

**HEALTH CARE RESTRUCTURING IN COURT:
CODE BLUE – THE BANKRUPTCY CODE IN ACTION**

The 2005 BAPCPA Health Care Amendments Almost Four Years Later

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INTRODUCTION

When the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 (the “BAPCPA”) was enacted, it amended the Bankruptcy Code with various provisions aimed at health care reorganizations (the “Health Care Amendments”). These Health Care Amendments impose additional duties on health care business debtors while granting new rights to patients and government entities. The Health Care Amendments were not Congress’s first attempt to reform the Bankruptcy Code’s treatment of health care-related issues.

Proposed health care amendments to the Bankruptcy Code began circulating in 2001 due to concerns generated by an increase in bankruptcy filings by long-term care facilities. In 2000, five of the largest nursing home chains in the United States filed for chapter 11 protection. These five chains comprised approximately 1,800 of the 17,000 long-term care facilities existing in the United States at that time.² The 2001 proposed amendments, which were not enacted, included provisions similar to those adopted under the BAPCPA, requiring the appointment of a patient care ombudsman (“PCO”), addressing the transfer of patients, specifying methods for disposal of health care records, and granting administrative expense claims for the costs incurred in health care business bankruptcies.³

In enacting the Health Care Amendments, the focus of Congress was to protect and promote the interests of patients when health care businesses file for bankruptcy protection, as well as to offer protection to governmental entities that provide financial assistance to these health care businesses. The result has been the imposition of additional duties and expenses on health care business debtors. For example, enhanced patient rights under the BAPCPA include

² *Nursing Homes: Aggregate Medicare Payments are Adequate Despite Bankruptcies*, Hearing Before the Special Committee on Aging of the United States Senate, 107th Cong. 1-2 (2000) (statement of Laura A. Dummit, Associate Director Health Financing and Public Health Issues, Health, Education and Human Services Division).

³ *See generally* H.R. 333, 107th Cong. (2001).

the appointment of a PCO, extensive procedural and notice requirements when handling and disposing of patient records, and new standards for the transfer of patients from health care providers in bankruptcy to other facilities. Additionally, federal and state agencies have been given additional clout as the result of a new exclusion from the automatic stay and an explicit requirement for approval under state law of transfers of property owned by not-for-profit health care debtors.

In the nearly four years since the enactment of the Health Care Amendments, courts have sought to strike a balance between the legislative intent which informs the new provisions and the policies underlying the Bankruptcy Code of maximizing the debtor's estate and achieving a successful reorganization. There is an inherent tension between application of the Health Care Amendments and these bankruptcy policies because many of the Health Care Amendments impose significant costs upon the bankruptcy estate. Thus, courts have struggled to apply the Health Care Amendments while attempting to ensure that the costs associated with their imposition do not vitiate the purpose of the Bankruptcy Code itself.

Thus far, bankruptcy courts have generally leaned towards restricting the application of the Health Care Amendments in order to limit their associated costs and expenses. Debtors have also recognized the costs that the Health Care Amendments would impose and have attempted to escape their application. In *Patient Care Ombudsman: Why so Much Opposition?*,⁴ Nancy A. Peterman and Suzanne Koenig noted that their research found 43 bankruptcy cases filed in the first few months after the enactment of BAPCPA that appeared to involve health care businesses.

⁴ Nancy A. Peterman & Suzanne Koenig, *Patient Care Ombudsman: Why so Much Opposition?*, Am. Bankr. Inst. J. 22, 55-56 (March, 2006).

However, only 11 of those 43 debtors identified themselves as health care businesses on their bankruptcy petitions.⁵

Rule 1021 of the Federal Rules of Bankruptcy Procedure (the “Bankruptcy Rules”), requires that if the bankruptcy petition identifies the debtor as a health care business, the case proceeds under the Health Care Amendments unless the court orders otherwise. However, if the bankruptcy petition does not identify the debtor as a health care business, the United States Trustee (the “U.S. Trustee”) or a party in interest may file a motion under Bankruptcy Rule 9014 for a determination as to whether the debtor is a health care business. Thus, whether a debtor constitutes a “health care business” under the Bankruptcy Code is an issue that has received attention from several bankruptcy courts as debtors attempt to prevent the application of the Health Care Amendments in their cases.

“HEALTH CARE BUSINESS” DEFINED

A threshold issue for whether the Health Care Amendments will apply is whether the debtor is a “health care businesses” as defined in section 101(27A) of the Bankruptcy Code.

Section 101(27A) states that a health care business:

(A) means any public or private entity (without regard to whether that entity is organized for profit or not for profit) 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; and

(B) includes—

- (i)** any—
 - (I)** general or specialized hospital;
 - (II)** ancillary ambulatory, emergency, or surgical treatment facility;
 - (III)** hospice;

⁵ *Id.* at 55. Official Forms 1 and 2, the new forms for voluntary and involuntary petitions, contain a box to be checked to designate the debtor as a “health care business.”

2009 Health Care Triage

- (IV) home health agency; and
 - (V) other health care institution that is similar to an entity referred to in subclause (I), (II), (III), or (IV); and
- (ii) any long-term care facility, including any—
- (I) skilled nursing facility;
 - (II) intermediate care facility;
 - (III) assisted living facility;
 - (IV) home for the aged;
 - (V) domiciliary care facility; and
 - (VI) health care institution that is related to a facility referred to in subclause (I), (II), (III), (IV), or (V), if that institution is primarily engaged in offering room, board, laundry, or personal assistance with activities of daily living and incidentals to activities of daily living.⁶

Several aspects of the definition of health care business have been utilized by debtors in order to avoid that label. Courts have found that debtors are not health care businesses where they (i) do not provide health care facilities and services to the general public, (ii) do not provide facilities and services for the diagnosis or treatment of injury, deformity, or disease and surgical, drug treatment, psychiatric or obstetric care, or (iii) are not of the type of health care business contemplated under section 101(27A)(B).

