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A Collision of Complex Laws: The Interplay Between and Among State and Federal Regulatory Laws in Health Care Cases

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Introduction

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Intersection of the Bankruptcy Code and Healthcare

- **Sections of the Bankruptcy Code Unique to Healthcare:**
  - 11 U.S.C. § 101(27A) – Defines "health care business" as a public or private entity that provides services for the diagnosis or treatment of injury, deformity, or disease and surgical, drug treatment, psychiatric, or obstetric care; and includes any (i) general or specialized hospital; (ii) ancillary ambulatory, emergency, or surgical treatment facility; (iii) hospice; (iv) home health agency, and (v) any long-term care facility, including, any skilled nursing facility, intermediate care facility, assisted living facility, home for the aged and domiciliary care facility.
  - 11 U.S.C. § 351 – Establishes procedures for storage, notice and disposal of patient records where the estate does not have sufficient funds to comply with applicable state law requirements in order to protect patient sensitive data (e.g., HIPAA).
    - The debtor is required to publish notice in one or more "appropriate" newspapers stating the patient records of the closing facility will be destroyed if unclaimed after 365 days. During the first 6 months of the one-year notice, the debtor must attempt to notify each patient directly by mail (or patient's family or contact person) and their insurance carrier of the pending disposal. *Id*. at § 351(1).
    - If files are unclaimed after newspaper notice and direct notice, debtor is required to notify "appropriate federal agencies" and request the agency accept the patient records. If a federal agency will not accept, the files must be destroyed in a way to ensure they cannot be reconstituted. *Id*. at §§ 351(2), (3).
  - 11 U.S.C. § 333 – Appoints a Patient Care Ombudsman to monitor the quality of patient care postpetition.
  - 11 U.S.C. § 362(b)(28) – Permits postpetition exclusion of provider agreements from Medicare, Medicaid, and other federal healthcare programs by the U.S. Health and Human Services Inspector General.
  - 11 U.S.C. § 503(b)(8) – Provides for administrative priority for closure costs of a Health Care Business (including patient transfers and record storage/disposal) and costs of a trustee or federal or state agency.
  - 11 U.S.C. § 704(a)(12) - A trustee shall use best efforts to transfer patients from a closing healthcare business to an appropriate nearby facility offering substantially similar services and maintaining reasonable quality of care.

Intersection of the Bankruptcy Code and Healthcare (Continued)

- **Other relevant provisions to consider:**
- **11 U.S.C. § 525(a)** – Protects against discriminatory treatment of a debtor by prohibiting the government from denying, suspending, revoking or refusing to renew a license, permit or similar grant solely because the debtor filed for bankruptcy.
  - *In re Sun Healthcare Grp., Inc.*, No. 99-3657, 2002 WL 2018868 (D. Del. Sept. 4, 2002): The Court held that the refusal to re-certify a terminated provider for participation in Medicare by the precursor to the current Centers for Medicare and Medicaid Services' ("CMS") violated section 525 of the Bankruptcy Code because the refusal of a Medicare provider agreement arose from debtor's failure to repay dischargeable prepetition debts.
  - However, in *In re Parkview Adventist Med. Ctr. v. United States*, 842 F.3d 757 (1st Cir. 2016), the court held that termination of the Medicare provider agreement was not a violation of section 525 because CMS's termination arose from the debtor's voluntary termination by way of a prepetition letter to CMS disqualifying itself as a hospital under the Medicare statute.
- **28 U.S.C. § 959** – Governs trustee/debtor-in-possession's obligation to manage and operate the debtor's property in accordance with applicable state law.

Application of Bankruptcy Code to Not-For-Profit Healthcare Businesses

- Section 1129(a)(16) applies the requirements of 363(d)(1) and 541(f) to confirmation of a plan. *Id*. at 1129(a)(16).
- Not-for-profit hospitals may not be subject to involuntary cases under Chapter 7 and 11 of the Bankruptcy Code, including involuntary conversion from a Chapter 11 case to a Chapter 7 case. 11 U.S.C. §§ 303(a), 1112(c).
  - Note: The protections afforded by section 1112(c) will not prevent dismissal of a health care business' chapter 11 case under section 1112(b) if appropriate, or appointment of a trustee and liquidation in chapter 11. *See In re Sheehan Mem'l Hosp.*, 301 B.R. 777, 780 (Bankr. W.D.N.Y. 2003) (exempting health care debtor from conversion to chapter 7 as an "eleemosynary institution," but granting motion to dismiss for cause shown).
- The absolute priority rule is typically inapplicable to not-for-profit businesses, as courts give deference to the status and public purpose of not-for-profit debtors. Courts acknowledge the challenges not-for-profits face in balancing its obligation to fill its charitable purpose and its obligation to creditors. Moreover, courts acknowledge that directors of not-for-profit businesses have no incentive to allocate goods and services to themselves at the expense of creditors. *See In re Wabash Valley Power Ass'n.*, Inc., 72 F.3d 1305 (7th Cir. 1995); *Official Comm. of Unsecured Creditors v. Henry Mayo Newhall Mem'l Hosp.* (*In re Henry Mayo Newhall Mem'l Hosp.*), 282 B.R. 444, 453 (B.A.P. 9th Cir. 2002) (noting that creditors of a not-for-profit hospital, with no equity owners, are in an "unusually disadvantaged negotiating position" because they are not able to assert the absolute priority rule).
  - "This [exception] assumes that the directors are complying with their fiduciary duties. To the extent that directors violate their duties and inappropriately manage the nonprofit's resources for their own gain, even the directors of an entrepreneurial nonprofit may be seen to violate certain policy goals of section 1129." Amelia Rawls, *Applying the Absolute Priority Rule to Nonprofit Enterprises in Bankruptcy*, 118 YALE L. J. 1231, 1237 n.31 (2009).

