AMERICAN BANKRUPTCY INSTITUTE

2017 Midwest Regional Bankruptcy Seminar

Commercial Track

How to Heal a Hospital

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CONCURRENT SESSION

2017

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What are the Causes of the Rise in Health Care Business Bankruptcies?

*** Reimbursement difficulties**

-Ratio of patients with Medicare/Medicaid and private insurance

-Audit issues with government agencies

-Unexpected withholding of reimbursement funds

-Near constant auditing requirements

*** Staffing difficulties**

-Finding physicians to serve (particularly acute in rural areas)

-Employee turnover

-Conflict with physicians/practices regarding grant of privileges

*** Operational difficulties**

-Lack of experienced management

-Conflicts within Board of Directors/governing body

-Reduced patient volume

-Increased litigation against physicians/nursing homes

-Increased competition

*** Regulatory difficulties**

-Changes in patient classifications/eligibility

-Adjustments to licenses which effect reimbursement rates

-Uncertainty of political climate hampers needed expansion

-New compliance rules (electronic medical record requirements/HIPAA)

What Qualifies as a Health Care Business?

The Bankruptcy Code defines a "health care business" broadly and includes far more than hospitals. The definition also includes nursing homes, urgent treatment centers, private physician offices, comprehensive outpatient rehabilitation facilities (CORF), federally qualified health centers (FQHC) as well as hospice facilities. **11 USC § 101(27A)**

Unique Statutory Requirements for a Health Care Business Bankruptcy

Patient Care Ombudsman – 11 USC § 333

Per the statute, the United States Trustee is required to appoint a Patient Care Ombudsman to monitor the quality of patient care and to represent the interests of the patients of the health care business *unless* the Court finds that such appointment is not necessary due to the specific facts of the case. The PCO's fees and expenses are borne by the estate.

Consumer Privacy Ombudsman - 11 USC § 332

In the event of a sale of the Debtor's assets, the Court may order the United States Trustee to appoint a Consumer Privacy Ombudsman to assist the Court in its consideration of the facts, circumstances and conditions of the proposed sale of personally identifiable information under 11 USC § 363(b)(1)(B). The CPO's fees and expenses are borne by the estate.

Patient Record Retention/Disposal – 11 USC § 351

11 U.S.C. § 351 permits a health care business without sufficient funds to pay for the storage of patient records in the manner required under applicable Federal or State law to destroy those records if permitted to do so by the Bankruptcy Court. This law specifically contemplates that the health care business cannot store the records in the manner required under "applicable Federal or State law" – which is often the case in health care business bankruptcies.

Despite the federal legislation permitting record disposal, there are many different laws and regulations that require a healthcare business to maintain records for various periods of time. First, an attorney must also consult state regulations which may set out deadlines that differ from the federal minimum retention requirement. States may also have special requirements for records belonging to minors or others who are under medical guardianship. Similarly, Medicare has a requirement that records in support of an entity's cost report be maintained for a period 5 years beyond the date the cost report was closed. 42 CFR 482.24(b)(1).

Second, HIPAA requires covered entity's to maintain documentation in support of its ability to protect PHI for a minimum of 6 years. See 45 CFR 164.316(b). This does not expressly require an entity to maintain the PHI for 6 years because HIPAA has no retention requirements. However, as a practical matter, it would be difficult to demonstrate the security of PHI, or be able to provide a patient with access, without being able to access the PHI (records). Because HIPAA supersedes less restrictive state laws, best practice is to follow the HIPAA requirements at minimum.

Third, an entity that is no longer operational is required to file a final cost report. See Medicare Provider Reimbursement Manual, Part 2, Ch 1, Sec 102.2(B). There is nothing in the manual that reduces or eliminates an entity's obligation to destroy the records in support of the cost report on a timeline that is shorter than is prescribed in 42 CFR 482.24(b)(1).