An early and oft-cited case, *In re 7-Hills Radiology, Inc.*,⁷ involved a debtor which had initially classified itself as a health care business in a “bare-bones” petition that provided few other clues to the debtor’s actual business. Concerned about the additional costs associated with this designation, including the appointment of a PCO, the Bankruptcy Court for the District of Nevada *sua sponte* issued an order to show cause as to why the debtor was a health care business. The debtor reversed course and successfully argued that it was not, in fact, a health care business. The debtor in this case was a provider of radiological services but such services

⁶ 11 U.S.C. §101(27A) (2005).

⁷ *In re 7-Hills Radiology, LLC*, 350 B.R. 902 (Bankr. D. Nev. 2006).

were only provided at the request of referring *physicians*. Although the debtor’s services were rendered to the general public, the court held that because it was not “engaged in *offering* to the general public” its facilities or services it did not fall within the definition of a health care business under section 101(27A)(A).⁸

The court also applied the canon of statutory construction *noscitur a sociis* – roughly “it is known from its associates” – to bolster its conclusion. Examining the exemplary list of businesses included in the definition of health care business under subparagraph (B), the court concluded that the “businesses that were the primary targets of the definition were businesses that had some form of direct and ongoing contact with patients to the point of providing them shelter and sustenance in addition to medical treatment.”⁹

The *7-Hills* court also raised an issue that it declined to address: whether a “debtor might argue that it is not in the business of *both* ‘diagnosis or treatment of injury, deformity, or disease’ *and* ‘surgical, drug treatment, psychiatric, or obstetric care,’ as the statute requires, given Congress’ use of the conjunction ‘and’ between clause (i) and clause (ii) [of subparagraph (A)].”¹⁰ Another court agreed that this would be a valid argument just over two months later in *In re Banes*.¹¹ Although it concluded that the outpatient dental practice there at issue would satisfy both prongs of subparagraph (A), the court cited *7-Hills* for its holding that the debtor was

⁸ *Id.* at 904.

⁹ *Id.* at 905.

¹⁰ *Id.*

¹¹ “Here, the result of applying the conjunctive ‘and,’ as it is written in the plain language of the statute, would be to restrict the definition of health care business so that not every health care provider’s bankruptcy would require the appointment of a health care ombudsman. There is no indication that Congress did not intend this result, nor is it an absurd outcome. Therefore, the conjunctive ‘and’ must be read into the statute as it is plainly written.” *In re Banes*, 355 B.R. 532, 534 (Bankr. M.D.N.C. 2006).

not a health care business because it did not provide its patients with shelter or sustenance as did the exemplars provided by Congress in subparagraph (B).¹²

The Bankruptcy Court for the Middle District of Florida adopted the reasoning of the *7-Hills* court in *In re Medical Associates of Pinellas, L.L.C.*¹³ There the court held that “the examples included in subparagraph (B) appear to contemplate something more than a doctor's office and clearly require more than an administrative support facility.”¹⁴ It supported this holding in part by quoting Senator Charles E. Grassley's repeated references to hospitals and nursing homes in contemplation of the BAPCPA.¹⁵ The court also refined the *7-Hills* holding into a four-part test: in order to be a health care business, the debtor must (i) be a public or private entity; (ii) be primarily engaged in offering facilities and services to the general public; (iii) offer these facilities and services to the public for the diagnosis or treatment of injury, deformity, or disease; and (iv) must offer these facilities and services to the public for surgical care, drug treatment, psychiatric care, or obstetric care.¹⁶

Despite these early arguments against the application of the health care business label, not all courts have been so reluctant to apply it. Beginning shortly after the adoption of the Health Care Amendments, there have been some cases where the U.S. Trustee or a party in interest has filed a motion under Bankruptcy Rule 9014 seeking a determination that the debtor is not a health care business. One such case is *In re McDonnell*.¹⁷ There the chapter 7 debtor was a radiologist who performed X-ray studies he received via the internet for various hospitals and clinics on a contractual basis. Presaging the argument later adopted by the *Banes* court, the

¹² *Id.* at 535.

¹³ 360 B.R. 356 (Bankr. M.D. Fla. 2007).

¹⁴ *Id.* at 361.

¹⁵ *Id.* (quoting 145 Cong. Rec. S2737-01, S2739 (1999) and 146 Cong. Rec. S11683-02, S11720 (2000)).

¹⁶ 360 B.R. at 359.

¹⁷ No. 06-50444 (Bankr. W.D. Tex. filed March 8, 2006).

debtor contended that he was not a health care business because his business did not fit within each of the three separate parts of the definition in section 101(27A), even though he admitted engagement in the activities listed in section 101(27A)(A)(i).¹⁸ Further, the debtor argued that he did not store any patient records or maintain any personal contact with patients. The bankruptcy court, in an extremely short order determining the motion, apparently implied that a broad interpretation of “health care business” is warranted by finding the debtor fit within the definition under the Bankruptcy Code. However, even though finding the debtor to be a health care business, the court ruled that the appointment of an ombudsman was not needed under the circumstances.¹⁹

While the definition of health care business could be interpreted broadly as in *McDonnell*, the weight of published authority seems to be toward the more restrictive definition offered by *7-Hills* and its progeny. It seems unlikely, then, that the Health Care Amendments will be applied to entities that provide health related services not obviously covered under the statute, such as health maintenance organizations (“HMOs”). But given HMOs’ voluminous collections of patient records, it could be argued that these entities should be subject to the same disposal procedures and administrative claims as other health care entities.

Even if a debtor does fit within the definition of a health care business, there are other ways in which debtors and the courts have attempted to mitigate the cost and expense of the Health Care Amendments. The Health Care Amendments are largely effectuated by section 333 of the Bankruptcy Code, which provides that a court must appoint a PCO if a debtor is a health care business. However, section 333 also provides that a PCO need not be appointed if the court

¹⁸ Motion of Debtors to Clarify that the Requirements of 11 U.S.C. §333 [*sic*] Do Not Apply to Debtors and in the Alternative, that the Appointment of an Ombudsman Is Not Necessary in this Case, *In re McDonnell*, No. 06-50444 (Bankr. W.D. Tex. March 23, 2006) (No. 11).