Closure/Transfer/Sale of Healthcare Facilities

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General Considerations for the Closure/Transfer of Healthcare Facilities

- Coordination with federal, state and local regulatory bodies is a must for closure/transfer of not-for-profit and for-profit healthcare facilities.
- For-Profit or Non-Profit Providers may be required to file and obtain approval of a Hospital Plan of Closure from the state regulatory agency, e.g., Department of Health and other applicable agencies.
- Some states require not-for-profits to provide written notice to and obtain written consent of the Attorney General prior to entering into any sale/transfer/closure transaction. *See e.g.*, CAL. CORP. CODE §§ 5914-5925, 10820, 10821; CAL. CODE REGS. tit. 11 §999.5. N.Y. NOT-FOR-PROFIT CORP. LAW §§ 510-511.
- State licenses must be reviewed individually for transfer/approval requirements.
    - Example: The Saint Vincent's bankruptcy, closure, and transfer of services involved coordination with over twelve agencies, including but not limited to, N.Y. Department of Health, N.Y. State Liquor Authority, N.Y. State Department of Motor Vehicles, U.S. Nuclear Regulatory Commission, N.Y. Department of Environmental Protection.
- In order to convert a not-for-profit healthcare provider to a for-profit healthcare provider, providers must be mindful of non-bankruptcy laws even if the provider has filed for bankruptcy.
- Section 704(a)(12) of the Bankruptcy Code requires the trustee to use reasonably best efforts to transfer of patients from a closing healthcare business to a nearby facility offering substantially similar services and maintaining reasonable quality of care. 11 U.S.C. § 704(a)(12).

Bankruptcy Court's Authority to Determine State Court Approval Matters

- Section 363(d)(1) of the Bankruptcy Code provides a not-for-profit business must coordinate transfers and sales in accordance with state law. 11 U.S.C. § 363(d)(1).
- Section 541(f) provides any corporation that is tax-exempt pursuant to 26 U.S.C. § 501(c)(3) or § 501(a) (sections of the Internal Revenue Code) may transfer assets to a nontax exempt entity only "under the same conditions as would apply if the debtor had not filed a case under this title." 11 U.S.C. § 541(f).
- The legislative history of sections 363(d) and 541(f) of the Bankruptcy Code indicate that the Bankruptcy Court has jurisdiction to approve transfers of not-for-profit healthcare businesses in accordance with non-bankruptcy law. Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 ("BAPCPA"), Pub. L. No. 109-8, § 1221(d), 199 STAT 196 (2005).
  - In obtaining authority for a transfer, the provider needs to consider potential conflicts between the Bankruptcy Court's review under section 363 and the state court review standard. See e.g., N.Y. NOT-FOR-PROFIT CORP. LAW §§ 510-511.
- In *In re HHH Choices Health Plan, LLC*, the Bankruptcy Court for the Southern District of New York held that while any substantive aspects or provisions of non-bankruptcy law that apply to the sale of its assets are applicable under section 363(d)(1), the ordinary state court procedural aspects are not. 554 B.R. 697, 700 (Bankr. S.D.N.Y. 2016).
  - Section 1221(e) of BAPCPA states, as a rule of construction, that: "Nothing in this section shall be construed to require the court in which a case under chapter 11 of title 11, United States Code, is pending to remand or refer any proceeding, issue, or controversy to any other court or to require the approval of any other court for the transfer of property." BAPCPA, Pub. L. No. 109-8, § 1221(e) (2005).
  - In the case of an insolvent not-for-profit corporation, section 511 of the New York Not-For-Profit Corporation Law ordinarily, would require the approval of the New York State Supreme Court for a transfer of assets. However, section 1221(e) of the BAPCPA explicitly provides otherwise. *In re HHH Choices Health Plan, LLC*, 554 B.R. at 700.
  - The judge's interpretation of section 1221(e) "is that substantive state law requirements are applicable, but that [the bankruptcy judge is] the one who is supposed to apply them, not the New York State Court." *Id*.

Fiduciary Duties of Directors Prior to and During Transfer of Healthcare Facilities

- **Duty of Care**
  - Directors of not-for-profits and for-profits must act with the diligence, care and skill that an ordinary prudent person would exercise under similar circumstances. *See e.g.*, N.Y. NOT-FOR-PROFIT CORP. LAW § 717 (2010); Cal. Corp. Code § 309(a).
- **Duty of Loyalty**
  - Directors of not-for-profits and for-profits must put the organization's interests before their own. *See Estate of Lemington Home for the Aged v. Baldwin (In re Lemington Home for the Aged Official Comm. of Unsecured Creditors)*, 777 F.3d 620 (3d Cir. 2015).
- **Duty of Obedience ("Charitable Mission")**
  - Not-for-profit directors possess a duty of obedience to ensure that the charitable mission is carried out since the ultimate objective of not-for-profits is perpetuation of particular activities that are central to the raison d'etre of the organization. *See Manhattan Eye, Ear & Throat Hosp. v. Spitzer*, 186 Misc. 2d 126, 152, 715 N.Y.S.2d 575, 593 (N.Y. Sup. Ct. 1999); *see also Shorter Coll. v. Baptist Convention*, 279 Ga. 466, 475, 614 S.E.2d 37, 43 (Ga. 2005) (duty of obedience requires faithfulness to the purposes of organization since "unlike business corporations, whose ultimate objective is to make money, nonprofit corporations are defined by their specific objectives") (citation omitted).
  - The charitable mission can be a key consideration for the sale or transfer of assets as the debtor's board of directors balances the need to maximize value for the estate's creditors, on the one hand, with preservation of the debtor's healthcare mission, on the other hand.
- **Duty During Insolvency**

