

Turmoil in the healthcare industry: what about the patients?

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Over the past several years the US healthcare industry has been in turmoil. Recently, certain segments of the healthcare sector have experienced financial difficulty – in particular, hospitals in New York, New Jersey and California. In New York, many hospitals sought protection under Chapter 11 of the Bankruptcy Code in direct response to sweeping changes to the New York hospital system proposed by the Commission on Healthcare Facilities in the 21st Century (known as the ‘Berger Commission’). The Berger Commission proposed closures, mergers and consolidations of hospitals in order to rectify the financial difficulties of the New York hospital system.

Throughout this turmoil, patients have struggled to maintain medical care – whether trying to maintain a standard of care or hoping that:

- their preferred hospital remains in business;
- they have access to emergency rooms; or
- they have access to their own medical records in the event of hospital closure.

As these hospitals have cycled through bankruptcy, the newly enacted healthcare provisions of the Bankruptcy Code have been tested – in particular, the provisions concerning the patient care ombudsman. The patient care ombudsman, whose role is to monitor patient care, has come under attack. With the financial difficulties facing these troubled healthcare businesses, the voice of the patient is of the utmost importance. This chapter explores the importance of the recently enacted healthcare bankruptcy provisions that are designed to protect the rights of the patients. First, however, the chapter explores the turmoil in the healthcare industry, including the Berger Commission.

Overview of healthcare and bankruptcy reforms

Commencement of overarching healthcare reform

Like any other business sector, the healthcare industry has seen its fair share of market-driven failures and bankruptcies. For example, in New York alone 70 hospitals and over 63 nursing homes closed between 1983 and 2006. Others have consistently lost money or sought bankruptcy relief. Although many parts of the country experience shortages in healthcare resources, others experience a duplication of services that contributes to across-the-board operational losses. This incongruity exists within individual states as well as across the states. Simple principles of economics dictate that where available services outnumber community need, failure is a virtual certainty. Changes in technology and medicine have also rendered certain providers obsolete. Both healthcare and bankruptcy reforms are a direct response to the lessons learned in the ever-changing healthcare sector.

Recently New York implemented a mechanism for the restructuring of its hospital and nursing home system and for reducing excess capacity. In 2006,

after undertaking an independent review of healthcare capacity and resources in New York state, the Berger Commission – a broad-based, non-partisan panel created by Governor Pataki and the New York state legislature – issued a report full of sweeping recommendations to restructure the hospital and nursing home system in New York state and reduce excess capacity.

The report recommended the removal of approximately 4,200 hospital beds statewide, the restructuring of nearly 50 hospitals and the closure of nine others. It also recommended the removal of approximately 3,000 nursing home beds statewide. The eventual estimated benefits of these recommendations is an annual saving of approximate \$1.5 billion to payers and providers, including an estimated \$806 million annual saving to Medicaid and other payors. However, the immediate effect of the report was to precipitate the bankruptcy filings of various entities slated for downsizing or closure. Moreover, the report was only the first step in a broader right-sizing process.

Bankruptcy reform directed at the healthcare industry

Whereas state-sponsored healthcare reform may be in its infancy, legislation focused on certain inadequacies of the Bankruptcy Code (Title 11 of the US Code), as it applies to healthcare bankruptcy cases, was enacted in 2005. These bankruptcy reforms were a direct result of the reality that patients are often caught in the middle of the bankruptcy process without a statutory right to be heard. Moreover, many patients lack the financial, emotional, mental and/or physical wherewithal to protect their interests in the event of bankruptcy of their healthcare providers. Indeed, many patients are unaware that their providers have sought bankruptcy relief. As legislatures became cognisant of a declining financial wherewithal within the healthcare industry and the hardships suffered by patients as a result, a process was begun to amend the Bankruptcy Code to ameliorate these hardships.

Originally drafted in 1998, on April 20 2005 Congress signed into law the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005, parts of which are aimed at addressing issues particular to healthcare bankruptcy cases. Specifically, Title XI of the act on healthcare and employee benefits amended federal bankruptcy law with an eye towards providing greater protection to patients in healthcare business bankruptcy cases. The protection provided to

patients under the act include provisions addressing:

- the disposal of patient records;
- the transfer of patients from a closing healthcare business; and
- the appointment of a patient care ombudsman.

