

New Jersey Law Journal

VOL. CLXXXV—NO.2—INDEX 100

JULY 10, 2006

ESTABLISHED 1878

HEALTH CARE LAW

Managing Health-care Business Bankruptcies

The 2005 bankruptcy amendments added complexity, oversight and expense

By Linda R. Brower

The Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 added new sections to the Bankruptcy Code specific to health-care businesses, and this article addresses certain of those amendments. Health-care businesses that file for protection under federal bankruptcy laws after Oct. 17, 2005, the effective date of most act provisions, must navigate these new initiatives that enlarge patients' rights and governmental regulatory powers while simultaneously imposing additional duties on health-care business debtors and increasing expense to their estates.

There has been only a handful of what the Bankruptcy Code now defines as "health care business" bankruptcy filings in New Jersey since Oct. 17, 2005. Bankruptcy Code § 101(27A). These have involved private medical practices. (Although the definition of a "health care business" in Section 101(27A) covers a

Brower is an attorney at Becker Meisel of Livingston, where she practices in two groups, bankruptcy and creditors' rights and health care. Brower served as litigation counsel to the Chapter 11 Trustee appointed in the Progressive Healthcare case.

broad spectrum of health-care providers, it is still unclear whether the private practice of medicine and affiliated medical services fall within the definition.) There have been no reported decisions in New Jersey involving the appointment of a "patient ombudsman," who is charged with the duty to monitor and report on the quality of patient care.

Still, we can make fairly considered assessments of how the cost and complexity of managing health-care business bankruptcy cases in New Jersey will increase under the amendments by examining pre-Oct. 17, 2005, cases, to determine, first, whether patient protections were already being addressed by debtors and trustees using the guidance of existing health-care law and, second, how the cost of providing such patient protection was borne previously. In particular, we will examine a pre-amendments bankruptcy case involving a long-term care facility whose patients were severely medically compromised or handicapped and often frail and elderly.

Patients of a health care business were not generally regarded as having standing as a recognized group in bankruptcy cases prior to the amendments (except as a "creditor"). The act added definitions of "patient" and "patient

records." Explicit protections for patients, through the appointment of a "patient ombudsman," were added in new Sections 333 and 351, giving "voice" to a previously silent constituency.

The Bankruptcy Court must appoint a patient ombudsman not later than 30 days after commencement of a health-care business bankruptcy case under Chapters 7, 9 or 11 of the Bankruptcy Code unless the court finds that the appointment of an ombudsman is not necessary for the protection of patients in the case. The patient ombudsman represents the interests of patients, monitors the quality of patient care, and reports to the Bankruptcy Court every 60 days on the quality of patient care. The duty to report is "immediate" if the quality of patient care is "declining significantly or is otherwise being materially compromised."

Specific times to issue reports, the parties to receive notice and requirements for maintaining the confidentiality of patient records are set forth in Interim Fed. R. Bankr. P. 2015.1 and 2007.2. Interim Rules were adopted as a stop-gap measure between the act's effective date and the promulgation of the rules by the Supreme Court through the regular

Rules Enabling Act process. Proposals for permanent rules are expected to be published for comment in August 2006. Fed. R. Bankr. P. 2007.2 provides that objections to an appointment must be filed within the first 20 days of the case. The rule also permits motions to terminate the appointment of a patient ombudsman once made.

Section 333 provides for two types of ombudsman: a patient ombudsman to assess long-term care facilities and to assess facilities other than long-term care facilities. The patient ombudsman may, but need not, be the state's long-term care ombudsman. Most states, including New Jersey, have a state ombudsman program. The Bankruptcy Code provides that the U.S. Trustee must appoint one "disinterested person" as the patient ombudsman. A "disinterested person" is defined as someone who "does not have an interest materially adverse to the interest of the estate," among other criteria.