¹⁹ Order Clarifying that the Appointment of a Patient Care Ombudsman Pursuant 11 U.S.C. §333 [*sic*] Is Not Necessary in this Case, *In re McDonnell*, No. 06-50444 (Bankr. W.D. Tex. March 31, 2006) (No. 22).

finds that one is “not necessary for the protection of patients under the specific facts of the case.”²⁰ Thus, many health care business debtors have attempted to limit the impact of the Health Care Amendments by arguing that the appointment of a PCO is not necessary in their bankruptcy cases. An overview of section 333, PCOs, and the developing caselaw with respect to PCO issues follows.

APPOINTMENT OF PATIENT CARE OMBUDSMEN

Prior to the enactment of the BAPCPA, when a health care business debtor filed for bankruptcy, patients were not given the right to be heard in court proceedings or negotiations between the health care facility and its creditors. The rationale was that patients did not have independent standing to appear in bankruptcy cases unless they had a claim against the debtor.²¹ Given that patients may be the ones most directly affected and at risk by a health care business’s bankruptcy filing, Congress sought to include patients in the bankruptcy process by ensuring the preservation of patient care quality during the course of a bankruptcy through the appointment of a PCO.

A. Overview of Section 333 of the Bankruptcy Code and Bankruptcy Rule 2007.2

The Health Care Amendments require the court to appoint a PCO no later than 30 days after the bankruptcy filing to “monitor the quality of patient care and to represent the interest of the patients of the health care business” unless the court finds that a PCO is not needed to protect

²⁰ 11 U.S.C. § 333.

²¹ The patient-health care business relationship is not a true debtor-creditor relationship, and therefore the patient generally does not have standing in bankruptcy proceedings. Additionally, many of the patients will not know about bankruptcy law and proceedings, will not get notice of the bankruptcy case, and may not be able to address issues arising in the bankruptcy case. *See The Business Bankruptcy Reform Act – Preserving the Quality of Patient Care in Health Care Bankruptcies: Hearing Before the U.S. Senate Committee on the Judiciary Subcommittee on Administrative Oversight and the Courts*, 105th Cong. (June 1, 1998) (statement of Keith J. Shapiro).

patients.²² Once the bankruptcy court orders the appointment of a PCO, the U.S. Trustee appoints a disinterested person to serve as PCO.

Bankruptcy Rule 2007.2 provides courts with some direction as to the appointment process. It states that the court must appoint a PCO in a bankruptcy case filed by a health care business unless the court determines, on motion by the U.S. Trustee or a party in interest filed within 20 days of commencement, that the appointment of a PCO is not necessary for the protection of patients under the specific circumstances of the case. If a PCO is appointed, the U.S. Trustee must then file notice of the appointment with a verified statement of the person appointed setting forth any connections the appointed PCO may have with the debtor, creditors, patients, any other party in interest, their respective attorneys and accountants, the U.S. Trustee, and any person employed by the U.S. Trustee. Additionally, the rule provides that at any time during the bankruptcy proceeding, on motion by the U.S. Trustee or party in interest, the court may appoint a PCO if it previously determined one was not needed or terminate the appointment if it finds the appointment is no longer necessary for the protection of patients.

B. *Appointment Procedures*

As noted above, under section 333 of the Bankruptcy Code, the U.S. Trustee is to appoint a disinterested PCO in a health care bankruptcy case within 30 days after the commencement of the bankruptcy case unless there is a determination by the court that one is not needed for the protection of patients. The statute contemplates two types of PCOs: (i) those appointed to assess long-term care facilities and (ii) those appointed to assess facilities other than long-term care facilities.

If the debtor is a health care business that provides long-term care as defined under section 101(27A)(b)(ii), the U.S. Trustee may select the state long-term care ombudsman

²² 11 U.S.C. § 333 (2005).

appointed under the federal Older Americans Act of 1965²³ for the state in which the case is pending.²⁴ However, if the U.S. Trustee does not elect to appoint the state's long-term care ombudsman, the court is obligated to notify such ombudsman and provide him or her with the name and address of the person appointed by the U.S. Trustee.²⁵

The Older Americans Act requires every state establish a long-term care ombudsman program whereby individuals are appointed as advocates for residents of nursing homes, board and care homes, and assisted living establishments.²⁶ The state ombudsman's duties include identifying, investigating, and resolving complaints made by or on behalf of patients in long-term care facilities, while providing services to protect the welfare, health, and safety of these patient residents. Additionally, the long-term care ombudsmen represent the interest of patient residents in long-term facilities before governmental agencies when issues arise.²⁷

State long-term care ombudsmen programs already in place have developed evaluation standards, ethical codes, and investigation protocols for long-term care facilities, which could readily be applied to health care business bankruptcies.²⁸ Thus, since the Health Care Amendments to the BAPCPA fail to create specific standards by which PCOs are to measure the quality of patient care, and those stated duties of state ombudsmen are far more comprehensive than those imposed upon a PCO, the U.S. Trustee and the bankruptcy courts may rely on the Older Americans Act for those standards as well as the kind of reporting systems established under that statute for collecting and analyzing data.

²³ 42 U.S.C. § 3001, et. seq. (the Older Americans Act of 1965 is codified in various sections of Title 42 of the U.S. Code).

²⁴ 11 U.S.C. § 333(a)(2)(C).

²⁵ 11 U.S.C. § 333(a)(1)(B).

²⁶ 42 U.S.C. § 3058(g)(a)(3); *see also* the National Long Term Care Ombudsman Resource Center website at <http://www.ltombudsman.org>.

²⁷ *Id.*

²⁸ *Id.*

In those cases where a patient ombudsman is appointed to assess health care businesses other than long-term care facilities, the standards, ethical codes, and investigation protocol are undefined. This means that the U.S. Trustee and the bankruptcy courts will have to carefully define the acceptable standards, codes and protocol of those PCOs appointed in bankruptcy cases for non-long-term care facilities.