The act also grants governmental authorities additional regulatory powers, including an exception to the automatic stay to allow the federal government to exclude a debtor healthcare business from the Medicare programme or other federally funded programme under certain circumstances and the ability to regulate the sale of not-for-profit entities.

Protections afforded by the act

The act's healthcare-related reforms provide certain protections to patients and governmental entities in the bankruptcy of a healthcare business. The amendments are addressed below. Prior to the enactment of the act, no specific provision of the Bankruptcy Code governed issues specific to the healthcare industry. The act added the definition of 'healthcare business' to the Bankruptcy Code, defined generally as a public, private, for-profit or not-for-profit entity that "is primarily engaged in offering to the general public facilities and services for (i) the diagnosis or treatment of injury, deformity or disease, and (ii) surgical, drug treatment, psychiatric or obstetric care" (11 USC §101(27A)(A)). The definition is intended to be broad and specifically includes hospitals, home health agencies, nursing homes and skilled nursing facilities, as well as other entities (11 USC §101(27A)(B)). Each of the act's healthcare-related amendments to the Bankruptcy Code applies only to healthcare businesses.

Like any bankruptcy case, a healthcare business commences its bankruptcy case by filing a bankruptcy petition under one of the chapters of the Bankruptcy Code and paying a filing fee. Amendments to the Federal Rules of Bankruptcy Procedure created a new rule that directs a debtor to check a box on its petition designating itself a 'healthcare business' (Fed R Bankr Pro 1021(a)). Surprisingly, a rough sampling of the healthcare cases filed to date reveals that fewer than one-third of such cases actually elected to make the 'healthcare business' designation. Although the revisions to the Bankruptcy Rules allow the Office of the US Trustee or another party in interest to file a motion for a determination as to whether the

debtor is a healthcare business (Bankruptcy Rule 1021(b)), no such action appears to have been taken in those bankruptcy cases where the debtor failed to so designate itself. Once a debtor is designated a healthcare business, it is subject to additional requirements under the act's amendments to the Bankruptcy Code.

Erosion of protections afforded to patients

Judicially created exceptions to the appointment of a patient care ombudsman

Perhaps the most significant contribution of the act is the requirement that a patient care ombudsman be appointed by the court in every healthcare business bankruptcy to assist patients in addressing the uncertainty stemming from the bankruptcy case (11 USC §333). Section 333(a) of the Bankruptcy Code now provides: "If the debtor in a case under chapter 7, 9, or 11 is a healthcare business, the court shall order, not later than 30 days after the commencement of the case, the appointment of an ombudsman to monitor the quality of patient care and to represent the interests of the patients of the healthcare business unless the court finds that the appointment of such ombudsman is not necessary for the protection of patients under the specific facts of the case."

The appointment of a patient care ombudsman provides patients with an advocate whose role is to monitor the quality of patient care. The ombudsman's main responsibility in a bankruptcy case is to monitor the quality of patient care, interview patients and physicians when necessary and report to the bankruptcy court every 60 days regarding any patient care issues which may arise in the case (11 USC §333(b)). Subject to confidentiality restrictions, the ombudsman has access to patient records consistent with other non-bankruptcy law or regulation (11 USC §333(c)).

Despite the clear benefits to patients and notwithstanding the seemingly broad range of healthcare-related bankruptcies that should mandate the appointment of an ombudsman, Section 333 is too often sidelined. As an initial matter, in certain cases the bankruptcy courts have simply taken no action to force compliance with Section 333 (eg, see *Integra Medical, PA*, Case No 05-60118, District of New Jersey, filed October 24 2005; *Pennsylvania Medical Transport I*, Case No 05-50102, Western District of Pennsylvania, filed November 3 2005; *Careford Medical, Inc*, Case No 06-20063, District of Kansas, filed January 25 2006). More

commonly, a patient care ombudsman is not appointed because the bankruptcy court finds either that the debtor is not a healthcare business or that the particular facts of the case do not warrant the appointment.