It is unclear whether the "disinterested" requirement applies to the state's ombudsman when appointed to serve in a bankruptcy case of a health-care business that provides long-term care. This is true because state regulators who have taken prepetition enforcement actions against the business are no longer "disinterested." Read together, Sections 333(a)(1) and 2(A) clearly require that the state ombudsman must be a "disinterested person" if the health-care business does not provide long-term care.

The ombudsman is given the same status to be compensated from a debtor's estate as a "professional" under Section 330(a)(1) of the Bankruptcy Code. Professionals, like attorneys and accountants, are employed by a debtor or trustee, after court approval, to carry out duties to the estate under the Bankruptcy Code. Patient ombudsmen arguably will owe a fiduciary duty to patients (but not to the debtor's estate), and will not simply serve as independent patient advocates.

New Section 704(a)(12) imposes a statutory duty on a debtor or trustee to use all "reasonable and best efforts" to

transfer patients from a health-care business debtor that is being closed in a Chapter 7 case. Transfer must be made to another "appropriate health care business" in the same vicinity that provides "substantially similar services" and "maintains a reasonable quality of care." If one has been appointed, it is reasonable to expect that the patient ombudsman will direct such transfers. The expense, with or without a patient ombudsman, will be chargeable to the debtor's estate as a priority administrative expense. 11 U.S.C. § 503(b)(8). The same statutory duty to transfer patients is made applicable to a Chapter 11 case by Bankruptcy Code § 1106(a)(1).

Bankruptcy Code § 351 provides procedures for disposing of patient records in a health-care business case. Advance notice must be published in "appropriate" newspapers, sent directly to each patient, and possibly to family members or other contact persons, insurance carriers, and to federal agencies, at specified times and contain specific information.

The decision to begin the process to destroy patient records will have to be made at the commencement of a case, whenever there is a reasonable belief that there will not be "a sufficient amount of funds to pay for the storage of patient records in the manner required" by applicable law. The process realistically will extend beyond one year from the first publication of notice. A court order is not required to act.

Often, it is impossible for a debtor or trustee to determine early in the case whether the estate will generate sufficient funds, through a sale of assets or otherwise, to pay for storage or whether a buyer, for a fee or set-off, will store patient records. Therefore, it will be prudent, in all cases, to incur the costs of proceeding with notice until this determination can be made.

It will be instructive to analyze how the new patient rights formalized by the amendments already were being addressed by debtors and trustees in the normal course of a bankruptcy proceeding involving a health-care business,

often without the costs to the debtor's estate that are now mandatory, by virtue of the guidance of existing health-care laws. See 28 U.S.C. § 959 (a trustee is required to manage and operate property in his possession "according to the requirements of the valid laws of the State in which such property is situated").

In the pre-2005 amendments health care business bankruptcy case, *In re Progressive Healthcare of Hudson County, LP*, Bankruptcy Case No. 01-36753, District of New Jersey, the debtor owned for five years and had been operating for even longer, two long-term care facilities, Progressive Nursing Center, formerly known as the Pollak Hospital in Jersey City, and the Meadowview Nursing Center in Secaucus.

On June 7, 2001, the debtor filed a voluntary Chapter 11 petition and continued in possession and management of its operations until July 13, 2001. On that date, the Bankruptcy Court approved the motion by the Office of the United States Trustee for the appointment of a Chapter 11 trustee.

Ultimately, all operations at Pollak ceased on or about Feb. 14, 2002. Meadowview continued to provide skilled nursing care to its residents for another two months, or until April 15, 2002, at which time the sale of Meadowview as a going concern to an independent third party approved by the Bankruptcy Court was closed.

Nursing homes must be certified to participate in federal health care reimbursement programs like Medicare and the joint federal and state Medicaid program. The New Jersey Department of Health and Senior Services (DOHSS) is engaged by federal agencies regulating these federal programs to conduct all certification surveys of facilities operating in New Jersey.

Gary N. Marks (trustee) was contacted by the United States Trustee's office at about 5:00 p.m. on Friday evening, July 13, and asked to accept the appointment as Chapter 11 trustee. That evening, the trustee visited Pollak with his litigation counsel for the first time.