Bankruptcy Court Consideration of Charitable Mission in Approval of Transfer of Not-For-Profit Healthcare Facilities

- Courts will consider the charitable mission of a not-for-profit healthcare business in assessing whether to approve a sale or transfer of the not-for-profits assets.
- Courts have upheld the notion that higher price does not necessarily yield the best use of healthcare assets. *See e.g., In re United Healthcare Sys., Inc.*, 1997 WL 176574 (D.N.J. Mar. 26, 1997)
- In In re United Healthcare Sys., Inc., the District Court of New Jersey found that preservation of the acute healthcare center's mission as an integrated children's hospital warranted approval of a sale transaction and that the Bankruptcy Court erred in approving another, purportedly higher competing transaction. *Id.*
  - United Healthcare received four sale proposals and awarded the sale to Saint Barnabas, who was committed to continuing the children's hospital in one location with comprehensive services. The Bankruptcy Court concluded the sale to Saint Barnabas would not be approved because the transaction hindered the ability to obtain a fair price for the assets for the benefit of creditors. The Bankruptcy Court believed UMDNJ/Cathedral's offer was higher and better and preserved more jobs and protected more physicians. *In re United Healthcare Sys., Inc.*, 1997 Bankr. LEXIS 2358, *24-25 (Bankr. N.J. March 5, 1997)
  - On appeal, the District Court of New Jersey reversed the Bankruptcy Court and found the "[c]ourt must not only weigh the financial aspects of the transaction but also look to the countervailing consideration of a public health emergency." *In re United Healthcare Sys., Inc.*, 1997 WL 176574, at *5.

Case Study: Saint Vincent's Westchester – Mission Oriented

- Saint Vincent's Westchester (a behavioral health hospital) was faced with two options – (1) close the hospital and sell the real estate for non-health care use or (2) sell the hospital to an acquirer that would continue to operate the facility.

Closure Option	Going Concern Sale

• Closure could have allowed for the sale of the entire 66 acre real estate parcel for residential or commercial development, favored by mortgage creditors, subject to zoning changes.
  • The real estate was encumbered by approximately $170 million in secured debt and the behavioral health business was encumbered by approximately $320 million in debt.
• Critical behavioral health care services would have been lost. There was inadequate "absorption" of the services by other providers due to the special care needs of the patients. As such, regulatory bodies opposed closure.
• Closure Costs would have been very significant:
  • Patient placement would have been time-consuming
  • No available alternative beds for in-patients
  • No one willing to take over many of the treatment programs (both inpatient and outpatient)
  • Medical records storage costs
• Saint Vincent's health care mission would have been abandoned. As such, its not-for-profit status provided flexibility in assessing alternatives.
	• Ensured patient safety and continuation of care.
	• Avoided extensive closure-related costs.
	• Marketing process demonstrated that only one viable health care provider could purchase the business.
	• Mortgage creditors believed that there was value in the real estate that could satisfy their claims. However, the state would not approve closure. Saint Vincent's Westchester put together creative solution since only one-half of the property was used by the hospital.
	  • To provide the mortgage creditors with the opportunity for increased value, the buyer agreed to make an option available to Saint Vincent's to buy back the real estate that the hospital did not use.
	  • Marketing process and bid procedures for the real estate option were established with the hospital buyer serving as the stalking horse.
	  • If a higher bid emerged for the option then the option could be purchased from the hospital buyer subject to obtaining zoning and related approvals to subdivide the property.

- Ultimately, with the support of New York State and the community, Saint Vincent's Westchester transferred the operations in a going concern sale.

Case Study: Gardens Regional Hospital and Medical Center, Inc.

- Gardens Regional Hospital and Medical Center, Inc. ("Gardens") filed for bankruptcy following financial difficulties. *In re Gardens Regional Hosp. and Med. Ctr., Inc.*, 567 B.R. 820 (Bankr. C.D. 2017).
- Within the first two months of the bankruptcy case, the Court approved a sale of the operating Hospital to Strategic Global Management, Inc. ("Strategic"), a for-profit entity, for $19.5 million. Strategic assigned its rights to KPC Global Management, LLC ("KPC"). *Id.* at 823.
- Per California Corporation Code § 5914(a), Gardens sought the California Attorney General's (the "Attorney General") approval to sell its assets. *Id.* The Attorney General approved the sale under certain conditions, which Gardens and representatives of two unions representing Gardens' employees subsequently sought to modify. *Id.* The Attorney General issued a letter denying the modification request, causing Strategic and KPC to terminate the sale contract. *Id.*
- By the time the sale fell apart, Gardens had exhausted nearly all of its debtor-in-possession financing. *Id.* 823-24. Gardens found it nearly impossible to obtain any additional financing and were on the verge of running out of cash. *Id.* at 824. Thus, Gardens sought and received approval of an emergency motion to close the hospital in accordance with the hospital's charitable mission of sustaining public health and welfare. Id. If the hospital continued to admit new patients without the funds to run the Hospital, the public health and welfare of its patients would be jeopardized. *Id.*
- Gardens found a purchaser for a number of its assets for substantially less than the purchase price Strategic had offered. Gardens asserted it was not required to obtain the Attorney General's consent because the Hospital was closed. *Id.*

Case Study: Gardens Regional Hospital and Medical Center, Inc. (Continued)