C. *The Necessity of Patient Care Ombudsmen*

Since the BAPCPA's enactment in October of 2005, bankruptcy courts have been reluctant to appoint a PCO. According to the U.S. Trustee Program,²⁹ 208 cases filed between BAPCPA's enactment and September 2007 implicated the appointment of a PCO. A PCO was only appointed in 57 of those cases. Appointment is much more common for certain types of debtors, however. Whereas a PCO was appointed in 64% of the 45 skilled nursing facility cases and 62% of the 29 hospital cases, an appointment only occurred in 7.4% of the other 134 cases.

One early case in which a PCO was appointed was *In re King Solomon Management*.³⁰ In *King Solomon*, the chapter 11 debtor was in the business of providing long term health care for patients in a skilled nursing care facility. The debtor and the U.S. Trustee agreed that an appointment of a PCO was appropriate and filed a joint motion seeking the appointment by the bankruptcy court. The bankruptcy court granted the motion, and the U.S. Trustee appointed the state's long-term care ombudsman to serve.

Bankruptcy courts quickly developed a two-step inquiry for deciding whether to appoint a PCO. First, the court will determine whether the debtor is a health care business. As discussed above, the *7-Hills* court found no cause to appoint a PCO on this basis alone. Similarly, the

²⁹ See Harold L. Kaplan, *The Evolving Standards for the Appointment of a Patient Care Ombudsman*, 27-Mar Am. Bankr. Inst. J. 40, 40 (Mar. 2008).

³⁰ No. 06-50000-VZ (Bankr. C.D. Cal. L.A. filed Oct. 31, 2005).

Banes and *Pinellas* courts³¹ declined to order the appointment of a PCO where they determined that the debtor was not a health care business. These two courts also performed the second part of the inquiry – whether the circumstances of the case warranted the appointment of a PCO.

A number of factors have been considered by the bankruptcy courts in determining whether the appointment of a PCO is warranted. One court in an early decision, for example, did not order an appointment because it determined that the debtor’s “bankruptcy filing was not precipitated by concerns relating to the quality of patient care or patient privacy matters.”³² In *In re Alternate Family Care*,³³ another bankruptcy court denied the U.S. Trustee’s motion to appoint a PCO based on its consideration of the following nine factors:

- 1) the cause of the bankruptcy;
- 2) the presence and role of licensing or supervising entities;
- 3) the debtor’s history of patient care;
- 4) the patients’ ability to protect their rights;
- 5) the patients’ dependence on the facility;
- 6) the likelihood of tension between the interests of patients and of the debtor;
- 7) the potential injury to patients if the debtor were to reduce its level of patient care drastically;
- 8) the presence of sufficiency of internal safeguards to ensure appropriate levels of care; and
- 9) the impact of the cost of a PCO on the likelihood of successful reorganization.³⁴

The *Alternate Family Care* factors weigh the threats to patient care against the cost of appointing a PCO and have been applied by a number of courts in determining whether a PCO should be appointed. In *In re N. Shore Hematology-Oncology Assocs., P.C.*,³⁵ the bankruptcy court found that the appointment of a PCO was not necessary when the *Alternate Family Care*

³¹ See *supra*.

³² *In re Saber*, 369 B.R. 631, 637 (Bankr. D. Colo. 2007).

³³ 377 B.R. 754 (Bankr. S.D. Fla. 2007).

³⁴ See *id.* at 758.

³⁵ 400 B.R. 7 (Bankr. E.D.N.Y. 2008).

factors were considered. Specifically, the court pointed to the facts that (i) the debtor did not plan significant reductions to the number of skilled workers (including doctors, nurses, and technicians), (ii) the debtor's formal program complied with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), (iii) patients could file any complaints with the state medical board, (iv) the New York State Department of Health monitored the debtor, (v) the debtor's labs followed directives from the Federal Food and Drug Administration (included bi-annual audits and lab inspections), (vi) the lab had only received three to five patient complaints in the prior fourteen months, and (vii) the debtor's ability to pay for the patients' medicines ensured there would no be interruption of treatment. The court was also explicitly "sensitive to the costs to the estate attendant to appointment of an ombudsman." Further, the court noted that the U.S. Trustee or another party in interest, could make a motion for the appointment of an ombudsman at any time during the bankruptcy proceeding if there was a change in circumstances or new evidence arose that demonstrated that an ombudsman was necessary.

Similarly, in *In re Valley Health Sys.*,³⁶ the bankruptcy court applied the *Alternate Family* factors to find that the appointment of a PCO was unnecessary. The *Valley Health* court also set forth four additional factors in the same vein: (i) the quality of the debtor's existing patient care, (ii) the debtor's financial ability to maintain high quality patient care, (iii) the existence of an internal ombudsman program to protect the rights of patients, and (iv) the level of monitoring and oversight by federal, state, local, or professional association programs which would render the services of a PCO redundant.

The *Valley Health* and *Alternate Family* factors illustrate the types of facts courts have considered in order to determine if a patient representative is necessary. From these factors, it appears that courts will not appoint a PCO unless the debtor health care business has had

³⁶ 381 B.R. 756 (Bankr. C.D. Cal. 2008).

significant patient care issues in the past or where the debtor's bankruptcy plans may pose significant harm to its patients. For example, in *In re Forum Health*,³⁷ the debtor brought motion seeking a determination from the bankruptcy court that a PCO was unnecessary. The U.S. Trustee opposed the motion, primarily on the grounds that the debtor may have to wind down one of its hospitals on an expedited basis, which posed a significant risk to its patients. The bankruptcy court ruled that because a hastened disposition of one of that hospital would raise patient care issues, the appointment of a PCO was warranted. However, taking a pragmatic approach, the court ordered that the PCO was not to perform any tasks until a disposition of the hospital was triggered pursuant to a prior order entered in the case and patient care issues arose.³⁸