Nonetheless, the federal bankruptcy statute at issue expressly contemplates that there are conflicting Federal and State laws requiring health care businesses to maintain records for a much longer period of time. Assuming all proper notice has been given in the bankruptcy case, this statute supersedes any conflicting Federal and State laws discussed above. In addition to creditor notices incident to the bankruptcy case, 11 USC § 351 requires additional notice to federal agencies providing them with the opportunity to maintain records.

Automatic Stay considerations - 11 USC § 362(b)(28)

The Bankruptcy Code has an express exception to the automatic stay to protect the Debtor from action by the U.S. Dept. of Health and Human Services.

Administrative Claims analysis - 11 USC § 503(b)(8)

The Bankruptcy Code establishes administrative claim status for costs related to the closure of a health care business by a Trustee or federal agency, as well as the cost of disposal of records as described in 11 USC § 351, and the cost of transferring patients to another health care business due to closing.

False Claim Act (Discharge) – 11 USC § 1141 (d)(6)(A)

A corporate debtor may not be discharged from a debt owed to a domestic governmental unit or owed to an individual person stemming from a claim filed under the False Claim Act.

Jurisdiction Issues

In re Bayou Shores, Docket No. 15-13731 (11th Cir. July 11, 2016)

Bayou Shores was a skilled nursing home almost completely funded by Medicare and Medicaid reimbursements. After a series of inspections, the Florida state agency that administered the state's Medicaid program issued a series of warnings to Bayou Shores for violations of health and safety requirements. After a few follow-ups in which Bayou Shores's management did not improve, but rather got worse, HHS sent the company a letter of noncompliance stating its intention to terminate the company's Medicare provider agreement (which would simultaneously terminate the Medicaid agreement with the state as well) on a date certain. Bayou Shores ultimately filed Chapter 11 as a means to stay that enforcement action.

Bayou Shores sought an injunction from the bankruptcy court to block the termination of the provider agreement. The bankruptcy court sided with Bayou Shores, invoking 28 USC § 1334 jurisdiction to support an injunction against the termination of the provider agreements. The bankruptcy court identified the provider agreements as property of the bankruptcy estate and subject to the automatic stay. The case proceeded quickly, and the bankruptcy court subsequently confirmed the Debtor's Chapter 11 plan, which included the assumption of the provider agreements.

In confirmation of Bayou Shores plan of reorganization, the bankruptcy court again relied on 28 USC § 1334 as its jurisdiction for its ruling. The bankruptcy court chose to override the government's argument that 42 USC § 405(h) which defines the finality of the agency's decision (in this case to terminate the provider agreement) precluded the bankruptcy court's jurisdiction to determine that the provider agreements could stay in the plan.

The case was appealed to the district court and the Eleventh Circuit Court of Appeals. The district court reversed the bankruptcy court and the Eleventh Circuit affirmed. The crux of the argument before those courts was the impact of an amendment to 42 USC § 405, in which 28 USC § 1334 (which was clearly referenced in the original) was omitted, leaving open the question as to whether 42 USC § 405 still superseded jurisdiction granted by 28 USC § 1334. Ultimately, the Eleventh Circuit found that despite the fact that the amended 42 USC § 405 did specifically reference bankruptcy jurisdiction, the clear intent of the statute was to preclude bankruptcy court jurisdiction from superseding decisions made by the agency's, and the decision by HHS to terminate the provider agreement could not be enjoined or stayed by application of bankruptcy law.

Bayou Shores petitioned for a writ of certiorari, which was denied in June 2017.

Bayou Shores is instructive to debtors and counsel who might be under the impression that entering into bankruptcy could protect valuable assets such as licenses and provider numbers

from termination or modification by government agencies. The reach of the bankruptcy law is broad but not absolute.

Buying/Selling a Health Care Business

A health care business bankruptcy often results in a sale of the debtor's assets. In order for a sale to be successful, the debtor must shore up its operations and take any necessary steps to preserve its licenses, certificates of need, and provider status – literally at all costs – as these are normally the most valuable of the debtor's assets.