- The Bankruptcy Court agreed that state approval was not necessary because the Gardens no longer qualified as a "hospital facility" under section 1250 of the California Health & Safety Code, which defines health facility as "a facility . . . that is organized, maintained, and operated for the diagnoses, care, prevention, and treatment of human illness . . . to which the persons are admitted for a 24-hour stay or longer . . . ." CAL. HEALTH & SAFETY CODE § 1250 (West 2017). Even if Gardens continued to "control" the hospital and new purchaser intended to re-open the hospital, the Hospital currently had no operations, could not diagnose or care for patients, or admit patients for a 24-hour stay or longer. *In re Gardens Regional Hosp. and Med. Ctr., Inc.*, 567 B.R. at 827-28.
- The Attorney General filed an appeal requesting the U.S. District Court for the Central District of California overrule the Bankruptcy Court's ruling that the closed hospital did not qualify as a health facility. However, the District Court dismissed this appeal as statutorily moot. *In re Gardens Regional Hospital and Medical Center, Inc.*, Case No. 17-cv-03708 (C.D. Cal. January 19, 2018), ECF No. 53.

Case Study: St. Francis' Hospital

- A few months shy of its 100th birthday, St. Francis' Hospital, a not-for-profit hospital in Poughkeepsie, New York, filed its bankruptcy petition in December 2013.
- In connection with selecting Health Quest as the stalking horse bidder for the debtor's assets, the debtor engaged in discussions with the U.S. and New York state anti-trust regulators for approval of the sale. Following significant negotiations, the debtors were able to establish an understanding with the regulators that: (i) no other party could be in a position to be stalking horse bidder on the timeline required to seek bankruptcy protection and avail the hospital of debtor-in-possession financing, and (ii) the debtor's aggressive post-petition marketing process could potentially result in an alternative buyer that would preserve the competitive landscape. The regulators reserved their rights, but agreed not to object at the outset of the bankruptcy case.
- Throughout the post-petition marketing process, Westchester Medical Center ("WMC") emerged as an interested party and submitted a significant overbid in exchange for the debtor's agreement to cancel the auction and declare WMC the successful purchaser. Accordingly, the debtors cancelled the auction.
- However, at the hearing to approve the sale to WMC, the court expressed significant concern over the debtor's decision to cancel the auction without first seeking court approval. Upon hearing further testimony from the parties, the court ultimately approved the sale, acknowledging that the debtor had accepted the highest or otherwise best offer for its assets. *In re St. Francis' Hospital, Poughkeepsie, New York*, Case No. 13-37725 (Bankr. S.D.N.Y. February 24, 2014), ECF No. 355.

Case Study: Daughters of Charity

- Daughters of Charity Health System ("DCHS") operated various hospitals in California. It undertook a nearly two year sale process, primarily because of the rigorous approval process.
- The DCHS sale process timeline:
  - **2013**: The DCHS board announces that without a sale, closure or bankruptcy was necessary.
  - **October 2014**: Following receipt of multiple bids, DCHS announces proposed sale to Prime Healthcare Services ("Prime").
  - **February 2015**: The California Attorney General approves the proposed sale to Prime but imposes 78 pages of conditions that included requiring acquirer to keep 4 of 6 hospitals open for 10 years as acute hospitals and operate fifth hospital as skilled nursing and emergency service facility – none of which were profitable parts of the business.
  - **March 2015**: Proposed sale to Prime collapses as a result of California Attorney General's "impossible" conditions. M&A and bankruptcy preparation efforts resume.
  - **December 2015**: California Attorney General approves a long-term management agreement (with a purchase option) with an affiliate of BlueMountain Capital Management. A key factor in the Attorney General's approval was a requirement of the buyer to maintain the system's essential services for at least 10 years and operate the system as a not-for-profit hospital for up to 15 years. DCHS is renamed as Verity Health System ("Verity").
- Despite recapitalization of the hospital system's operations, Verity continued to struggle and filed for bankruptcy on August 31, 2018. The Debtors cited a number of factors leading to its bankruptcy filing, including, below market rate payments on its payor contracts, increase of $65 million in payroll costs, $66 million in expected pension funding requirements, $50 million in required IT investments, $150 million in required seismic and energy expenditures and delays in approval and receipt of lower than expected amounts of Hospital Quality Assurance Fees. Verity is selling all six of its hospitals through sales under section 363 of the Bankruptcy Code.

Case Study: Daughters of Charity (continued) – Verity Health System

- The Verity sale process timeline:
  - **October 2018**: Verity obtained approval of Santa Clara County as stalking horse bidder for two of Verity's hospitals, along with approval of related bid and auction procedures. The stalking horse bid was for $235 million.
  - **December 2018**: The judge entered a memorandum decision (the "Memorandum Opinion") and order (the "Sale Order") approving the sale to Santa Clara County, free and clear of the 2015 conditions imposed by the California Attorney General.
  - **January/February 2019**: The Attorney General filed a notice of appeal of the Sale Order and Memorandum Opinion, as well as a motion to stay the Sale Order pending conclusion of his appeal. The bankruptcy court denied the stay motion and the Attorney General appealed to the district court. The district court denied the stay motion as well.
  - **February 2019**: Verity reached a settlement with the California Department of Health Care Services ("DHCS"), regarding the terms of the transfer of certain Medi-Cal provider agreements and the U.S. Department of Health and Human Services ("HHS") regarding the transfer of the Medicare provider agreements that were the subject of their sale objections.
  - **February 2019**: Verity obtained approval of Strategic Global Management, Inc. ("SGM") as stalking horse bidder for the remaining four of Verity's hospitals, along with approval of related bid and auction procedures. The stalking horse bid was for $610 million.
  - **March 2019**: Verity and the Attorney General agreed to dismiss the Attorney General's appeal of the Sale Order and Memorandum Opinion.
  - **April 2019:** The sale hearing for the remaining four Verity hospitals is tentatively scheduled for April 17, 2019.

