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Special Issue Editors: Ashley M. McDow and Aram Ordubegian
Judith A. Waltz [1]

WHAT ABOUT THE PATIENTS?

In health care bankruptcies involving providers and suppliers of health care items and services, a critically impacted population is often silent, and/or un- or under-represented--the patients who need and use these items and services. [2] Even when an ombudsman is appointed by the Bankruptcy Court to represent patient interests, [3] the very nature of bankruptcy cases involving health care businesses results in a continuing threat to those interests.

This article discusses some key issues often arising in provider bankruptcies for which the impact on patients should be included amongst the equities addressed by the court as it moves towards resolution of the case.

1. Patient Interests May Not Be Consistently Aligned with the Interests of the Estate and its Creditors

A. Patient Care vs. Cost to the Estate

While virtually all health care providers pursue the goal of good patient care, in some situations the provider's financial stress and the bankruptcy process ***252** itself may put patient interests in quality care in conflict with the financial interests of the estate and its creditors.

This premise is aptly demonstrated by one case reflecting quick action by a trustee to preserve the assets of the estate against the continuing costs of operation of a health care business. In September 1997, the actions taken at a bankrupt California nursing home, and its impact on its patients, shocked the local health care community, and received national press coverage, as summarized in an excerpt below.

> WOODLAND HILLS--A state health official said Monday that a bankrupt Reseda nursing home broke the law by suddenly evicting its patients late at night, and an angry federal judge appointed a trustee to take over three other financially troubled homes managed by the same Arizona company.
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> Sixty-three residents of the Reseda Care Center, some in wheelchairs, were ejected from the building and relatives were called to pick them up after 9 p.m. Friday. In one case, a family watching the eviction on late-night TV news realized that it was the same home where they had left a 106-year-old relative. [4]

Another news article reported that “one 88-year-old Alzheimer's patient shrieked as she was wheeled out at 2:30 a.m. and a 39-year-old stroke victim was forced from his home of 18 years.” [5] As noted in the press coverage, the debtor was facing significant financial stress from continuing to operate the nursing facility.

This situation illustrates a frequent dichotomy: the decision to terminate operations may have been in the best interests of the estate and some creditors, but it adversely impacted, at least temporarily, the 63 patients (called "residents" in long term care facilities) who were moved unexpectedly.

***253 B. Patient Privacy and Record Retention vs. Cost to the Estate**

Protected health information (PHI) means individually identifiable health information. [6] This definition includes patient records, which can be an important asset of the estate, e.g., facilitating operations for a buyer of the health care debtor's business as an ongoing operation. However, these often voluminous records can also impose a significant cost to the estate to maintain and protect them in accordance with strict privacy and security laws included in the federal Health Insurance Portability and Accountability Act (HIPAA) and additional state requirements. Even at the basic level of compiling lists of creditors and schedules of assets and liabilities, patient privacy may be implicated, for example, if patient refunds are owed or if patient payments to the provider are outstanding. Outside of bankruptcy, health care providers typically retain patient records for periods of up to ten years, a period often much longer than the contemplated duration of the debtor's case, and in some cases the life expectancy of the provider. While the Bankruptcy Code provides a process for the disposition of patient records, if the estate does not have sufficient funds to pay for storage in accordance with applicable laws, that process itself may be time-consuming and costly. [7]

2. The Bankruptcy Process Has Been Used in Some Cases to Disrupt the Usual Processes for Patient Protection Provided by Government Oversight Entities

Some health care providers have filed for bankruptcy as a result of enforcement actions threatened or taken by the federal and state governments because of alleged deficiencies in care provided to patients. [8] Although a provider is typically offered an opportunity to address the alleged deficiencies through corrective action plans (usually called plans of correction), if that avenue is not successful, the provider may face loss of its license or termination of its participation in Medicare and Medicaid (called Medi-Cal in California). Loss of license, or Medicare and Medicaid participation will severely limit the provider's revenues. Commercial payers, i.e., private insurance companies, often follow the lead of Medicare with respect to certification requirements, so that a loss of a Medicare provider agreement can be financially disastrous for the provider. This ***254** may lead a provider to file for bankruptcy protection, and may also lead to urgent requests for injunctive relief once the bankruptcy case has been filed. The bankruptcy court may then be forced to decide how to reconcile the government's allegations of patient care deficiencies against the debtor's dispute of those deficiencies and its pleas to protect the estate from the proposed federal or state action. Both sides will likely cite the interests of the patients in support of their position.