D. Scope of PCO's Role in the Bankruptcy Process

The statute provides for three general duties of a PCO: (i) monitor the quality of patient care and report periodically to the court, (ii) immediately file a report to the court and parties in interest, and file a motion, as needed, if the PCO determines that the quality of patient care is materially declining or at issue, and (iii) maintain confidentiality as to patient records and information.³⁹

The Health Care Amendments provide that the PCO will serve to protect the interest of patients by monitoring the quality of patient care and reporting to the bankruptcy courts at least every 60 days. In monitoring the quality of care, the PCO is to do all that is necessary under the circumstances, which may include interviewing patients and physicians. However, challenges for the PCO may arise in the context of monitoring due to the confidentiality restrictions found in the new provisions. These restrictions prevent a PCO from access to confidential patient records without advance court approval, which approval will impose restrictions to protect

³⁷ No. 09-40795-kw (Bankr. N.D. Ohio filed March 16, 2009).

³⁸ *Id.*, Hr'g on May 27, 2009.

³⁹ 11 U.S.C. § 333(b)(1)-(3).

confidentiality. Even though protective mechanisms to guard patient privacy are needed, these restrictions could result in inefficiencies and financial burdens for the PCO.

In addition to the monitoring requirement, a PCO also has an obligation to report his or her findings to the bankruptcy court. The BAPCPA requires that the PCO report to the court on the quality of patient care being provided to patients by the debtor every 60 days at a hearing or in writing with notice to the parties in interest. However, if there is a determination by the PCO that the quality of patient care is “declining significantly or is otherwise being materially compromised,” he or she must report those findings to the court immediately by filing a written report with notice to parties of interest or address the issues by filing a motion.

In ascertaining the scope of the responsibilities of a PCO, does the PCO owe fiduciary duties to patients, the bankruptcy estate or both? If the appointment of a PCO creates fiduciary obligations, in addition to the issue of what party is owed the duty, there are additional concerns as to the possible costs of liability insurance and potential conflicts of interest. The Bankruptcy Court for the Northern District of Texas recently addressed this issue in *In re Renaissance Hospital*.⁴⁰ The court there contrasted the economic interests in the estate of the trustee or debtor in possession and of a statutory committee against the non-economic interest of the PCO in ensuring the well-being of the debtor’s patients. The PCO’s duty/interest will often mean that he or she is urging the debtor in possession or trustee to take measures that will deplete the estate and diminish creditors’ recovery. “The result is that the court and other parties cannot view a PCO as they do a fiduciary whose job includes improving an estate's value.”⁴¹

The *Renaissance* court was specifically addressing the issue of whether a PCO could retain professionals, a question left unresolved by the Health Care Amendments. Under the

⁴⁰ 399 B.R. 442, 446 (Bankr. N.D. Tex. 2008).

⁴¹ *Id.*

BAPCPA, the PCO is to be compensated as a “professional person” by the debtor in possession or trustee pursuant to section 330(a)(1) of the Bankruptcy Code. However, there is no specific provision under the BAPCPA providing that a PCO may hire counsel or other professionals. One of the ongoing criticisms of the Health Care Amendments as a whole is the additional cost to be incurred by the bankruptcy estate.⁴² In fact, although the *Renaissance* court ultimately found that PCOs should be allowed to retain professionals “in proper circumstances and limited purposes,”⁴³ it explicitly stated that “retention by an ombudsman of professionals is not consistent with the central purpose of bankruptcy in general and chapter 11 in particular: improving return to creditors and equity owners.”⁴⁴

In reaching its seemingly paradoxical conclusion, the *Renaissance* court made two pragmatic observations. First, as apparently contemplated by section 333(b)(3) and Bankruptcy Rule 2015.1, the PCO may be required to file motions with the court and advocate the same. The court noted that not every otherwise suitable candidate to be a PCO would possess the requisite legal expertise to prepare and file motions, and found the Congress “must have anticipated” PCOs hiring counsel.⁴⁵ Second, the court noted that the U.S. Trustee must appoint a “person,” but that the Bankruptcy Code’s definition of person includes partnerships and corporations. Since partnerships and corporations may only appear in court through an attorney, the court reasoned, any corporation or partnership would need to be able to hire counsel in order to serve as a PCO.⁴⁶ Thus, the court concluded that while reality necessitated allowing PCOs to

⁴² Some practitioners have suggested the following methods as ways to control costs that may be potentially incurred by the ombudsman: (i) provide a budget that the ombudsman must work within or an agreed-upon carve-out under a financing or cash collateral order; (ii) specifically identify the scope of the work to be performed by the ombudsman and (iii) place time restrictions on the ombudsman’s appointment. Of course, some of these methods will be problematic in some health care bankruptcies.

⁴³ 399 B.R. at 448.

⁴⁴ *Id.* at 446.

⁴⁵ *Id.* at 448.

⁴⁶ *Id.*

hire professionals, such employment “should be authorized only upon a clear showing of need.” The court cautioned that a PCO should not be able to outsource the duties specifically assigned to him or her, nor should the PCO become involved in the bankruptcy case outside the scope of these duties. These considerations would help a court authorizing the employment of professionals by a PCO balance the practical necessity of such employment against the importance of maximizing economic return to other constituencies.

In *In re Bayonne Medical Center*,⁴⁷ the official committee of unsecured creditors objected to the PCO’s applications to employ attorneys and “medical operations advisors.” The PCO in *Bayonne* argued that the medical operations advisors, which happened to be her own firm, and attorneys were needed to help her discharge her statutory duties. The creditors’ committee, on the other hand, set forth numerous arguments against the retention applications including the expense to the estate and the fact that the Bankruptcy Code does not provide for a PCO’s retention of professionals. As another example of how courts have balanced the requirements of the Health Care Amendments and their cost to bankruptcy estates, the court entered an order which allowed the PCO to retain professionals but set a cap on the fees that they could be paid. The court recognized a PCO’s need for attorneys to assist with filing its bi-monthly report and provided for an allowance of \$2,000 in fees to the PCO’s attorneys for reporting months, while prohibiting the payment of any PCO legal fees in non-reporting months.