Licenses:

Assuming that all licenses and accreditations are in good standing, the debtor must maintain that standing. If not, the debtor should take the opportunity to remedy as many issues as possible in order to maximize its potential value to purchasers. Typically, cash collateral and DIP loan budgets contain multiple line items for performing necessary tasks to bring the health care business back into license compliance, if the license is in jeopardy. The automatic stay will not delay enforcement against the debtor in the event of patient endangerment, so in some cases, licenses cannot be saved, and the health care business must cease operations.

Certificate of Need:

Debtors must also maintain its certificate(s) of need. Certificates of need were originally created to regulate the growth of health care businesses so that excessive growth did not lead to untenable costs in a given community. Because many states still have limitations on health care business growth, acquiring a certificate of need from a struggling debtor might be the only way a health care system seeking to expand can do so.

A cessation of operations of the health care business usually terminates the viability of a certificate of need – and once lapsed, it is very difficult to resurrect. Certificate of need laws vary from state to state. Kentucky, Ohio, Illinois, Missouri and West Virginia are certificate of need states. Indiana and Pennsylvania are not. (Visit the website for National Conference of State Legislatures www.ncls.org for a guide to certificate of need statutes for all states.)

Provider Status:

Finally, the debtor must preserve its provider status. Should the debtor's relationship with Medicare/Medicaid be severed, it will cease to receive reimbursement from those agencies, which in most cases is the substantial majority source of its income. A loss of the provider agreement is a significant loss of accounts receivable that could be part of a sale. To transfer a provider number, a health care business will note a change in ownership by filing a Form 855 (CHOW) with Medicare. An operating debtor in possession does not need a CHOW to continue to operate, but a trustee should submit a CHOW in order to keep reimbursement in place.

Though the debtor should maintain its provider/reimbursement relationship with Medicare through a sale in order to fund operations that are necessary to maintain licenses, and

certificate(s) of need, the potential buyer must take care in deciding whether to either assume and assign, or reject, the Medicare provider number. In the absence of a rejection, the new owner will essentially step into the shoes of the debtor in the existing reimbursement stream. Assumption can bring risks to the new buyer, however. If there is an assumption, the buyer will have to accept the setoffs or holdbacks that Medicare/Medicaid might asset later in the billing reconciliation process. The buyer that assumes an existing provider number may also be responsible for monetary penalties. Weighing those options is critical to a potential buyer.

Due Diligence:

In addition to careful review of the debtor's regulatory status, potential buyers must take care to fully investigate the following:

- Existing lawsuits against the debtor or employees of the debtor (e.g. medical malpractice) – successor liability;
- False Claim Act Claims- successor liability;
- WARN Act Claims – successor liability;
- Assumption of Leases – future use restrictions; and
- Unwanted Obligations – assumption of employment contracts of physician referral services.

11 USC § 101 (27A):

The term "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;
    (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.

11 U.S. Code § 333:

(a)

(1) If the debtor in a case under chapter 7, 9, or 11 is a health care business, the court shall order, not later than 30 days after the commencement of the case, the appointment of an ombudsman to monitor the quality of patient care and to represent the interests of the patients of the health care business unless the court finds that the appointment of such ombudsman is not necessary for the protection of patients under the specific facts of the case.

(2)

(A) If the court orders the appointment of an ombudsman under paragraph (1), the United States trustee shall appoint 1 disinterested person (other than the United States trustee) to serve as such ombudsman.

(B) If the debtor is a health care business that provides long-term care, then the United States trustee may appoint the State Long-Term Care Ombudsman appointed under the Older Americans Act of 1965 for the State in which the case is pending to serve as the ombudsman required by paragraph (1).

(C) If the United States trustee does not appoint a State Long-Term Care Ombudsman under subparagraph (B), the court shall notify the State Long-Term Care Ombudsman appointed under the Older Americans Act of 1965 for the State in which the case is pending, of the name and address of the person who is appointed under subparagraph (A).