A. The California Regulatory Landscape

Even absent a crisis event like a threatened termination of Medicare participation, every day compliance with multiple layers of non-bankruptcy requirements and enforcement authorities may result in operational tension and cost for the debtor in the context of bankruptcy process. States, including California, have specific licensing requirements for different types of providers, set forth and enforced by the California Department of Public Health (CDPH). [9] In addition to an applicable license, providers must enroll in Medicare and Medi-Cal to receive federal health care payments. As a part of enrollment, the federal Medicare program requires that many categories of providers meet Conditions of Participation or Conditions for Coverage specific to that provider category, in addition to meeting separate requirements relating to coverage and payment of individual claims. [10] More recently, the Centers for Medicare & Medicaid Services (CMS), a component of the federal Department of Health & Human Services (HHS)has implemented regulations that allow it to revoke the billing privileges of its providers for a wide range of reasons. [11] Medi-Cal also has many requirements for payments to providers set forth and enforced by the state Department of Health Care Services (DHCS). Medi-Cal may also place providers on a "no pay" list known as the Suspended and Ineligible Provider list. [12]

In addition, the Office of Inspector General (OIG), the enforcement component of HHS, has taken the position that ongoing requirements of Corporate Integrity Agreements (CIAs), which sometimes include quality of care provisions ***255** over and above those required of all Medicare providers of that type, must be met throughout the duration of the CIA despite a bankruptcy filing. (CIAs are frequently required as part of the settlement of a False Claims Act case to resolve the OIG's discretionary authority to exclude the defendant from participation in the federal health care programs.) For example, OIG recently entered

into a CIA with Vanguard Healthcare LLC and related entities that imposes significant quality of care compliance obligations, despite Vanguard's bankruptcy filing in 2016. [13] OIG has stated in at least one CIA that compliance with the terms and conditions of the CIA shall constitute an element of the provider's responsibility with regard to participation in the Federal health care programs. [14]

B. Conflicting Jurisdictional Authorities

HHS, CDPH and DHCS will generally expect continued compliance with all of their requirements for provider participation despite a bankruptcy filing. The debtor or trustee must be well-versed in all these requirements to avoid government enforcement activity. Government enforcement activity may or may not be channeled through the bankruptcy court. Enforcement actions against a debtor are sometimes characterized, if challenged, as an exercise of the government's "police power" or as a condition of the provider's continued program participation (comparable to continued performance under the terms of an executory contract).

Litigation initiated by debtors, and sometimes creditors, has often ensued when these actions would result in harm to the estate, raising significant issues with respect to the jurisdictional authorities of the bankruptcy court. Those authorities are not entirely consistent with the jurisdictional limitations (and delays) applicable to these cases outside of bankruptcy. Specifically, outside of bankruptcy, administrative exhaustion is typically required by statute and by many courts, sometimes taking years for the dispute to be resolved. Patient interests are implicated in these disputes, which typically put at risk their continuing access to health care services from a particular provider, or allow allegedly substandard care to continue.

*256 C. The Risks of Transfer Trauma

While it is important to consider the implications of halting or altering the government's process for enforcing its quality of care standards, an enforcement action that will ultimately halt the operations of a facility may also have adverse implications for the patients, as will any other decision by the debtor to cease operations. "Transfer trauma" is a well-recognized, if not universally accepted, concept reflecting the danger to the ongoing mental and physical health of patients who are transferred to new living situations. [15]

The Bankruptcy Code itself recognizes the risks to patients associated with closure of a health care facility, reflecting appropriate transfers as one of the duties of the trustee. Specifically, the trustee must use all reasonable and best efforts to transfer patients from a health care business that is in the process of being closed to an appropriate health care business that--(A) is in the vicinity of the health care business that is closing; (B) provides the patient with services that are substantially similar to those provided by the health care business that is in the process of being closed; and (C) maintains a reasonable quality of care. [16] Fed. R. Bankr. P. Rule 2015.2 further requires that:

> Unless the court orders otherwise, if the debtor is a health care business, the trustee may not transfer a patient to another health care business under § 704(a)(12) of the Code unless the trustee gives at least 14 days' notice of the transfer to the patient care ombudsman, if any, the patient, and any family member or other contact person whose name and address has been given to the trustee or the debtor for the purpose of providing information regarding the patient's health care ....

