect the health and safety of Medicare Advantage enrollees who have been promised and have come to rely on access to benefits like NEMT from a given contracted provider (like ModivCare).

The termination provisions in Section 12.4 of the HealthSpring-ModivCare contract (Exhibit 1)[DE 1283-1] and the related Statement of Work (Exhibit 2) [DE 1283-2] were designed to guarantee that in any transition of the NEMT provider, the services would be provided to plan members through the transition—as required by these regulatory requirements. As both parties' witnesses testified at the hearing, such provisions are common in the industry, and typically provide for a 180-day "runout" period of continued services while the plan transitions to a new provider, while also requiring the outgoing provider to hand over certain information needed to enable the transition. Both witnesses also confirmed that when ModivCare took over the NEMT role from HealthSpring's prior provider, it required roughly six months—and cooperation from the old provider—before beginning service. ModivCare has offered no evidence that such a

transition can be effected in the sub-two-month timeframe that would apply were it permitted to reject the contract now.[1]

Allowing ModivCare to terminate services on short notice, based merely on its assertion that continued performance is not in its best interest, would undermine patient health and safety and would directly conflict with the Medicare Advantage regulations designed to protect those third-party interests. HealthSpring witness Kayla McKenzie testified that HealthSpring does not yet have a contract finalized with the potential replacement NEMT provider, and that the new provider would not be in a position to offer adequate substitute services until roughly April 1, 2026. She also testified that HealthSpring has not yet sent out notices of ModivCare's termination to plan members, because it has not been clear when ModivCare would cease providing the services and how or when it would be replaced. And Ms. McKenzie explained that without continued service from ModivCare, vulnerable plan members—including many of the roughly 24,000 elderly and disabled patients who use the plan's NEMT services each quarter—would be unable to find transportation to dialysis and chemotherapy appointments. Immediate termination would thus require violation of the federal regulations and create precisely the harm those regulations were designed to avoid. There is no evidence to the contrary.

The hearing also demonstrated that ModivCare has aggravated the issue by refusing to provide the transition assistance required under the contract. Since at least January 12, HealthSpring has asked ModivCare to turn over various items needed for a new provider to begin service. Exhibit 56 [DE 1283-56]. But more than two weeks later, ModivCare's representative

[1] While ModivCare sent a "notice of termination" on December 18 (Ex. 9) [DE 1283-9], for several weeks it refused to respond as to whether it would comply with the run-out obligations that notice triggered. The response was only given in a call between Mr. Shepard and HealthSpring's Dana Mott on January 9. Mott Decl. ¶ 11. It thus is providing far less than two months' notice.

explained that he could not provide certain information because its leadership had still not given him the "green light" to do so. *Id.* And ModivCare refused to provide certain key items, including the list of transport companies who had been driving the patients. *Id.* Ms. McKenzie confirmed that it has still not done so.

Even ModivCare's witness Ken Shepard admitted that immediate termination would disrupt the plan members' medical care. In a February 6, 2026 email to a HealthSpring executive, he warned that if HealthSpring did not pay ModivCare the additional amounts it was demanding for 2024 and 2025 services, ModivCare would not provide the runout services, thus "putting [HealthSpring's] members at risk of a disruption in services[.]" Exhibit 59 [DE 1283-59]. While his purpose was to use the threat of patient harm to pressure payment ("The choice is in HealthSpring's hands"), the email was a potent confirmation of HealthSpring's point.

ModivCare has never asserted that it could meet the heightened standard described in *Mirant* and the other cases. And because ModivCare cannot show that the currently applicable contract terms make the contract unprofitable, it cannot show that "the equities balance in favor of rejecting." *Mirant,* 378 F.3d at 525 (quoting *Bildisco,* 457 U.S. at 526-27). Indeed, as discussed below, it has not even met the less stringent business judgment standard.

II. Even Under the Business Judgment Standard, ModivCare Has Not Met Its Burden.

While the ordinary § 365 standard gives the debtor fair leeway to exercise its business judgment, it does not require the Court to issue a rubber stamp. *Orion Pictures Corp. v. Showtime Networks, Inc. (In re Orion Pictures Corp.)*, 4 F.3d 1095, 1099 (2d Cir. 1993) (bankruptcy court is not a "rubber stamp" for a debtor in making contractual determinations).[2] But given the record

[2] *See also In re Pilgrim's Pride Corp.,* 403 B.R. 413, 426 (Bankr. N.D. Tex. 2009) ("[T]he business judgment rule does not provide [the debtors] unfettered freedom to use the power given by Code § 365(a) however they will.").

here, that is precisely what ModivCare is seeking. The hearing revealed the inconsistency and hollowness of its explanations of its business judgment rationale, and it confirmed that ModivCare has actually sought to use § 365 rejection in bad faith as a tool to gain leverage in a separate legal dispute against HealthSpring. The Code does not endorse such conduct.