E. *Prospective Issues*

- Will each district enact its own explicit procedures for mechanically determining how the bankruptcy court clerk’s office, the court, and the U.S. Trustee coordinate with each other in appointing a PCO?

⁴⁷ Case No. 07-15195 (Bankr. D. N.J.).

- Should a state long-term care ombudsmen be compensated by the bankruptcy estate and, if so, on what basis?

OTHER HEALTH CARE AMENDMENT PROVISIONS AND ISSUES

Thus far, the bulk of the case law involving the Health Care Amendments has focused upon the appointment of PCOs and the interpretation of “health care business” under section 101(27A) of the Bankruptcy Code. However, the BAPCPA introduced various other health care related provisions which have not received as much attention. Although they have not been the subject of many reported opinions, they do raise important issues which will have to be addressed by courts in the future.

A. Disposal of Patient Records

1. “Patient” and “Patient Records” Defined

Two definitions other than “health care business” were added through the Health Care Amendments: (i) patient and (ii) patient records. The BAPCPA defines a “patient” under section 101(40A) as “any individual who obtains or receives services from a health care business,” and “patient records” under section 101(40B) as “any written document relating to a patient or a record recorded in a magnetic, optical, or other form of electronic medium.” Even four years after the adoption of the Health Care Amendments, no decisions have been found significantly addressing the boundaries of who or what qualifies as a patient or patient record, respectively.

2. Section 351 of the Bankruptcy Code and Bankruptcy Rule 6011

In those cases where a health care business files for bankruptcy under chapter 7, 9, or 11 without sufficient funds to pay for the storage of patient records in the manner required under

federal or state law, the Health Care Amendments and Bankruptcy Rule 6011 provide detailed procedures for disposing of patient records.

Section 351 of the Bankruptcy Code provides that, if the trustee does not have sufficient funds to pay for the storage of patient records in the manner required under federal or state laws, the trustee must (i) publish a notice at least 365 days in advance of its intent to destroy patient records, (ii) send notice during the first 180 days of the one-year period calculated to reach each patient or the appropriate insurance carriers regarding the claiming or disposal of the patient records, and (iii) make a written request to each appropriate federal agency to accept any unclaimed records that remain. After proper notice, if the appropriate federal agency does not agree to deposit the records, the trustee may then destroy any unclaimed written patient records by shredding or burning, and unclaimed electronic records by disposing of the electronic data so that it cannot be retrieved.⁴⁸

As additional guidance, Bankruptcy Rule 6011 discusses the disposal of patient records in health care business bankruptcies and requires that the court approve the form of any notice of intent to dispose of patient records. Bankruptcy Rule 6011 provides that there are two ways in which the trustee must provide notice of the disposal of patient records: (i) by publication under section 351(1)(A) and (ii) by mail under section 351(1)(B).

For publication notice, the publication must identify the health care facility whose patient records the trustee proposes to destroy, provide specific contact information of any person from whom information about the patient records may be obtained, state how and by what date the records must be claimed, and provide notice that if the records are not claimed they will be destroyed. For mail notice, the trustee must provide all the information that is required under

⁴⁸ 11 U.S.C. § 351 (2005).

notice by publication *and* direct that a patient's family member or representative inform the patient of the notice, mail the notice to the patient and any family member or contact person whose name is provided to the trustee by the debtor, and mail the notice to insurance companies known to have provided health care insurance to the patient. Once the patient records are destroyed, the trustee must file within 30 days of disposal a report certifying that the unclaimed records were destroyed and the method by which they were destroyed.⁴⁹

The statute and rule provide specific guidance and details to the trustee as to how to handle the disposal of patient records in health care business bankruptcies. However, there are concerns as to the costs involved with these detailed notice requirements and disposal procedures, which costs are to be paid out of the bankruptcy estate as administrative expenses. Even though these provisions arguably relieve the estate of the cost of record retention, the benefit may not outweigh the cost of the notice procedures.

This issue was recently addressed by the Bankruptcy Court for the Eastern District of North Carolina in *In re LLSS Management Co., Inc.*⁵⁰ The chapter 7 trustee in that case filed a motion to determine whether the debtor was a health care business and, if so, what procedures would be required for the disposal of patient records. The usual cost concerns were exacerbated by the fact that the estate had virtually no funds or other assets with which to compensate or reimburse the trustee for the costs associated with record disposal. The court did not actually address whether the debtor was a health care business because the designation was ultimately unimportant to the disposal issue – section 351 did not technically apply because HIPAA was inapplicable to the debtor and North Carolina state law had no retention requirement. Despite this finding, it analyzed section 351 to provide guidance on how to direct the trustee to proceed.

⁴⁹ Bankruptcy Rule 6011 (2005).

⁵⁰ No. 07-02678-5-ATS, 2008 Bankr. LEXIS 607 (Bankr. E.D.N.C. Feb. 11, 2008).

The debtor's sole business was the treatment of nicotine addiction through patient counseling and injections of a combination of prescription medications. Some patients were subsequently prescribed anti-depressants by one of the debtor's physicians. All of the patient histories were self-reported, and records were otherwise limited to the foregoing and blood pressure and EKG readings. The court found that these facts established that there was little valuable medical information to be preserved and that costs should be minimized in order to prevent the trustee from incurring expenses for which he could not be reimbursed. Thus it ordered the trustee to provide mail notification of the proposed destruction to patients treated during the preceding year, to shred any records not claimed after 60 days, and to retain a compact disc containing the names and addresses of those patients who were given injections and for whom anti-depressants were prescribed.⁵¹

3. Prospective Issues

- Does the reference to “drug treatment” in subparagraph (A)(ii) of section 101(40B) refer to treatment with pharmaceuticals or to the treatment of substance abuse?⁵²
- Will bankruptcy courts seek other means to protect and promote the interests of patients and governmental agencies in cases filed by debtors who perform health care related services and activities but are not covered under the definition of a health care business?
- Should there be cost/benefit analysis done as to the cost of record retention and those of notifying and destroying records before approval is given by the court to dispose of patient records?