For example, in *In re Medical Assocs of Pinellas, LLC* (360 BR 356 (Bankr MD Fla 2007)) the debtor was established to provide administrative support to a group of physicians and their practices, with any services to the public only ancillary to that primary function. Looking at the types of business covered by Section 101(27A) of the Bankruptcy Code and the legislative history of that section, the court concluded that Congress intended a healthcare business to be something more than an administrative body and contemplated in-home or in-patient care (id at 360-61). Similarly, in *In re Elan Senior Living Inc* (Case No 06-90040 (Bankr ED Cal _____)) the debtor argued that its outpatient and residential counselling facility did not fall under the definition of a 'healthcare business', given that the services rendered were directed at controlling the behaviour of addicts as opposed to curing disease. Over the objection of the Office of the US Trustee, which argued that alcoholism was a disease and therefore the debtor treating this disease was a healthcare business, the bankruptcy court agreed with the debtor and found that the debtor was not a healthcare business and the appointment of an ombudsman was unnecessary. In *In re 7-Hills Radiology LLC* (350 BR 902 (Bankr D Nev 2006)) the debtor administered radiology tests to patients referred by treating physicians. However, given that the debtor did not advise patients of the test results and instead sent the test results to the treating physician, the bankruptcy court held that the debtor was not a healthcare business.

Even in those cases where the debtor meets the definition of 'healthcare business', the discretion bestowed on the bankruptcy court to refuse appointment of an ombudsman has been exercised repeatedly, effectively establishing a broad array of situations where no ombudsman has been appointed. The testimony given in support of the healthcare bankruptcy provisions of the act suggests certain exceptions to the appointment of an ombudsman not explicitly referenced in Section 333. Specifically, testimony was provided to the effect that the filing of a pre-packaged bankruptcy plan may excuse the appointment of a patient care ombudsman (US Senate Committee on Judiciary Subcommittee on Administrative Oversight and the Courts: Hearing Regarding S 1914, The Business Bankruptcy Reform Act, 144 Cong Rec D564-02,

105th Cong (2d Session, 1998)). To the extent that a pre-packaged plan is proposed and confirmation is delayed, a bankruptcy court could revisit the need for the appointment of an ombudsman.

The range of judicially created justifications for not appointing an ombudsman threatens to rewrite Section 333 of the Bankruptcy Code. In the event of widespread healthcare right-sizing, patients may well find themselves in the midst of an epidemic – a wave of healthcare-related bankruptcies with no voice in such proceedings. At one end of the extreme are cases refusing to appoint an ombudsman where the equivalent of a patient care ombudsman is already in place. For example, in *In re Moshannon Valley Citizens* (Case No 06-00095 (Bankr MD Pa ____)) the bankruptcy court denied the motion to appoint an ombudsman, finding that the debtor was subject to strict oversight as part of state licensing requirements and employed a full-time patient safety officer whose primary duties were to monitor the quality of patient care and serve as a patient advocate. Although such holdings are not unreasonable, they represent only the beginning of the erosion of what purportedly was intended to be a statutory right in most circumstances. That said, non-ombudsman oversight is not subject to bankruptcy court oversight and provides patients with no voice in the bankruptcy case itself.

This process of erosion is further exacerbated by the courts allowing debtors to put the proverbial cart before the horse – that is, for some courts the issue of appointment of an ombudsman centres on whether there are imminent patient issues and whether the bankruptcy filing was precipitated by concerns relating to the quality of patient care. For example, in *In re Total Woman Healthcare Center* (Case No 06-52000 RFH, 2006 WL 3708164 (Bankr MD Ga Dec 14 2006)) the debtor argued that it was a sole practitioner with only one office and that pre-petition patient care was not adversely affected by the bankruptcy filing. Finding that the debtor had the same staff as before the bankruptcy filing and had received no complaints since the bankruptcy filing, and that the bankruptcy filing did not yet affect the physician's scheduling of appointments for patients, the court agreed with the debtor and held that the appointment of an ombudsman was unnecessary. The approach taken by the court in *Total Woman Healthcare Center* is not alone. Fortunately, not all courts have adopted this approach.

