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## Healthcare Cases— Get Thee To A Specialist, Stat

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Healthcare industry bankruptcy cases are unique in complexity and sensitivity. Hospitals, nursing homes and doctor provider groups, among just a few health industry types, are heavily regulated, can be an area's largest employer, and provide critical, life saving services. As such, healthcare bankruptcy cases are financially and legally multifaceted, and may contain political dynamics often unseen in other types of bankruptcies.

In 2005 Congress added additional wrinkles to healthcare cases through the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 (BAPCPA). The effects of BAPCPA are still being tested. While this article addresses some of the important issues raised in the wake of BAPCPA and how some courts have confronted them, no article – let alone this one – can address all nuances. As such, persons uninitiated to the ways of healthcare bankruptcy cases would be wise to read well beyond this article and, if faced with such a case, consider retaining counsel who has experience.

### Is the debtor a healthcare business?

One of the first issues that may need to be confronted in a healthcare bankruptcy

case is whether the debtor at issue constitutes a "health care business." Falling within this definition triggers additional issues under the Bankruptcy Code that may further complicate the case.

BAPCPA added "health care business" as a defined term under Bankruptcy Code section 101(27A). The definition sets forth what the term "means" (basically, any entity offering services or facilities to the public for diagnosis, treatment, or other health-related care) as well as examples of what the term "includes" (e.g., hospitals, acute and long-term care facilities, hospice, home health agencies and similar health care institutions). 11 U.S.C. § 101(27A). Although the definition includes several examples of entities that may constitute a "health care business," there is significant room for debate as to whether or not a particular debtor falls within the definition.

In fact, just because a debtor operates in the health care market does not mean it necessarily constitutes a "health care business" for bankruptcy purposes. For example, in *In re Medical Associates of Pinellas, L.L.C.*, 360 B.R. 356 (Bankr. M.D. Fla. 2007), the court dissected Bankruptcy Code section 101(27A) and ruled that to qualify as a "health care



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business”: (a) the debtor must be a private or public entity (b) that is primarily engaged in offering to the general public facilities and services (c) for diagnosis or treatment of injury, deformity or disease and (d) for surgical care, drug treatment, psychiatric care or obstetric care. *Id.* at 359. The court went on to hold that the debtor at issue – a facility that primarily offered administrative support, as well as ancillary laboratory support, to a group of doctors and did not deal with the general public – did not constitute a “health care business.” *Id.* at 359-61. Similarly, in *In re Banes*, 355 B.R. 532 (Bankr. M.D.N.C. 2006), the court held that an outpatient dental practice was not a “health care business” because it did not provide patients with shelter and sustenance in addition to medical treatment. *Id.* at 535. Moreover, the court found that the statute is written in the present tense and the debtor no longer engaged in the practice of dentistry. *Id.* In *In re 7-Hills Radiology, LLC*, 350 B.R. 902 (Bankr. D. Nev. 2006), a radiology facility that only offered its services and facilities to referring physicians and not the general public was held not to be a “health care business.” *Id.* at 904-06.

In contrast, in *In re Alternate Family Care*, 377 B.R. 754 (Bankr. S.D. Fla. 2007), despite the debtor’s indication on its petition that the nature of its business was “other” rather than “health care business,” the Office of the United States Trustee moved for the appointment of a patient care ombudsman (whose role is described in the next section). *Id.* at 756. As a threshold matter, the court held that the debtor, a state licensed child placing and caring agency, constituted a “health care business” because, among other things, it operated *primarily* through referrals but was also accessible by the public, and it provided medically supervised treatment, which the court found was sufficient to satisfy the *Pinellas* definition even without involving pharmacological treatment. *Id.* at 758. Similarly, in *In re William L. Saber, M.D.*, 369 B.R. 631 (Bankr. D. Colo. 2007), the debtor indicated on its petition that it was a “health care business” but then argued against such a finding during the case. *Id.* at 635. The court ruled against it, holding that as a single-owner/physician medical practice that provided plastic

and reconstructive surgery to the public, it was a “health care business.” *Id.* at 636-37 (distinguishing language in *Pinellas* that the examples in section 101(27A)(B) “appear to contemplate something more than a doctor’s office,” 360 B.R. at 361). In *In re Valley Health Systems*, 381 B.R. 756 (Bankr. C.D. Cal. 2008), the court found that the chapter 9 debtor, a local health care district that owned and operated three acute hospitals and one skilled nursing facility providing health and medical services to the general public, did constitute a “health care business.” *Id.* at 760-61.