Real Estate and Zoning Considerations in Closure/Transfer of Healthcare Facilities

- When a health care business is determining whether to close its facilities, the value of the underlying real estate (often the most lucrative asset) is an important consideration.
- However, it is not unusual for real estate used by hospitals to be specifically zoned for health care purposes only, thereby requiring rezoning for an alternative use.
- For example, requests for rezoning in New York City are subject to the city's Uniform Land Use Review Procedure (ULURP) process. The ULURP process takes approximately 200-215 days and requires the following steps:
  - Filing of ULURP Application
  - Certification of Completed Application
  - Committee Board Review
  - Borough President Review
  - City Planning Commission Review
  - City Council Review
  - Mayoral Review

  See New York City Planning, Uniform Land Use Review Procedure, https://www1.nyc.gov/site/planning/applicants/applicant-portal/step5-ulurp-process.page.
- **Case Study:** Saint Vincent's Manhattan: The hospital undertook a marketing process of the main Manhattan hospital campus focused on maximizing value for stakeholders while also providing a health care alternative for the community. The key challenge was that the real estate would need to be rezoned if used for non-health care related purposes. To assist in this process, the debtors required that any land purchaser provide a "health care solution" for part of the former campus. Saint Vincent's secured a purchaser that paid $260 million for the real estate (not conditioned on zoning or regulatory approval) and agreed to develop (with North Shore/LIJ) the first free-standing emergency department in New York City on one parcel. It took the purchaser 200 public meetings over the span of over one year to ultimately obtain rezoning.

Treatment of Charitable Donations in Closure/Transfer of Not-For-Profit Healthcare Facilities

- Not-for-profits, including health care institutions and systems, often receive gifts and bequests which may be property of the estate, depending on whether there are restrictions on use. *See In re Winsted Mem'l Hosp.*, 249 B.R. 588, 591 (Bankr. D. Conn. 2000); *Hunter v. Saint Vincent Med. Ctr. (In re Parkview Hosp.)*, 211 B.R. 619, 629 (Bankr. N.D. Ohio 1997) ("Where property is given to a charitable corporation without restrictions as to the disposition of the property, the corporation is under a duty, enforceable at the suit of the Attorney General, not to divert the property to other purposes but to apply it to one or more of the charitable purposes for which it is organized." (quoting RESTATEMENT (SECOND) OF TRUSTS § 348)).
- Generally, restricted donations, delineated for a specific purpose, may only be used for the purpose delineated by the donor.
- A health care institution may utilize the state law doctrine of cy pres to allow for a restricted donation to be used for another similar purpose or transferred to another institution that can promote the testator's intent. *See Salisbury v. Ameritrust Tex., N.A. (In re Bishop Coll.)*, 151 B.R. 394, 400-01 (Bankr. N.D. Tex. 1993).
  - Three conditions that generally have to be satisfied before the application of *cy pres* are: (a) the gift or trust is charitable in nature; (b) the donor demonstrated a general intent rather than specific; and (c) changed circumstances after the bequest or gift render compliance with the terms impossible or impracticable. *In re Estate of Othmer*, 815 N.Y.S.2d 444, 447(N.Y. Surr. Ct. 2006).

Assignment of Provider Agreements

- In order to receive reimbursements for services rendered to Medicare and Medicaid beneficiaries, health care providers must enter into "provider agreements." *See generally* 42 U.S.C. § 1395cc (Medicare).
  - Hospitals will also enter into provider agreements with private payors.
- Provider agreements are the primary source of revenues for many hospitals and other healthcare providers. The ability of the government (or other payors) to recoup, offset or reduce payables can have an immediate and detrimental impact upon a distressed provider's liquidity and ability to operate.
- If a debtor wants its Medicare Provider Agreement assigned, courts consider whether the agreement is an "executory contract." 11 U.S.C. § 365.
  - The overwhelming majority view is that provider agreements are executory contracts, and can be assumed and assigned under section 365, which requires obtaining CMS' consent and that the buyer cures all pre-petition and post-petition defaults. *See, e.g., In re Univ. Med. Ctr.*, 973 F.2d 1065, 1076 (3d Cir. 1992); *In re Slater Health Center, Inc.*, 398 F.3d 98, 105 (1st Cir. 2005); *United States v. Consumer Health Services*, 108 F.3d 390, 394 (D.C. Cir. 1997).
    - However, note that, in general, Medicare "suppliers" (i.e., those who enroll under Medicare Part B, such as individual physicians or durable medical equipment sellers) cannot assign their supplier agreements and new owners must complete a new initial enrollment.
  - Even if a court were to find provider agreements are not executory contracts, debtors and purchasers must still meet requirements of section 363(f) in order to sell such agreements free and clear of liens, claims and interests of CMS. Cf. *Hollander v. Brezenoff*, 787 F.2d 834, 839 (2d Cir. 1986) (noting that plaintiff's claims for reimbursement did not arise from provider agreements, but rather from his claim that the statutory and regulatory scheme entitling providers to payment for services properly reimbursable under Medicaid had been violated).
    - As a practical matter, provider agreements cannot be "sold" to a new owner "free and clear" of interests pursuant to 11 U.S.C. § 363 because none of the requirements of § 363(f)(1)-(5) can be met.
    - Again, when provider agreements are assigned to a new owner, the new owner is responsible for overpayments incurred under the same provider agreement by the previous owner. 42 C.F.R § 489.18.