At the risk of overstating the obvious, Section 333 of the Bankruptcy Code directs the

appointment of an ombudsman to monitor the quality of patient care throughout the bankruptcy case. Accordingly, issues relating to pre-petition quality of patient care, the lack of patient care issues precipitating the bankruptcy filing and the lack of any post-petition patient care issues should each be viewed as a red herring when evaluating whether the specific circumstances of a given case justify an exception to the general requirement to appoint an ombudsman. As patient care issues could arise at any time, an ombudsman should be appointed to evaluate patient care issues independently and to work with debtors and other parties in interest throughout the case to address any such issues. At the very least, an ombudsman offers the opportunity for an independent evaluation of whether such issues exist. To the extent that such issues truly do not exist, the ombudsman's role could be limited, rather than non-existent.

At the other end of the extreme, at least one court has suggested that an ombudsman need not be appointed where the debtor has ceased all business operations. In *In re Anne C Banes, DDS, PLLC* (355 BR 532 (Bankr MDNC 2006)) the court excused the appointment of an ombudsman after finding that the debtor was not a healthcare business. However, the court noted that although access to patient records for ongoing medical care is an important consideration that alone may justify the appointment of an ombudsman when a healthcare business is no longer operating, the appointment of an ombudsman could be excused where the debtor had ceased operations, dissolved its corporate identity and made patient records available to all patients. It is entirely unclear why a court would excuse the appointment of a patient care ombudsman under these circumstances as opposed to ensuring the protection of patient rights through the appointment of an ombudsman whose role may turn out to be limited in scope and duration.

Perhaps the most extreme exercise of judicial discretion in the appointment of an ombudsman can be found in those courts that have excused such appointment on the basis of expense. For example, in *In re Moshannon Valley Citizens* (Case No 06-00095 (Bankr MD Pa ____)) the debtor was a relatively small hospital with an average of only 12 in-patients per day and 85 out-patients per day. The debtor sought to be excused from the requirement of ombudsman oversight on the grounds that the expense of such ombudsman would adversely affect the hospital and its patients. Although it was not aware of any facts suggesting that patient care at the hospital was at risk, the Office of the US

Trustee objected, based on its concern that financial and operating constraints associated with the bankruptcy filing could adversely impact on patient care in the future. The bankruptcy court denied the motion to appoint an ombudsman, finding that the expense of an ombudsman would adversely affect the debtor.

Similar to the appointment of an examiner, trustee or any professional employed in a bankruptcy case, the expenses associated with the appointment of an ombudsman are part of the cost of seeking bankruptcy relief and can be addressed through budgets, negotiations and other arrangements. In enacting Section 333 of the Bankruptcy Code, revising Section 330(a)(1) to provide for the compensation of an ombudsman as a “professional person” and adding new Section 503(b)(8) to provide for the administrative expense priority of various costs associated with protecting patient rights, Congress was acutely aware that there would be costs associated with the appointment of an ombudsman that would need to be satisfied from a debtor’s estate. In short-changing patient care concerns by redirecting debtor resources away from the protection of patient rights, courts are effectively writing out newly enacted healthcare legislation from the Bankruptcy Code.

Collateral damage: disposal of patient records and transfer of patients

The erosion of the requirement to appoint an ombudsman may have a domino effect, potentially threatening other newly enacted patient care-related legislation – namely, rules governing the disposal of patient records and transfer of patients. Prior to the enactment of the act, the only obligations that a bankruptcy trustee or debtor in possession had with respect to the storage and disposal of patient records was its duty to comply with any applicable non-bankruptcy law governing such issues. Often a bankruptcy estate simply does not have sufficient funds to comply fully with the disposal requirements and patient records may be disposed of in the quickest and least expensive manner available, notwithstanding the harm caused to patients. In addition, in bankruptcy cases where a healthcare business is closing there may not be sufficient funds to pay the extended storage costs for the required time periods under federal or state law. Finally, there was no guarantee that a patient’s most critical concern when faced with the closing of a healthcare business (ie, finding a new facility that

meets the patient’s medical needs) would be addressed in a manner most beneficial to patients.