Thus, a practitioner involved in such a case must not only understand how this provision has been interpreted but enough healthcare case law and business to address the matter in the particular case at hand. All the remaining challenges presented below apply to a healthcare debtor that constitutes a “health care business.”

### Must an ombudsman be appointed and should you seek to prevent it?

Under BAPCPA, a new party in interest, the “patient care ombudsman,” was created for health care businesses. 11 U.S.C. § 333. In fact, a health care business debtor is *presumed to need* a patient care ombudsman to monitor the quality of patient care during the case and represent patients’ interests. As counsel, you may be called upon to determine whether such a person is needed, and at what cost.

Under new Bankruptcy Code section 333, a court must order the appointment of a patient care ombudsman as a “professional person” (*i.e.*, paid for by the debtor) within 30 days of the bankruptcy filing *unless* it determines that an ombudsman is not necessary to protect the debtor’s patients under the specific facts or circumstances of the case. 11 U.S.C. § 333; Fed. Interim R. Bankr. P. 2007.2(a)(1). Even if the court decides not to appoint an ombudsman in the first instance, it may later appoint one upon finding that such appointment has become necessary to protect the debtor’s patients.

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Fed. Interim R. Bankr. P. 2007.2(b). This provision originates from Congressional concerns about the fairness of the bankruptcy process to patients, declines in quality of care during bankruptcy cases, and how patients are transferred from the bankrupt organization to another hospital. See Kevin A. Spainhour, *Statutory Quixotics*, 24 Emory Bankr. Dev. J. 193, 194-95 (2008) (citing 144 Cong. Rec. 5892 (1998) (statement of Sen. Grassley)).

BAPCPA does not expressly provide when appointment of a patient care ombudsman is necessary. However, courts have recognized factors to consider in determining or declining to appoint an ombudsman. For example, in *In re Alternate Family Care*, 377 B.R. 754 (Bankr. S.D. Fla. 2007), the court set forth the following nine non-exclusive factors it considered in making its determination to appoint an ombudsman: (a) the cause of the bankruptcy; (b) the presence and role of licensing or supervising entities; (c) the debtor's past history of patient care; (d) the ability of the patients to protect their rights; (e) the level of dependency of the patients on the facility; (f) the likelihood of tension between the interests of the patients and the debtor; (g) the potential injury to the patients if the debtor drastically reduced its level of patient care; (h) the presence and sufficiency of internal safeguards to ensure appropriate level of care; and (i) the impact of the cost of an ombudsman on the likelihood of a successful reorganization. *Id.* at 758. In *Valley Health Systems*, the court declined to appoint a patient care ombudsman using the *Alternate Family Care* factors and four additional factors: (w) the high quality of the debtor's existing patient care; (x) the debtor's financial ability to maintain high quality of patient care; (y) the existence of an internal ombudsman program to protect the rights of patients; and/or (z) the level of monitoring and oversight by federal, state, local or professional association programs that renders the services of an ombudsman redundant. 381 B.R. at 761.

Potential disadvantages to an ombudsman include cost and unneeded intrusion if patients would be otherwise protected during the case. However, the absence of a patient care ombudsman may push the

burden of patient care onto the debtor and debtor's counsel. For example, in *Saber*, the court found the appointment of an ombudsman unnecessary based largely on being "satisfied the Debtor has sufficient procedures in place to enable it to continue to protect the privacy of its patients." 369 B.R. at 638.

In short, a practitioner entering such a healthcare case must have a firm grasp of a debtor's capabilities to self-regulate and whether or not a patient care ombudsman is appropriate. This requires an understanding of the health care business at hand, as well as its regulatory and economic demands.

### What will you do if HHS seeks to affect medicare reimbursements or exclusion of the debtor from a federal healthcare program?

Upon the filing of a bankruptcy case an automatic stay is created that prevents creditors and parties in interest from taking various actions without court authority. Historically, healthcare debtors were generally protected from most actions taken against them absent motion for relief from the automatic stay. BAPCPA created a wrinkle to this issue by adding Bankruptcy Code section 362(b)(28), which creates a specific exception to the automatic stay for the Secretary of Health and Human Services (HHS) to "exclude" the debtor "from participation in the medicare program or any other Federal health care program."

On its face, the statute grants HHS a power that was not stated previously. However, whether or not it practically provides HHS with either more rights or nothing new remains to be seen. At least one commentator has indicated that the provision has not really provided HHS with anything new because HHS always had a police power exemption from the stay to exclude a participant under Bankruptcy Code section 362(b)(4) and the term "exclusion" is a limited term of art under Medicare law that would not apply to payment defaults. See Samuel R. Maizel & Rachel Caplan, *Chicken Little Comes to Roost in Bankruptcy*, 25-AUG Am. Bankr. Inst. J. 22 (July/Aug. 2006).