Assignment of Provider Agreements (Continued)

- Whether the government has excluded or terminated the debtor's provider agreements is an important consideration in a transfer of a healthcare facility.
- **Provider Exclusion and Termination of Provider Reimbursement Agreements**
- As noted, private and government provider agreements are the key agreements by which healthcare providers are reimbursed for services rendered to patients. Actual or threatened loss of these payor agreements has caused bankruptcy cases as providers seek the protection of the automatic stay.
  - Exclusion of Provider from Medicare, Medicaid, and other federal healthcare programs by the U.S. Health and Human Services Inspector General: permissible pursuant to Section 362(b)(28) of the Bankruptcy Code.
  - Termination of provider agreements: not expressly exempt from the automatic stay but falls under the Government's police and regulatory power exception. 11 U.S.C. § 362(b)(4).
    - *Parkview Adventist Med. Ctr. v. United States*, 842 F.3d 757 (1st Cir. 2016) (Termination of Medicare provider agreement was not violation of bankruptcy automatic stay because police and regulatory power exception to the stay of the Bankruptcy Code applied)
    - *In re Bayou Shores SNF, LLC*, 828 F.3d 1297, 1322 (11th Cir. 2016) (Pursuant to 42 U.S.C. § 405(g), (h), Bankruptcy Courts lack jurisdiction over issues "arising under" the Medicare Act, including whether to stay termination of Medicare provider agreement; rather, any such issues must be pursed exclusively through the administrative process).
- **Recoupment of Medicaid/Medicare Overpayments**
- Healthcare providers may be subject to recoupment of their government receivables due to overpayments for services rendered affecting liquidity and security interests.
- The majority of federal circuits have found that the Medicare system of estimated payments and later adjustments qualifies as a single transaction for purposes of recoupment and therefore there are no limitations on recoupment. *See, e.g., In re Holyoke Nursing Home Inc.*, 372 F.3d 1, 4 (1st Cir. 2004). Only the Third Circuit limits Medicare to recouping overpayments for Part A providers from claims for reimbursement within the same cost report year because the Third Circuit has taken the minority view that they are different transactions. In re Univ. Med. Ctr., 973 F.2d 1065, 1080 (3d Cir. 1992). However, once a provider assumes its provider agreement, Medicare's recoupment rights (including for prior overpayments for different cost years) are not limited. Id. at 1075.

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2019 ABI Annual Spring Meeting

Health Care Provider Bankruptcy Issues: Preservation of Revenue Streams and Other Practical Concerns to Consider Once a Bankruptcy has been Filed

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I. Extent of the Automatic Stay – Exclusion vs. Termination of Medicare/Medicaid Provider Agreements

If the Debtor wishes to preserve its value as a going concern and continue operations, preserving incoming receivables due under its Medicare and Medicaid provider agreements is a critical component in ensuring the hospital can continue operations. Unfortunately, the Automatic Stay does little to prevent the Centers for Medicare & Medicaid Services ("CMS") from discontinuing provider agreements for payments under these services.

a. The Automatic Say does not prevent "Exclusion" from Medicare or Medicaid

i. Bankruptcy Code Section 362(b)(28) specifically provides that the automatic stay will not apply to "the **exclusion** by the Secretary of Health and Human Services of the debtor from participation in the Medicare program or any other Federal health care program (as defined in section 1128B(f) of the Social Security Act [42 USCS § 1320a-7b(f)] pursuant to title XI or XVIII of such Act [42 USCS §§ 1301 et seq. or 1395 et seq.])." 11 U.S.C. 362(b)(28) (emphasis added).

ii. In the context of Medicare and Medicaid, "exclusion" is a specifically defined term. The standards and remedies for exclusion are found in 42 U.S.C. 1320a-7. If excluded, an individual or entity may be prohibited from participation in any federal healthcare program for a period of one to five years. If a provider is excluded from these programs, the provider will likely have no way to continue operations. Because the consequences of exclusion are so severe, however, the standards for its allowance are reserved for the most serious offenders and include mandatory exclusion for certain criminal offenses (such as felonies for unlawful drug distribution, health care fraud, or patient abuse) and permissive exclusion for other lesser but still serious issues such as license revocation due to incompetence or poor performance, claims for excessive or unnecessary charges, or failure to take appropriate corrective actions.

iii. Although exclusion from federal health care programs is specifically excepted from the automatic stay by § 362(b)(28), due to the parameters of what constitutes exclusion, pursuit of this remedy also can be viewed as excluded from the automatic stay through the "police and regulatory power" exception found in § 362(b)(4) as a necessity to

protect the health and welfare of the existing and potential future patients of the debtor healthcare provider.

b. *The Bankruptcy Court likely lacks jurisdiction to prevent termination of Medicare and Medicaid provider agreements.*

i. Termination is a less serious remedy than exclusion and involves the discontinuation or refusal to renew a provider's Medicare/Medicaid program contract on a non-permanent basis. If terminated, the provider may immediately re-apply for a new contract which should be granted if the reasons for termination have been resolved. Nevertheless, for financially stressed healthcare providers, even a short suspension of participation in these programs can have serious consequences to the healthcare provider's continued operation.

ii. Unfortunately, if CMS believes termination is warranted and elects to pursue that remedy, most Circuits have held that the Bankruptcy Court lack jurisdiction to oversee the issue and termination will not be prevented through the automatic stay or other injunction issued by the Bankruptcy Court. The reasons for this, however, are found not in the Bankruptcy Code, but in provisions specifically limiting court's ability to decide the issue until the provider exhausts the administrative remedies available to it through the Social Security Act ("SSA").

iii. The SSA provides that:

1. "Any individual, after any final decision of the [Secretary] made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the [Secretary] may allow." 42 U.S.C. § 405(g).