Demonstrating the lack of harmony between bankruptcy law and applicable health care laws, California also has requirements, recently enhanced, for nursing homes contemplating closure to reduce the impact on patients, [17] with extended time frames (much longer than that suggested in Rule 2015.2) that may prove problematic for a provider in bankruptcy. The bankruptcy court may be forced to *257 decide between these seemingly competing requirements, with direct implications for patients/residents.

Moreover, the impact on patients of closure of a health care business is not limited to facility care. Direct caregivers are seldom considered fungible by their patients. For example, a hospice or home health patient who is cared for in his/her home may develop trust in, and an attachment to, a particular caregiver, whose employment may be at risk if the entity ceases operations. If the health care business is not sold as an ongoing operation, but as an asset sale at auction, caregivers may be left at the mercy of the buyer as to whether their jobs will continue and if they are available to continue to care for particular patients. In such cases,

patients may be faced with a change of both health care provider and specific caregiver. A long delay in determining the future of the business may result in caregivers seeking other employment--and again making the caregiver potentially unavailable for continuing care of the patients of the debtor.

Conclusion

Health care bankruptcies involve "customers" of the debtor--its patients--whose interests in the administration of the estate add significant complications to resolution of the underlying case. Their interest in access to quality care (however defined) must be a factor considered at each significant junction in the administration of the case.

Footnotes

1 Judith A. Waltz, a partner at Foley & Lardner LLP in San Francisco who is co-chair of its Health Care Industry Team, provides ongoing compliance counseling and Medicare/Medicaid coverage and payment advice. Prior to joining the firm in 1998, Judy served as assistant regional counsel for the U.S. Department of Health and Human Services (HHS) in San Francisco, where she primarily handled CMS (then HCFA) Medicare issues, including survey and certification disputes.

2 The term "health care business" is defined in 11 U.S.C. § 101(27A). This article applies the terminology used by Medicare, the federal health care insurance program for the aged and disabled, which distinguishes between providers (including hospitals, skilled nursing facilities, and hospices) and suppliers (including physicians, durable medical equipment suppliers, and clinical laboratories). For purposes of this article, the term "providers" is used to include both providers and suppliers. The Medicare program, a frequent creditor in health care bankruptcies, is administered by the Centers for Medicare and Medicaid Services (CMS), a component of the federal Department of Health and Human Services.

3 Under 11 U.S.C. § 333(a)(1), the Bankruptcy 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."

4 Julie Tamaki & Julie Marquis, Los Angeles Times, *Evictions at Reseda Care Center Called Illegal*, http://articles.latimes.com/1997/sep/30/news/mn-37831.

5 Eric Slater, *Business*: *Critics say owner of shuttered nursing homes, including one in Reseda, lived lavishly amid unpaid bills,* http://articles.latimes.com/1997/oct/23/news/mn-45876.

6 45 C.F.R. § 160.103.

7 11 U.S.C. § 351; Fed. R. Bankr. P. 6011.

8 *See e.g.,* Fla. Agency for Health Care Admin. v. Bayou Shores SNF, LLC (*In re* Bayou Shores SNF, LLC), 838 F.3d 1297 (11th Cir. 2016), *cert. denied*, Bayou Shores SNF, LLC v. Fla. Agency for Health Care Admin., 137 S. Ct. 2214 (2017).

9 https://www.cdph.ca.gov/Programs/CEH/Pages/CLPR.aspx.

10 https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/index.html. For a helpful overview of Medicare, and the federal requirements for Medicaid programs, see the publication by the Centers for Medicare and Medicaid Services (CMS) entitled *Brief Summaries of Medicare and Medicaid*, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/SummaryMedicareMedicaid.html.

11 42 C.F.R. § 424.535.

12 http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp.

13 DOJ Press Release (Feb. 27, 2019), https://www.justice.gov/opa/pr/vanguard-healthcare-agrees-resolve-federal-and-state-false-claims-act-liability.

14 Corporate Integrity Agreement Between the Office of Inspector General of the Department of Health and Human Services and Integrated Health Services, Inc. (2003)., https://oig.hhs.gov/fraud/cia/agreements/ihs_exceptional_care_llc_09%2009%202003.pdf.

15 *See e.g.*, https://www.desmoinesregister.com/story/news/health/2015/09/28/transfer-trauma-can-awful-when-elderly-moved/72988204/.

16 11 U.S.C. § 704(a)(12).

17 *See e.g.*, AFL 18-10 (LTC Facilities Closure), https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-18-10.aspx.

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