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Other commentators argue that the provision clarifies – if not actually creates – a police type exception for HHS and effectively gives HHS added leverage to force a debtor to make various structural changes and payments of prepetition amounts. That is, because HHS now has an automatic stay exception to “exclude” the debtor from Medicare, it can wield this power to gain payment of amounts owed to it. *See, e.g.,* Kaplan & Casey, *supra*, at 59; Jeffrey D. Sternklar, *The Collision of the New Bankruptcy Code and Health Care Law*, 50-OCT B.B.J. 14, 15 (Sep./Oct. 2006); Nathaniel M. Lactman & Keith C. Owens, *Health Care Providers and the Automatic Stay*, 25-NOV Am. Bankr. Inst. J. 32, 71 (Nov. 2006).

Given that statutory additions are presumed to be non-duplicative of existing provisions, and that at least one published decision held that certain actions by HHS action do not necessarily fall within the exception of 362(b)(4), it appears, at minimum, that the new provision clarifies HHS’s ability to exclude a debtor from Medicare without violating the automatic stay. *See, e.g., Freytag v. Comm’r*, 501 U.S. 868, 877 (“Our cases consistently have expressed ‘a deep reluctance to interpret a statutory provision so as to render superfluous other provisions in the same enactment.’ The scope of [one] subsection . . . must be greater than that of [the other] subsections.” (internal citations omitted)); *In re Rusnak*, 184 B.R. 459, 464-66 (Bankr. E.D. Pa. 1995) (holding that the basis for exclusion by HHS, although expressly permitted by statute, was of a collection nature that had “nothing to do with the police or regulatory functions of HHS” and therefore was not excepted from the stay) (superseded by statute on other grounds). Naturally, however, this raises the issue of whether HHS will seek to employ such program exclusion without first receiving bankruptcy court approval.

A broader and potentially more troubling issue is whether the new section 362(b)(28) provides HHS with leverage to effectuate structural changes at the debtor’s business or payment to HHS of amounts owed to it under Medicare. Many healthcare entities, including urban and rural hospitals, are highly dependant on federal Medicare receivables.

Delay in receiving payment on such receivables, or exclusion from participation in the Medicare program can be the death-knell to such healthcare debtors. Historically, there has been a split among some jurisdictions as to whether Medicare’s efforts to withhold postpetition payments due to unpaid prepetition amounts constitutes to a setoff subject to the automatic stay, or recoupment which is not subject to the stay. *Compare, e.g., Univ. Med. Ctr. v. Sullivan (In re Univ. Med. Ctr.)*, 973 F.2d 1065 (3d Cir. 1992) (holding that HHS’s withholding post-petition reimbursements was neither a valid setoff nor eligible for recoupment and thus violated the automatic stay) (superseded by statute on other grounds), *with Sims v. U.S. Dept. of Health and Human Svcs. (In re TLC Hosps. Inc.)*, 224 F.3d 1008 (9th Cir. 2000) (allowing HHS to recoup prepetition overpayments from post-petition underpayments without violating the stay), and *United States v. Consumer Health Care Svcs. Of Am.*, 108 F.3d 390 (D.C. Cir. 1997) (concluding that Medicare’s prepetition claim for overpayments and provider’s post-petition claim for reimbursement were part of same transaction to permit recoupment); *see also* Harold L. Kaplan & Timothy R. Casey, *Recoupment in Health Care Bankruptcies: A Shrinking Issue?*, 26-OCT Am. Bankr. Inst. J. 16, 57-58 (Oct. 2007). In light of BAPCPA, HHS may attempt to avoid the setoff/stay argument by threatening “exclusion,” knowing (or at least counting on) a debtor may agree to payment of past due Medicare amounts to avoid exclusion. While such an action might appear to constitute an indirect improper setoff, there is pre-BAPCA authority holding that it does not. *See N.Y. Therapeutic Techs., Inc. v. Shalala (In re The Orthotic Ctr., Inc.)*, 193 B.R. 832, 835 (N.D. Ohio 1996) (holding that HHS’s suspension of Medicare payments on grounds of suspected fraud did not violate the stay per the police or regulatory exception of § 362(b)(4)). However, a different result might be warranted if HHS’s underlying grounds to exclude were improper or without basis. This, in turn, might depend on the meaning of “exclude.” *Compare* 11 U.S.C. § 525(a) (prohibiting a government unit from discriminating against a debtor for, among other things, failure to pay a debt) *and* Maizel & Caplan, *supra* (arguing that “exclusion” is a defined term under Medicare that does not include nonpayment