2. "The findings and decision of the [Secretary] after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the [Secretary] shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the [Secretary], or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter." 42 U.S.C. 405(h).

iv. SSA Section 405(h) bars claims under 28 U.S.C. § 1331 (federal question jurisdiction) and 28 U.S.C. 1334 (jurisdiction when the United States is a defendant) until the terminated provider exhausts all of its administrative remedies with CMA. Section 405(h) makes no mention of the statute concerning Bankruptcy Court jurisdiction found in 28 U.S.C. 1334. However, most circuits have taken the majority position that the jurisdictional limits set in SSA Section 405(h) were designed to limit all challenges so that they first go through the CMA. In doing so, these courts typically hold that the SSA jurisdictional limit also applies to bankruptcy court jurisdiction under § 1334. See *Fla. Agency for Health Care Admin. v. Bayou Shores SNF, LLC (In re Bayou Shores SNF, LLC)*, 828 F.3d 1297 11th Cir. 2016). Accordingly, these courts have held that decisions to terminate federal health program provider agreements are unreviewable by the

bankruptcy court unless the debtor first proceeds through the administrative process for challenging termination found in the SSA.

v. The only Circuit in the country that has adopted a contrary position allowing bankruptcy court review of termination of these agreements is the Ninth Circuit. *See Do Sung Uhm v. Humanana, Inc.,* 620 F.3d 1134, fn. 11 (9th Cir. 2010). Still, this case did not offer a full-throated support for the contention that bankruptcy courts have jurisdiction to review decisions to terminate these types of agreements. Rather, *Do Sung Uhm*, a non-bankruptcy case, merely mentions this contention in a footnote instead of providing detailed analysis of the issue.

vi. If healthcare debtors are likely to find little support in the law to block exclusion or termination of their participation in Medicare and Medicaid, practically this means that these debtors (and their attorneys) need to be proactive about initiating negotiations early with the government. This is so the debtor can be aware of what tasks administrators of these programs believe need to occur for the debtor to continue to remain in the federal health care program and continue to receive revenue under these programs.

II. Other Medicare/Medicaid Provider Agreement Issues

Under the payment systems established through Medicare and Medicaid, payments are delivered before the final correct amount of reimbursement is calculated. See 42 C.F.R. § 413.60. Once the correct amount is determined, amounts are then settled later - either through delivery of extra funds in instances of underpayment, or return of funds when an overpayment has occurred. Once a bankruptcy petition has been filed, however, repayment of overpayments becomes an issue because the claim for overpayment return becomes a pre-petition claim that typically would be paid through post-petition revenue if the bankruptcy had not been filed.

a. Recoupment vs. Setoff

i. Typically, the withholding of post-petition payments to satisfy pre-petition claims will be considered a setoff and will be barred by the automatic stay under Section 362(a)(7). In most Circuits around the country, however, the government has successfully argued around this prohibition by categorizing its recovery of overpayments as a "recoupment." "Recoupment is the setting up of a demand arising from the same transaction as the plaintiff's claim or cause of action, strictly for the purpose of abatement or reduction of such claim." *University Medical Center v. Sullivan (In re University Medical Center)*, 973 F.2d 1065, 1079-80 (3rd Cir. 1992) (emphasis added). Under the doctrine of recoupment because the funds used are considered part of the same transaction, they are not viewed as the debtor's property, and, unlike setoff, will not be viewed as a violation of the automatic stay.

ii. As a series of continued pre-payments for program reimbursement, calculations on actual amounts owed, and true-ups to correct both under and over-payments, The First, Seventh, Ninth, and D.C. Circuits have all held that a provider's participation in the Medicare system is a "single, ongoing, integrated transaction." Accordingly, these Circuits allow these programs to reduce post–petition reimbursements by the amount of the pre-petition overpayments due. *See, e.g., In re Slater Health Ctr., Inc. (Slater)*, 398 F.3d 98 (1st Cir. 2005); *In re Holyoke Nursing Home, Inc.*, 372 F.3d 1 (1st Cir. 2004); *In*

re Doctors Hosp. of Hyde Park, Inc., 337 F.3d 951 (7th Cir. 2003); *In re TLC Hosps., Inc.*, 224 F.3d 1008 (9th Cir. 2000); *United States v. Consumer Health Servs. of Am., Inc.*, 108 F.3d 390 (D.C. Cir. 1997).

iii. Taking a different approach, the Third Circuit has reached the opposite conclusion and has limited the single transaction analysis to the same fiscal year to block recoupment of funds by Medicare in that Circuit. *See University Medical Center v. Sullivan (In re University Medical Center)*, 973 F.2d 1065, 1079-80 (3rd Cir. 1992).

iv. Understanding how your jurisdiction will treat these funds is essential to understanding what funds will be on hand for continued operation of the health care facility after filing. Because amounts for overpayments under these programs can be substantial and are treated differently throughout the country, careful attention should be paid to the local case law to understand what likely funds will be on hand before entering the provider into the bankruptcy process.

b. Curing overpayment claims and assumption of Medicare and Medicaid provider agreements

i. Besides cash concerns associated with recoupment, Medicare and Medicaid overpayments also play a factor in determining the practical consideration associated with assumption of these agreements. Although there is some debate over whether Medicare and Medicaid provider agreements are executory contracts that can be assumed and assigned[1], generally Bankruptcy Courts do treat these agreements as executory contracts subject to the assumption provisions of the Bankruptcy Code. In bankruptcy cases not involving shutdown of the facility, it will be necessary to assume the hospital's provider agreements so that it may either proceed as a reorganized entity, or transfer the agreement as a part of a sale pursuant to § 363. If assuming these agreements, it will be necessary to cure any amounts owed under the contract including pre-petition overpayment claims.

ii. Special attention should be paid to the timing of any election to assume a Medicare or Medicaid provider agreement. Often the hospital will not want to immediately assume the agreement. Likely the amount of any potential overpayment claim will not be immediately known and the hospital should wait until the these amounts are fully calculated to make an informed business decision whether to assume the agreement and accrue the payment associated with the overpayment cure. Additionally, even when the hospital knows that the assumption is needed, special attention to timing is necessary to ensure that the cure payment does not have an overly negative effect on current cash flow.