⁵¹ See *id.* at *6-7.

⁵² See *id.* at *3-4 (noting the issue but finding the designation non-determinative in the case at issue); *In re Pinellas*, 360 B.R. at 360 n.3 (rejecting the “treatment with pharmaceuticals” reading because it “would render meaningless the balance of section 101(27A)(A)(ii) because virtually all areas of medical treatment involve the prescription of drugs”).

- What role will privacy issues and confidentiality concerns play in the disposal of patient records and notification of disposal?
- Some states allow health care businesses to deposit patient records with a designated state agency when the business closes. *Collier on Bankruptcy* suggests that a viable alternative to the destruction of patient records under section 351 would be to transfer them to such a state department but warns that a narrow reading of section 351 might foreclose this option.⁵³ Will bankruptcy courts accept this suggestion?

B. *Duty to Transfer Patients*

1. Section 704(a)(12) of the Bankruptcy Code

In some health care business bankruptcies, facilities housing patients may need to be shut down. As a result, patients in these facilities will have to be relocated to other facilities. The trustee or debtor in possession has a duty to “use all reasonable and best efforts” to transfer patients to another health care facility under the Health Care Amendments. Section 704(a)(12) of the Bankruptcy Code states that the trustee shall use such efforts when transferring patients from a health care business being closed to an appropriate health care business that is (i) in the vicinity of the health care business closing, (ii) provides substantially similar services to the health care business being closed, and (iii) maintains a reasonable quality of care.⁵⁴

Since there have been no reported cases to date addressing this issue, it is uncertain as to what qualifies as “reasonable and best efforts” by the trustee or debtor in possession. Section 704(a)(12) provides courts with general instructions that the transferee facility should be located near the transferring facility, provide similar services, and maintain a reasonable quality of care. However, what is needed factually to satisfy these requirements under the BAPCPA is unknown

⁵³ 3 *Collier on Bankruptcy* ¶ 351.03[3], at 351-9 (15th ed., as revised March 2008).

⁵⁴ 11 U.S.C. § 704(a)(12)

at this point. One point of interest is the role which the PCO will play in those cases where patients need to be transferred to another facility given that the ombudsman serves in a monitoring and oversight capacity as to the patient's health care needs during the bankruptcy proceedings.

2. Prospective Issues

- How will courts determine if the trustee or debtor used “all reasonable and best efforts” to transfer patients?
- What notice procedures will be required prior to the transferring of patients?
- What input, if any, will the patients in the closing facilities have as to where they are transferred?
- What role will the PCO play in the transfer of patients to new facilities?

C. *Administrative Expense Priority*

1. Effect of Section 503(b)(8) of the Bankruptcy Code on Health Care Bankruptcies

Section 503(b)(8) of the Bankruptcy Code grants administrative expense priority for the actual and necessary costs and expenses of closing a health care business incurred by a trustee, by a federal agency, or by a department or agency of a state or political subdivision. These administrative expenses include the costs associated with the disposing of patient records and transferring patients to new facilities.⁵⁵ Prior to the BAPCPA, a trustee or debtor contemplating closing a health care facility had to rely on section 503(b)'s general grant of administrative expense claims for actions taken that provided a benefit to the estate. Thus, the trustee had to be concerned as to whether she or he would be reimbursed for monies spent in complying with

⁵⁵ 11 U.S.C. § 503(b)(8) (2005).

federal and state laws when closing a health care facility in those cases where it was not clear that closing the facility would provide a direct benefit to the estate.⁵⁶

Even though the revisions under section 503(b)(8) do not create significant changes to pre-BAPCPA law on administrative expenses, they do indicate Congressional intent to elevate the repayment status of the costs and expense of closing health care businesses as a means of ensuring that these health care businesses are not abandoned.⁵⁷ Since section 503(b)(8) grants administrative expense priority to the actual, necessary costs and expenses of closing a health care business, “including any cost or expense incurred in” record disposal and patient transfer costs,⁵⁸ other kinds of closing costs and expenses may similarly obtain administrative expense status.

2. Prospective Issues

- What costs and expenses of closing a health care business in addition to record disposal and patient transfer costs, if any, will qualify as administrative expenses under section 503(b)?

D. *Exception to Automatic Stay*

1. Section 362(b)(28) of the Bankruptcy Code

New section 362(b)(28) of the Bankruptcy Code creates an exception to the automatic stay to enable the Department of Health and Human Services (“DHHS”) to exclude a debtor

⁵⁶ See *Oregon v. Witcosky (In re Allen Care Centers, Inc.)*, 96 F.3d 1328 (9th Cir. 1996). In this case, the State of Oregon asserted a \$200,000 administrative expense claim under section 503(b) for reimbursement of the costs associated with closing a long-term care facility. The State argued that its costs benefited the bankruptcy estate because by closing the facility pursuant to state laws it avoided any potential tort liability. However, the court did not agree that any benefit had been provided to the estate and denied the State’s administrative expenses claim.

⁵⁷ Shapiro testimony, *supra* note 21. Shapiro argued that if the costs of closing a health care facility were not provided the status of an administrative expense claim, there would be little incentive for the trustee or debtor-in-possession to spend the time and money needed to properly close down health care facilities, transfer patients to appropriate facilities and dispose of medical waste and patient records with care. Thus, the 2005 amendments address this issue by ensuring that costs and expenses incurred in closing health care facilities will be reimbursed by the estate as an administrative priority claim.

⁵⁸ *Id.*

from participation in the Medicare program or any other federal health care program. There was some concern when section 362(b)(28) was enacted that since the revenue stream from federal programs administered by DHHS is vital to many, if not most, health care businesses, the Health Care Amendments may give the DHHS a larger role with greater leverage in health care bankruptcies and a more significant role in the outcome of these cases.⁵⁹ However, to the writers' knowledge, this has not happened.