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as basis) *with Psychotherapy & Counseling Ctr.*, 195 B.R. at 528-29 (noting that “[t]here are two possible avenues that HHS may pursue to accomplish this exclusion [of the debtor from the provider payment program]. HHS may either seek to enforce the exclusion remedy provided in the terms of the settlement agreement based on the debtor’s breach of that agreement. Or HHS may seek to exclude the debtor from the program pursuant to its statutory authority . . .” but ultimately concluding that exclusion per the provider agreement would not be excepted from the stay because section 362(b)(4) does not permit “government agencies to enforce *contractual* rights against debtors without first seeking relief from the automatic stay” (quoting *In re Corporacion de Servicios Medicos Hosp.*, 805 F.2d 440, 445-47 (1st Cir. 1986) (emphasis in original))). Published legislative history, albeit scant, suggests that the provision may have been designed to provide HHS with such leverage. BAPCPA was introduced by Senator Charles E. Grassley, who earlier had proposed the Home Health Integrity Preservation Act of 1999 to, among other things, “reform bankruptcy rules to make it harder for all Medicare providers . . . to avoid penalties and repayment obligations by declaring bankruptcy.” 145 Cong. Rec. S756 (daily ed. Jan. 20, 1999) (statement of Sen. Grassley).

At bottom, Bankruptcy Code section 362(b) (28) creates issues for a health care business debtor that remain unresolved. Thus, in addition to understanding existing law concerning issues of setoff and recoupment, counsel may need to develop a grasp on the right of HHS to “exclude” a debtor from the Medicare program, a right that is acknowledged by BAPCPA but expressly governed by non-bankruptcy law. See 42 U.S.C. § 1320a-7. Counsel must learn what “exclusion” may include. See *id.* One needs to understand the different grounds for mandatory and permissive exclusion as well as the difference between exclusion and termination, and be prepared to argue successfully that the debtor should not be stripped of its rights under the Medicare program. See 42 U.S.C. §§ 1320a-7, 1395cc(b)(2); see also Lactman & Owens, *supra*, at 71-72. If counsel fails to advocate on this point entirely, either itself or through specialized

counsel, it may have to work harder to convince lenders and potential acquirers that the business is still more valuable as a going concern without the assurance of future Medicare reimbursements. See, e.g., Timothy M. Lupinacci, Eric L. Pruitt & R. Spencer Clift, III, *The Changing Face of Health Care Bankruptcies*, 2006 No. 04 Norton Bankr. L. Adviser 2 (Apr. 2006).

### What if you need to shut down a facility? Would you know how to transfer the patients?

When a health care facility closes, the healthcare debtor in possession must “use all reasonable and best efforts” to transfer its patients from that closing facility to another facility that is “appropriate” (*i.e.*, nearby, with similar services, and with reasonable quality of care). 11 U.S.C. § 704(a)(12). Although BAPCPA creates a duty for the healthcare debtor in possession to transfer a patient and establishes certain requirements related thereto (such as the type of facility to which patients can be transferred and notice that must be provided), BAPCPA does not regulate the actual transfer of patients. 11 U.S.C. §§ 704(a)(12), 1106(a)(1), 1107(a).

Some states have regulations on patient transfer, but there is no consistency regarding how a closing health care facility should transfer its patients and who is responsible for the transfer. See, e.g., American Bankruptcy Institute, *ABI Health Care Insolvency Manual*, 108 (2d Ed. 2005) (“Depending on the applicable law, transfer arrangements may be the primary responsibility of the patient’s family, the facility or a particular state agency”). Thus, counsel must know the applicable regulations in order to advise the debtor regarding compliance.

### Protecting patient records

Under new Bankruptcy Code section 351, the debtor health care business must satisfy detailed requirements for the retention and disposal of health care records. See 11 U.S.C. § 351. The healthcare debtor must arrange for commercial storage of patient records pursuant to federal and/or state

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regulations (as applicable to the facility) or, if it lacks the funds to do so, take appropriate steps to provide notice that records will no longer be stored and how they may be claimed before they are destroyed; and such notice must take certain precautions in confidentiality. *Id.*; Fed. Interim R. Bankr. P. 6011.