(b) An ombudsman appointed under subsection (a) shall—

(1) monitor the quality of patient care provided to patients of the debtor, to the extent necessary under the circumstances, including interviewing patients and physicians;

(2) not later than 60 days after the date of appointment, and not less frequently than at 60-day intervals thereafter, report to the court after notice to the parties in interest, at a hearing or in writing, regarding the quality of patient care provided to patients of the debtor; and

(3) if such ombudsman determines that the quality of patient care provided to patients of the debtor is declining significantly or is otherwise being materially compromised, file with the court a motion or a written report, with notice to the parties in interest immediately upon making such determination.

(c)

(1) An ombudsman appointed under subsection (a) shall maintain any information obtained by such ombudsman under this section that relates to patients (including information relating to patient records) as confidential information. Such ombudsman may not review confidential patient records unless the court approves such review in advance and imposes restrictions on such ombudsman to protect the confidentiality of such records.

(2) An ombudsman appointed under subsection (a)(2)(B) shall have access to patient records consistent with authority of such ombudsman under the Older Americans Act of 1965 and under non-Federal laws governing the State Long-Term Care Ombudsman program.

11 USC § 332:

(a) If a hearing is required under section 363(b)(1)(B), the court shall order the United States trustee to appoint, not later than 7 days before the commencement of the hearing, 1 disinterested person (other than the United States trustee) to serve as the consumer privacy ombudsman in the case and shall require that notice of such hearing be timely given to such ombudsman.

(b) The consumer privacy ombudsman may appear and be heard at such hearing and shall provide to the court information to assist the court in its consideration of the facts, circumstances, and conditions of the proposed sale or lease of personally identifiable information under section 363(b)(1)(B). Such information may include presentation of—

(1) the debtor's privacy policy;

(2) the potential losses or gains of privacy to consumers if such sale or such lease is approved by the court;

(3) the potential costs or benefits to consumers if such sale or such lease is approved by the court; and

(4) the potential alternatives that would mitigate potential privacy losses or potential costs to consumers.

(c) A consumer privacy ombudsman shall not disclose any personally identifiable information obtained by the ombudsman under this title.

11 USC § 362(b)(28):

(b) The filing of a petition under section 301, 302, or 303 of this title, or of an application under section 5(a)(3) of the Securities Investor Protection Act of 1970, does not operate as a stay—

(28) under subsection (a), of 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 pursuant to title XI or XVIII of such Act).

The provisions of paragraphs (12) and (13) of this subsection shall apply with respect to any such petition filed on or before December 31, 1989.

11 USC § 503(b)(8):

(b) After notice and a hearing, there shall be allowed administrative expenses, other than claims allowed under section 502(f) of this title, including—

(8) the actual, necessary costs and expenses of closing a health care business incurred by a trustee or by a Federal agency (as defined in section 551(1) of title 5) or a department or agency of a State or political subdivision thereof, including any cost or expense incurred—

(A) in disposing of patient records in accordance with section 351; or

(B) in connection with transferring patients from the health care business that is in the process of being closed to another health care business; and

11 USC § 1141 (d)(6)(A):

(d)

(6) Notwithstanding paragraph (1), the confirmation of a plan does not discharge a debtor that is a corporation from any debt—

(A) of a kind specified in paragraph (2)(A) or (2)(B) of section 523(a) that is owed to a domestic governmental unit, or owed to a person as the result of an action filed under subchapter III of chapter 37 of title 31 or any similar State statute; or

(B) for a tax or customs duty with respect to which the debtor—

(i) made a fraudulent return; or

(ii) willfully attempted in any manner to evade or to defeat such tax or such customs duty.