ModivCare's sole witness, Mr. Shepard, was not only evasive throughout his testimony, but was unable to plug the holes in the company's shifting stories. He admitted that ModivCare's primary asserted reason for rejection was the losses it incurred due to non-payment of disputed amounts for 2024 and 2025 services. But he also acknowledged that under § 12.4 of the parties' contract, ModivCare's termination of the contract meant that the only performance remaining—the only performance HealthSpring seeks—is the 180-day run-out services in 2026. What HealthSpring allegedly should pay for past services has nothing to do with whether ModivCare will lose money if it provides run-out services now, as ModivCare's own counsel has conceded. ModivCare Exhibit 6 [DE 1282-6].

Mr. Shepard also confirmed that ModivCare had offered to provide services to HealthSpring in 2027 at rates that Mr. Shepard himself designed to be profitable and beneficial to ModivCare, and that HealthSpring had offered to pay those rates for the runout services. ModivCare has never offered any analysis suggesting that it would be unprofitable for it to perform the services at those rates. Nor was Mr. Shepard able to articulate any such analysis at the hearing. That is unsurprising, as it makes no sense why terms that would be beneficial next year would be harmful this year.[3]

[3] To the extent ModivCare seeks to rely on Mr. Shepard's claims that after his deposition, he conducted additional analyses of performance under the 2027 proposed terms, that testimony should be disregarded or entitled to no weight, as it was uncorroborated and HealthSpring has not been afforded any discovery into the assertions.

The hearing made clear what was obvious but unspoken: that ModivCare's motion to reject the contract is not based on a good-faith determination that providing runout services would itself harm ModivCare's business, but rather is part of a bad-faith scheme to use misrepresentation and rejection to pressure HealthSpring to pay disputed funds that ModivCare could not otherwise secure. A series of exhibits, as well as testimony from both witnesses, showed that from the day after ModivCare filed its Chapter 11 petition, it went out of its way to reassure HealthSpring that it would continue providing service through 2026, despite the bankruptcy. Exhibits 32, 36, 37, 46, and 50 [DE 1283-32, 1283-36, 1283-37, 1283-46, and 1283-50]. And ModivCare continued these representations up until December 18, when it suddenly pivoted and said it would terminate services within 30 days unless HealthSpring agreed to pay the amounts ModivCare demanded for 2024 and 2025 services. Exhibit 9 [DE 1283-9]. Both witnesses confirmed that ModivCare had said nothing about any potential termination or rejection of the contract between the petition filing and mid-December, and Ms. McKenzie testified that HealthSpring relied on the assurances in deciding not to seek an alternative provider sooner.

Mr. Shepard's testimony, and his prior communications to HealthSpring, lay the scheme bare. He had no credible, good-faith explanation for ModivCare's misrepresentations. He has repeatedly confirmed that ModivCare will not provide the necessary runout services—no matter how generous the rates HealthSpring offers—unless HealthSpring agrees to ModivCare's demands regarding payments for prior years' service. Exhibits 9, 59, 53 [DE 1283-9, 1283-59, and 1283-53]. And he admitted that ModivCare knew that seeking to resolve the prior payment dispute through litigation—rather than by threatening HealthSpring's members—would be "expensive, drawn-out, and uncertain." Exhibit 57, ¶ 16 [DE 1283-57].

Section 365 was designed to allow debtors to escape contracts that a *good-faith* evaluation of business judgment establishes are burdensome. It was not enacted to provide a sword to a debtor,

honed by deception, ambush, and threats to vulnerable third parties, so that the debtor could extort resolution of a separate legal dispute. Based on the record established to date, ModivCare has not shown that rejection would be a good-faith exercise of its genuine business judgment regarding the terms of the contract at the time of the proposed rejection.

III. Conclusion

The Court should deny ModivCare's motion to reject the HealthSpring contract. In the alternative, if the Court is inclined to permit rejection, it should postpone the effective date of any rejection until HealthSpring has been able to provide the 30-day notice required under 42 CFR § 422.111(e) to plan members who rely on ModivCare's NEMT services, and it should order ModivCare to fully comply with its transition assistance obligations under Section 12.4 of the contract and Exhibit 2 [DE 1283-2] of the Statement of Work, including providing the information necessary for a replacement provider to begin service. Anything less would reward ModivCare's bad-faith conduct and leave tens of thousands of vulnerable patients without access to critical medical care.

Dated: February 17, 2026

Respectfully submitted,

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that on February 17, 2026, the foregoing was served electronically via CM/ECF for those parties registered to receive such service.

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