He arrived only hours after then-New Jersey Health Commissioner Christine Grant and a DOHSS survey team inspected Pollak.

During the first weekend, the trustee began to stabilize the crisis in patient care at Pollak. The trustee, guided by federal, state and local health-care law without the overlay of the Bankruptcy Code, became the de facto patient ombudsman, reporting to patients, to federal and state regulatory agencies and to the Bankruptcy Court. Within days of his appointment, the Trustee issued his first report and made clear his top priority: *"I have made clear to all with whom I have dealt since my appointment on Friday evening, however, that my first and foremost responsibility is to ensure the continued health and safety of the residents..."* (emphasis in original).

Well before the Chapter 11 petition was filed and Marks was appointed the Chapter 11 trustee, there were significant health, fire safety and environmental deficiencies at Pollak, including, but not limited to: suspected bacteriological contamination of the facility's water supply; the presence of combustible carcinogenic materials; seeping raw sewerage; widespread pest and rodent infestation in the kitchen, nursing and resident living quarters; fire and smoke alarm detection and equipment failures; and lapses or impending lapses of liability, professional and other kinds of insurance at Pollak and Meadowview.

Early on July 13, Pollak and its residents were the focus of visits from several County Freeholders, state and local officials, and local newspaper and television reporters. Media attention culminated in the previously mentioned visit by Health Commissioner Grant. The DOHSS survey team found "immediate jeopardy" to the health and safety of

Pollak's residents — the most serious violation level. The DOHSS imposed an immediate ban on new admissions to Pollak.

To remedy the immediate threat to the health and safety of the residents and to continue operating the debtor's business as a long-term care facility, the trustee to the following actions, among others:

a. Engaged an excavator and certified plumber to excavate and examine a tunnel five feet below the building to check for leaks in the water main, to repair or replace piping, as necessary, and to re-fill the tunnel.

b. Engaged a fire and safety expert to correct violations. The Jersey City Fire Department made precautionary walk-throughs of Pollak every three to four hours until city fire officials were satisfied that the fire detection equipment was working properly.

c. Engaged a professional nursing home manager to operate and manage the two facilities and to correct the deficiencies that existed at Pollak.

d. Engaged a professional water consultant and remediation expert to remedy and eliminate elevated total coliform counts in the water supply.

e. Engaged a waste company to remove and dispose of hazardous waste materials.

On or about August 2, 2001, the city water and fire officials reinspected the premises and determined that "immediate jeopardy" to residents had been eliminated. On August 3, DOHSS surveyors conducted a resurvey of Pollak and concluded that deficiencies had been remedied.

The other patient protections formalized by the 2005 amendments, and discussed in this article, also were addressed by the trustee in *Progressive* in the ordinary course of managing the

bankruptcy case. The professionals at DOHSS, working together with the trustee's nursing home manager, directed the transfer of Pollak residents to other appropriate long-term nursing care facilities once the closing of Pollak had been approved by the Bankruptcy Court. The transfers were accomplished without additional expense to the debtor's estate and under professional regulatory guidance.

The trustee arranged to store, not dispose of, patient records. As part of the monetary adjustments between the estate and the asset buyer, the buyer agreed to store patient records and to make them available to the trustee, government agencies and former residents or authorized representatives, at no charge to the requesting party.

The 2005 amendments represent Congress's intent to provide patients with affirmative rights in health-care business bankruptcy cases. New powers to government regulators represent yet another policy directive, the costs of which will be borne by debtors (and their creditors). New time pressures will require immediate decisions by bankruptcy practitioners who understand how health-care issues play out in health-care business bankruptcy cases, all with the "brass ring" goal of conserving the most assets possible for distribution to creditors.

It is too soon to tell whether the amendments will leave practitioners familiar with health-care business bankruptcy cases prior to Oct. 2005 questioning whether these new initiatives were necessary. However, it is always the case that the greater the drain on a debtor's resources, the less likely that successful business reorganizations will be achieved. ■