Although BAPCPA preempts otherwise applicable federal and state storage rules if the debtor cannot afford compliance, a debtor must comply with federal or state regulations if it can afford to do so. State statutes and agencies often impose more stringent requirements for the retention and destruction of documents, and record keeping requirements vary from state to state. *See, generally, ABI Health Care Insolvency Manual* at 108. Counsel must be cognizant of the numerous and distinct requirements. Counsel should also consider issues of potentially direct liability if he or she is deemed to qualify as the debtor's "business associate" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191. *See, generally, Sarah B. Foster, Sometimes a Little Information Is a Dangerous Thing On the Other Hand, Having No Information Can Get You Blindsided, available at 041207 ABI-CLE 419.*

Counsel must also understand the cost of compliance with non-bankruptcy regulations in order to calculate whether the debtor can afford it. This in turn raises certain questions, including whether storage expenses would be entitled to the same administrative priority as costs incurred to close a facility under section 351 pursuant to section 503(b)(8)(A) or as "the actual, necessary costs and expenses of preserving the estate" under section § 503(b)(1)(A). *See also 3 Collier on Bankruptcy* ¶ 351.04[1], at 351-10 (noting that this may be the "most reasonable view").

Further, counsel must be careful given BAPCPA's definitions of "patient records" and "patients." The term "patient records" is drafted to include any "record recorded in a magnetic, optical, or other form of electronic medium," seemingly regardless of whether it relates to a patient or has a healthcare nature, plus "any written document relating to a patient," again regardless of whether it has a

healthcare nature. *See* 11 U.S.C. § 101(40A); *see also Sternklar, supra*, at 14; 3 *Collier on Bankruptcy* ¶ 351.02, at 351-5. "Patient" refers to "any individual who obtains or receives services" – not just medical services – "from a health care business." *See* 11 U.S.C. § 101(40B); *see also Sternklar, supra*, at 14.

Thus, the practitioner advising a healthcare debtor must have knowledge of the debtor's business and the applicable regulations governing its business records in order to advise the debtor how to comply appropriately and to protect itself from liability through association.

### What are the rules of sale/transfer?

If the healthcare debtor is a non-profit entity, BAPCPA requires that any sale or transfer of its assets comply with non-bankruptcy law regulating such transfers. Specifically, a tax-exempt debtor may transfer its assets to a non-exempt business "only under the same conditions as would apply if the debtor had not filed a case under" the Bankruptcy Code. 11 U.S.C. § 541(f); *see also* I.R.C. § 501(a), (c)(3) (describing a tax-exempt business). Similarly, a debtor in possession "that is not . . . moneyed, business, or commercial" may sell its assets during the case or transfer its assets pursuant to a plan of reorganization "only in accordance with applicable nonbankruptcy law." 11 U.S.C. §§ 363(d) (1), 1129(a)(16). Although not written into the text of the Bankruptcy Code, BAPCPA now appears to support the standing of the attorney general of the state in which the debtor was incorporated or conducted business to be involved in any section 363(d) proceedings, introducing yet another party in interest. *See Daniel A. Demarco & Nancy A. Valentine, Health Care Hazards and Eleemosynary Elocutions, 24-OCT Am. Bankr. Inst. J. (Oct. 2005) (citing BAPCPA § 1221(d)).*

The recent United States Supreme Court decision in *Florida Department of Revenue v. Piccadilly Cafeterias, Inc.*, 128 S. Ct. 2326 (2008), added a further wrinkle. In *Piccadilly*, the Supreme Court held that asset sales and transfers are only exempt from transfer taxes under Bankruptcy Code section

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1146(a) when they are made pursuant to a plan “that has been confirmed.” *Id.* at 2339. Previously, many circuits had held that such tax advantage could be obtained in sales that occurred prior to plan confirmation.

Thus, given the new rules of sale under both BAPCPA and *Piccadilly*, sales of many healthcare entities and assets will be more challenging. See Lupinacci et al., *supra* (“These new limitations could preclude future transfers and sales, especially of hospitals in bankruptcy, thus limiting the recovery to creditors of nonprofit borrowers.”); Demarco, *supra* (noting how the increased restrictions will likely decrease the pool of interested buyers and lower the bid price for such entities). In response counsel will need an even greater understanding of healthcare in order to structure a recovery plan that is beneficial to the debtor, its creditors, and potential buyers.

## Conclusion

In addition to the usual professional risks and responsibilities that are part and parcel of debtor representation, representation of a healthcare debtor under BAPCPA brings along additional risk for someone who is not adequately prepared for the challenges. In the worst case, failure to advise the client properly may expose the debtor, and counsel, to liability.

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