III. Retention of atypical professionals

a. The Patient Care Ombudsman

i. Added through the 2005 BAPCPA amendments, Bankruptcy Code § 333 provides that in cases involving a health care business, the Bankruptcy Court shall appoint an "ombudsman" within 30 days after the commencement of the case to monitor the quality of the patient care and represent the interests of the patients.

ii. Section 333 also provides that the Bankruptcy Court may determine that the appointment a patient care ombudsman is not necessary. In making this determination,

[1] *See e.g. In re BDK Health Management, Inc.*, 1998 WL 34188241 (Bankr. M.D. Fla. Nov. 16, 1998.)

often Court's will cite to the non-exclusive 9 factor test found in the *In re Alternate Family Care*. The nine factors detailed in that case concerning consideration of appointment of a patient care ombudsman include:

1. the cause of the bankruptcy;
2. the presence and role of licensing or supervising entities;
3. debtor's past history of patient care;
4. the ability of the patients to protect their rights;
5. the level of dependency of the patients on the facility;
6. the likelihood of tension between the interests of the patients and the debtor;
7. the potential injury to the patients if the debtor drastically reduced its level of patient care;
8. the presence and sufficiency of internal safeguards to ensure appropriate level of care;
9. the impact of the cost of an ombudsman on the likelihood of a successful reorganization.

In re Alternate Family Care, 377 B.R. 754, 758, (Bankr. S.D. Fla 2007).

iii. If appointed, the ombudsman must file a report with the Bankruptcy Court every 60 days to report on the status of ongoing care to patients at the health care facility. Additionally Section 330(a) provides that the patient care ombudsman is a professional and is entitled to apply for compensation from the estate.

iv. Hospitals typically resist the appointment of a patient care ombudsman to prevent the need to pay the ombudsman's fees and expenses. Doing so may not be wise. Typically, if the hospital is seeking to continue operations, it is likely that an ombudsman will be appointed. Additionally, the optics of challenging the appointment an ombudsman may lead to assertions that the hospital board of trustees is not appropriately concerned with maintaining patient care during the bankruptcy leading to negative public perception and a reduction in continuing business.

v. Appointment of an Ombudsman may serve as a benefit to the debtor. If a hospital is able to work well with the ombudsman and address concerns that may arise timely and appropriately, positive reports from the ombudsman may be used to direct the public's perception that the hospital is maintaining good care of its patients while dealing with its financial difficulties. Additionally, maintaining a positive perception with the ombudsman may serve as a shield against challenges from other parties in the bankruptcy seeking shutdown. The Bankruptcy Court and public at large will likely give more weight to positive reviews of patient care by an impartial ombudsman than statements concerning proper patient care offered by the hospital alone.

b. Consideration of employing a PR firm on behalf of the estate

i. The filing of bankruptcy by a hospital is likely to generate significant news coverage in the local area the hospital services. In order to preserve incoming revenue, it is essential that both doctors and potential patients maintain confidence in the hospital's ability to still

provide quality care. To that effect, the debtor may consider employing a public relations firm to develop a coordinated program to communicate a consistent and coherent message to the public at large concerning the hospital's continued operations during the bankruptcy process.

IV. Key Employee Retention Plans (KERPs)

In a hospital setting, where employees and doctors are highly skilled workers, it is essential for a hospital wishing to continue to operate during bankruptcy to retain its high performing employees. To that effect, it may be necessary for the hospital to implement a Key Employee Retention Plan ("KERP") to ensure that the hospitals best employees do not leave. Employee loss is especially likely for health care providers in a hospital setting, where doctors typically contract to serve at multiple hospitals in the area. It is very easy for high performing doctors to take their patients (and accompanying revenue) to other hospitals they already serve. Paying bonuses and offering other incentives to these employees to stay may be necessary to ensure continued revenue.

a. *Interplay with BAPCPA provisions limiting payments to insiders*

   i. Prior to BAPCPA, employee retention plans in bankruptcy typically were structured as retention bonus plans offering bonuses to key personnel if they remained with the company for a set period. Often these types of plans would be approved as an exercise of the debtor's business judgment. After perceived abuse of these types of plans by delivering large bonuses to management of failing businesses, BAPCPA added Section 503(c)(1) to combat abuse of these types of bonus plans. Under that section, bonuses paid to insiders to remain with a company are limited to certain limited scenarios such as when the employee has a bone fide offer to join another business for the same or higher pay.

   ii. Although Bankruptcy Code Section 503(c)(1) serves to limit employee retention plans, Debtors can typically receive approval of a KERP if it is structured instead as an *incentive* plan. Instead of structuring the plan to provide bonuses based solely on time the employee remains at the company, the debtor can structure the plan to provide bonuses when key metrics are met. Such metrics can include meeting certain revenue targets or exceeding the stalking horse bid price at a sale of the hospital's assets.