Congress attempted to assist patients with these problems by developing certain procedures for dealing with patient records in the event of the closing of a healthcare business and creating an affirmative duty to assist patients being transferred to a new facility in the hopes of minimising any transfer trauma.

Under Section 351 of the Bankruptcy Code, if the debtor or trustee does not have sufficient funds to comply with existing federal or state laws, the trustee must publish a notice in one or more appropriate newspapers informing patients and insurance providers (if appropriate) that they may claim medical records, and that if such medical records are not claimed within 365 days of the publication notice they will be destroyed (11 USC § 351(1)(A)). In addition, during the first 180 days of the 365-day notice period the trustee must attempt to notify each insurance company and each patient directly sending to the most recent known address of that patient, a family member or other contact person an appropriate notice informing the patient of the right to claim the medical records (11 USC § 351(1)(B)). If the medical records are not claimed during the notice period, the trustee must send a written request by certified mail to any appropriate federal agency seeking permission to deposit the records with such agency (11 USC § 351(2)). Importantly, Section 351(2) specifically provides that no federal agency is required to accept the records. If the patient records remain unclaimed after the notice period, they may be destroyed (11 USC § 351(3)). The Bankruptcy Rules also require that the trustee file a report within 30 days of the destruction of the patient records certifying that the unclaimed records have been destroyed and explaining the method used for the destruction (Fed R Bankr Pro 6011).

With respect to the transfer of patients residing in a healthcare facility that is closing, the act amended the duties of a trustee in a liquidating bankruptcy case under Chapter 7 of the Bankruptcy Code by adding a new Section 704(a)(12). The duties imposed on a trustee under this new subsection are threefold. The Chapter 7 trustee is to use all reasonable and best efforts to transfer patients from a closing healthcare business to an appropriate healthcare business that:

- is in the vicinity of the closing business;
- provides services substantially similar to those provided by the closing healthcare business; and

- maintains a reasonable quality of patient care (11 USC § 704(a)(12)).

Like their non-bankruptcy law counterparts, Sections 351 and 704(a)(12) provide certain patient protections for which failure to comply may result in liability. Imposing liability after the fact is a far cry from ensuring that patients are afforded certain basic rights in the first instance, a role specifically reserved for the patient care ombudsman. Limiting the circumstances in which the appointment of an ombudsman is warranted relegates patient protections to remedial rights. However, the patient care protections enacted by the act were intended to shield patients from the uncertainty, instability and potential adverse effects on patient care precipitated by a bankruptcy filing. Dispensing with the requirement to appoint an ombudsman does nothing to further this goal and simply leaves the fox to watch the henhouse.

Protections afforded to governmental entities

In the face of a potential wave of healthcare bankruptcy filings and ever-increasing exceptions to the appointment of a patient care ombudsman, at times the best that patients can hope for is that the economic interests of the debtor are in line with their own interests in undisturbed healthcare services. Two sets of the act's amendments to the Bankruptcy Code provide protection to governmental entities that potentially limit the ability of a bankrupt healthcare business to reorganise. The ultimate impact of these amendments is yet to be seen. However, what can be said for certain is that under the correct confluence of circumstances the protections afforded to governmental entities may prove to be the final straw that undermines the patient protection intended by the act.

Generally, upon commencement of a bankruptcy case, the debtor is afforded breathing space to further its rehabilitative efforts. Section 362 of the Bankruptcy Code provides an automatic stay which prevents creditors and other parties in interest from collecting amounts due to them or from taking actions against the debtor or the estate (11 USC § 362). Historically, Medicare simply offset any overpayments against amounts owed by the business. However, when a healthcare business filed for bankruptcy protection it became unclear whether Medicare set-offs or other regulatory action violated the automatic stay. Additional jurisdictional issues arose in relation to ongoing

proceedings to exclude the debtor from participation in the Medicare programme or any other federally funded healthcare programme, and whether such proceedings should be addressed by the bankruptcy court or the appropriate administrative body. Section 362(b)(28) of the act created a specific exception to the automatic stay for the secretary of health and human services to deal with these recurring problems.