11 U.S.C § 351:

If a health care business commences a case under chapter 7, 9, or 11, and the trustee does not have a sufficient amount of funds to pay for the storage of patient records in the manner required under applicable Federal or State law, the following requirements shall apply:

(1) The trustee shall—

(A) promptly publish notice, in 1 or more appropriate newspapers, that if patient records are not claimed by the patient or an insurance provider (if applicable law permits the insurance provider to make that claim) by the date that is 365 days after the date of that notification, the trustee will destroy the patient records; and

(B) during the first 180 days of the 365-day period described in subparagraph (A), promptly attempt to notify directly each patient that is the subject of the patient records and appropriate insurance carrier concerning the patient records by mailing to the most recent known address of that patient, or a family member or contact person for that patient, and to the appropriate insurance carrier an appropriate notice regarding the claiming or disposing of patient records.

(2) If, after providing the notification under paragraph (1), patient records are not claimed during the 365-day period described under that paragraph, the trustee shall mail, by certified mail, at the end of such 365-day period a written request to each appropriate Federal agency to request permission from that agency to deposit the patient records with that agency, except that no Federal agency is required to accept patient records under this paragraph.

(3) If, following the 365-day period described in paragraph (2) and after providing the notification under paragraph (1), patient records are not claimed by a patient or insurance provider, or request is not granted by a Federal agency to deposit such records with that agency, the trustee shall destroy those records by—

(A) if the records are written, shredding or burning the records; or

(B) if the records are magnetic, optical, or other electronic records, by otherwise destroying those records so that those records cannot be retrieved.

Bankruptcy Rule 6011. Disposal of Patient Records in Health Care Business Case

(a) Notice by Publication Under §351(1)(A). A notice regarding the claiming or disposing of patient records under §351(1)(A) shall not identify any patient by name or other identifying information, but shall:

(1) identify with particularity the health care facility whose patient records the trustee proposes to destroy;

(2) state the name, address, telephone number, email address, and website, if any, of a person from whom information about the patient records may be obtained;

(3) state how to claim the patient records; and

(4) state the date by which patient records must be claimed, and that if they are not so claimed the records will be destroyed.

(b) Notice by Mail Under §351(1)(B). Subject to applicable nonbankruptcy law relating to patient privacy, a notice regarding the claiming or disposing of patient records under §351(1)(B) shall, in addition to including the information in subdivision (a), direct that a patient's family member or other representative who receives the notice inform the patient of the notice. Any notice under this subdivision shall be mailed to the patient and any family member or other contact person whose name and address have been given to the trustee or the debtor for the purpose of providing information regarding the patient's health care, to the Attorney General of the State where the health care facility is located, and to any insurance company known to have provided health care insurance to the patient.

(c) Proof of Compliance With Notice Requirement. Unless the court orders the trustee to file proof of compliance with §351(1)(B) under seal, the trustee shall not file, but shall maintain, the proof of compliance for a reasonable time.

(d) Report of Destruction of Records. The trustee shall file, no later than 30 days after the destruction of patient records under §351(3), a report certifying that the unclaimed records have been destroyed and explaining the method used to effect the destruction. The report shall not identify any patient by name or other identifying information.

42 USC § 1395 (g)(a):

(a) Determination of Amount

The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) and prior to audit or settlement by the Government Accountability Office, from the Federal Hospital Insurance Trust Fund, the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments; except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.

42 CFR 405.37(a)(1) and (2):

(a) *General rules:* Medicare payments to providers and suppliers, as authorized under this subchapter (excluding payments to beneficiaries), may be –

(1) Suspended, in whole or in part, by CMS or a Medicare contractor if CMS or the Medicare contractor possesses reliable information that an overpayment exists or that the payments to be made may not be correct, although additional information may be needed for a determination;

(2) In cases of suspect fraud, suspended, in whole or in part, by CMS or a Medicare contractor if CMS or the Medicare contractor has consulted with the OIG, and, as appropriate, the Department of Justice, and determined that a credible allegation of fraud exists against a provided or supplier, unless there is good cause not to suspend payments; or

(3) Offset or recouped, in whole or in part, by a Medicare contractor if the Medicare contractor or CMS has determined that the provider or supplier to whom payments are to be made has been overpaid.