The intent of Congress in adopting this amendment was to make it harder for Medicare providers to avoid penalties and repayment obligations in bankruptcy by allowing DHHS expanded debt collection powers against a health care business debtor. The provision appears to be derived from a bill introduced by Senators Charles Grassley of Iowa and John Breaux of Louisiana in the 106th Congress, known as the "Home Health Integrity Preservation Act of 1999." This bill was introduced as a means of modifying the Social Security Act, and Senator Grassley stated that the purpose of the 1999 Act was to "make it harder for all Medicare providers, not just home health agencies, to avoid penalties and repayment obligations by declaring bankruptcy."⁶⁰ However, what has resulted from the new provisions is the elevation and protection of the government's pecuniary interest as a creditor – placing its interests above those of other creditors. This priority for governmental agencies may materially and adversely affect a health care business debtor's efforts to reorganize.

⁵⁹ See, e.g., Harold L. Kaplan, *BAPCPA: Health Care Lenders Beware?*, Am. Bankr. Inst. J. 32, 69 (Jan. 2006). Kaplan writes that, prior to BAPCPA, DHHS regularly sought to enforce various regulations and statutes against debtors, including suspension and exclusion from Medicare programs, but bankruptcy courts would enjoin DHHS from enforcing these regulations or statutes under section 105's equitable powers in hopes of improving the debtors' ability to reorganize. He notes, however, that bankruptcy courts may be reluctant to use their equitable powers under section 105 to enjoin DHHS from taking action after BAPCPA's enactment since bankruptcy courts have generally disfavored using equitable powers in those cases where a particular provision of the Bankruptcy Code would impede the requested exercise of such powers.

⁶⁰ William W. Kannel & Sara R. Bollerup, *Impact of the New Bankruptcy Law on Health Care Bankruptcies*, ABI Committee News, April 2005 (citing to a statement of Senator Grassley found in 145 Cong. Rec. S750, S756 (daily ed. Jan. 20, 1999)).

2. Prospective Issues

- What will be the overall effect of DHHS's enhanced authority to exclude the debtor from participation in Medicare on the efforts of health care businesses to reorganize?
- How will bankruptcy courts respond to steps taken by DHHS which may interfere with reorganization efforts of the debtor? More specifically, will bankruptcy courts interpret section 362(B)(28) or use section 105 to enjoin action by DHHS to aid reorganization efforts by the debtor?

E. *Not-for-Profit Health Care Businesses*

1. Revisions to Section 363(d) of the Bankruptcy Code and their Impact on Nonprofit Health Care Business Bankruptcies

A significant number of health care businesses are not-for-profit corporations regulated by state law. In those cases, the Health Care Amendments require that when a not-for-profit entity sells assets under section 363 of the Bankruptcy Code or pursuant to a confirmed plan, the sale or transfer of assets must comply with applicable nonbankruptcy laws governing the transfer of property by not-for-profit entities. Section 363(d) of the Bankruptcy Code has been revised to provide that the trustee may use, sell, or lease property only in accordance with applicable nonbankruptcy law that governs the transfer of property by a corporate or trust.⁶¹

This new requirement for not-for-profit entities will result in additional expenditure and perhaps some delay for many health care business debtors when selling bankruptcy assets. For example, in New York, this new amendment requires a not-for-profit hospital seeking to sell substantially all of its assets to seek approval by the state court (or perhaps the bankruptcy court) that section 511 of the New York Not-for-Profit Corporation Law has been satisfied and then to

⁶¹ 11 U.S.C. § 363(d) (2005).

obtain all the required regulatory approvals.⁶² Additionally, the BAPCPA grants standing to the attorney general of the state in which the not-for-profit entity is incorporated and does business, such that it can be heard in the bankruptcy court on issues relating to the sale and transfer of assets. In some cases, as a result, a nonprofit health care business debtor may have a more difficult time selling or transferring assets in bankruptcy due to BAPCPA's explicit recognition of the state attorney general's role.⁶³

In addition to the sale or transfer of assets, section 1129(a)(16) of the Bankruptcy Code now contains a similar provision limiting the transferability of assets pursuant to a plan. It provides that the court can confirm a plan only if all of the transfers of property to be made under the plan are made in accordance with any applicable provisions of nonbankruptcy law that governs the transfer of property by a corporation or trust.⁶⁴ Thus, prior to the confirmation of a plan under chapter 11, the bankruptcy court must find that all the transfers of property under the plan were made in accordance with applicable provisions of non-bankruptcy law that govern the transfer of property by a not-for-profit entity. As with the sale and transfer of assets, this requirement may result in more frequent challenges to the confirmation of plans by not-for-profit health care business debtors.

2. Prospective Issues

- Will state attorneys generally agree that a debtor selling all of its assets under section 363 of the Bankruptcy Code comply with section 511 of the New York Not-for-Profit

⁶² Under section 511(d) of the New York Not-for-Profit Corporation Law (McKinney 2005), the sale by a not-for-profit corporation of all or substantially all of its assets requires state court approval. In order to approve a sale, the state court finds that (a) "the consideration and terms of the transaction are fair and reasonable to the corporation" and (b) "the purposes of the corporation or the interests of the members will be promoted" by the sale.

⁶³ Kaplan, *supra* note 29, at 70.

⁶⁴ 11 U.S.C. § 1129(a)(16) (2005).

Corporation Law or a similar state statute elsewhere by requesting that the bankruptcy court make the required findings rather than by commencing a separate state proceeding?

CONCLUSION

In an effort to better protect the interests of patients, governmental entities, and the public, Congress has made health care bankruptcies more complex and more expensive. Courts have recognized that the costs imposed by the Health Care Amendments may override their intended benefits. Thus, in the nearly four years since the Health Care Amendments have been enacted, the bankruptcy courts have moved towards limiting the burden imposed by the new health care provisions on bankruptcy estates.