Section 362(b)(28) now specifically allows the secretary of health and human services to exclude a debtor from participation in the Medicare programme or any other federal healthcare programme without violating a debtor's rights under the automatic stay of Section 362 (11 USC § 362(b)(28)). The sheer breadth of this section may allow a debtor to be excluded from certain healthcare programmes if, for example, the debtor owes money to the federal government due to prepetition overpayments under the Medicare programme. New Section 362(b)(28) provides a disincentive for governmental entities to work out a payment plan with healthcare business debtors, given that they may simply exclude the debtor from the Medicare programme. As a result, healthcare debtors that are heavily dependent on Medicare monies may be unable to reorganise.

In adopting Section 362(b)(28) the drafters may have intended simply to uphold the administrative rules and regulations regarding the Medicare programme and exclusion from this programme. However, Section 362(b)(28) essentially elevates the role and interests of the secretary of health and human services in the bankruptcy case above all other creditors, jeopardises a debtor's ability to reorganise and exposes patients to the very risks that the act is designed to alleviate.

A second set of Bankruptcy Code amendments provides a series of limitations on a healthcare business's ability to effectuate a sale of its business. A great deal of successful bankruptcy proceedings are attributable to a sale of all or part of a debtor's business. Prior to the act, arguably assets owned by a not-for-profit corporation could be transferred to a for-profit entity, and any restrictions on transferability would be invalidated. The act places new restrictions on the transferability of the property of a not-for-profit debtor, the corporate form taken by many healthcare businesses. Specifically, the act introduced three amendments to the Bankruptcy Code that require any transfer of assets of not-for-profit entities to comply with applicable non-bankruptcy laws:

- Section 541 was amended by adding a new

subsection (f) requiring that a Section 501(c)(3) corporation may be transferred to an entity that is not a 501(c)(3) corporation “but only under the same conditions as would apply if the debtor had not filed a case under this title” (11 USC § 541(f)).

- An additional requirement to confirmation of a Chapter 11 plan was added to Section 1129, providing that a plan shall be confirmed only if all the transfers of property made pursuant to the plan are made “in accordance with any applicable provisions of non-bankruptcy law that govern the transfer of property by a corporation or trust that is not a moneyed, business, or commercial corporation or trust” (11 USC § 1129(a)(16)).
- Section 363(d) was amended to limit the trustee’s ability to use, sell or lease property. Section 363(d) now provides that such use, sale or lease be effectuated only “in accordance with applicable non-bankruptcy law that governs the transfer of property by a corporation or trust that is not a moneyed, business, or commercial corporation or trust” (11 USC § 363(d)).

Accordingly, the act now provides state regulators with greater leverage to enforce state and federal law limitations on the transfer of assets for not-for-profit corporations. Bankruptcy protection may no longer offer as many reorganisation avenues

for not-for-profit corporations as are provided to other unregulated corporate entities, potentially displacing patients without the oversight of an ombudsman.

Conclusion

Although the act was enacted over two years ago, there has been relatively little case law interpreting the act’s provisions specifically enacted to address healthcare-specific issues. Whereas these new provisions were intended to provide protection to patients and instruction to debtors and trustees faced with the reorganisation or liquidation of a healthcare business, bankruptcy courts have used their equitable discretion to sidestep some of the most basic protections purportedly afforded to patients pursuant to the act. In addition, the fact that the act works with state and federal laws and regulations that may already be in place may deprive healthcare debtors from the safe havens afforded to other debtors under the Bankruptcy Code. Arguably, depriving certain healthcare debtors of the ability to reorganise may be in line with state-sponsored reforms aimed at right-sizing the industry. With the uncertainty of the US healthcare industry and the uncertainty surrounding financially troubled healthcare businesses, patients may have challenging times ahead of them.