Healthcare Bankruptcies and Regulatory Considerations

The Hon. Brenda T. Rhoades
U.S. Bankruptcy Court, Eastern District of Texas, Plano Division

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13th Anniversary
Bankruptcy Bench Bar Conference 2019
Sponsored by the Bankruptcy Law Section of the Texas State Bar
Fairmont Austin
April 17 - 19, 2019

13th Anniversary Bankruptcy Bar Bench Conference

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April 2019

BANKRUPTCY LAW SECTION
STATE BAR OF TEXAS

PANELIST INTRODUCTION

The Hon. Brenda T. Rhoades

Biography

The Hon. Brenda T. Rhoades was appointed by the Fifth Circuit as Bankruptcy Judge for the Eastern District of Texas in 2003. She was named Chief Judge from 2010 to 2017. At the time of her appointment, Judge Rhoades became the only sitting Asian-American bankruptcy judge in the country.

Casey Roy

Assistant Attorney General

Biography

Casey Roy is an Assistant Attorney General with the Texas Attorney General's Office. Casey is part of a team of lawyers primarily responsible for all non-tax related bankruptcy matters for the State of Texas. He has over 20 years of practice as a bankruptcy specialist, and for the past 10 years Casey has represented state agencies in a wide variety of bankruptcy regulatory matters, with a focus on health care and environmental cases.

Liz Boydston

Partner

K&L GATES

Biography

Liz is a Partner with K&L Gates with more than 10 years of experience representing debtors, lenders, shareholders, committees, purchasers, boards, and landlords in complex restructuring, insolvency, and litigation matters. She filed, ran, and successfully confirmed the 140-debtor Adeptus Health (In re ADPT DFW Holdings LLC) cases in fewer than six months.

Russell Perry, CFA, CIRA

Senior Managing Director

ankura

Biography

Russell Perry is a Senior Managing Director at Ankura with more than a decade of experience across complex financial situations involving distressed companies, with a significant emphasis on the US healthcare market. His restructuring advisory experience includes interim management and various leadership roles across financial, operational and strategic situations.

BANKRUPTCY CODE HEALTH CARE ENTITIES

§ 101(27)(A) of the Bankruptcy Code defines "health care business" as:

"… 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 …."

"health care institution … primarily engaged in offering room, board, laundry, or personal assistance with activities of daily living and incidentals to activities of daily living" related to SNFs, CCRCs, long-term care, assisted-living, nursing homes, or retirement centers

The various types of healthcare entities include:

- Hospitals
- Physician Group Practices
- Municipalities
- Skilled Nursing Facilities (SNF)
- Senior Car/Housing/Retirement Centers (e.g. CCRC)
- Hospice
- Home Health
- Acute Care
- Ambulatory Care
- Pharma
- Medical Services

A Different Frame of Mind

While a quick solution and the balance sheet are top of mind in most bankruptcy cases, **the majority of healthcare bankruptcies involve ongoing medical services, meaning patient care is paramount.**

- Generally, the mindset in a Ch. 11 is "the best interests of creditors and the estate."
- A healthcare debtor has a mission.
- For a non-profit, the mission is part of the "duty of obedience" owed by leadership.
- Court's recognize and respect the duty of obedience, esp. in 363 sale context. The best offer may not be the most money, but instead may be the one that takes into account existing patient concerns and the public policy concerns to preserve an ongoing healthcare provider's business without disruption.
- Working with regulators, politicians, local community groups, etc.

SIGNS OF FINANCIAL DISTRESS. NOW WHAT?

Retain Healthcare-Specific Legal and Financial Professionals

- Imperative to retain both restructuring attorneys experienced in healthcare bankruptcies and healthcare attorneys (regulatory).
- Equally imperative to retain financial professionals experienced in distressed healthcare matters.

Fiduciary Duties of For-Profit versus Non-Profit

- **For-Profit:** accountable to company's shareholders-duty to maximize revenue, asset value, generate a return for shareholders.
- **Non-Profit:** accountable to the mission, the institution, the community it serves.

BANKRUPTCY: PRE-FILING CONSIDERATIONS

Calls or meetings and open communication with the Texas Attorney General

- Texas has a special interest in the regulation of healthcare entities within its borders, thus a healthcare entity should notify the Texas Attorney General before it files for bankruptcy.
- Open and candid communication can facilitate cooperation and help avoid strained relations.

Determine status of licenses, certifications, permits, authorizations, charters, etc. that will need to remain in place/in effect during the bankruptcy case.

- Consider the impact bankruptcy could have on licenses, permits, etc. and whether specific actions will be needed to preserve or relinquish them.
- While government entities are prohibited from revoking licenses, permits, etc. solely because of the bankruptcy case, it is likely to trigger increased scrutiny.
- Work closely with regulators. Start early (pre-filing). Be mindful of a regulatory agency's ability, if any, to expedite review, approval, audits, etc.

BANKRUPTCY: PRE-FILING CONSIDERATIONS

Calls and meetings with the U.S. Trustee

- The U.S. Trustee's office appreciates a head's up and appreciates a voluntary pre-filing meeting. Such meetings facilitate the exchange of information and streamline the first and second day hearings, esp. when the Debtor(s) anticipates needing more time to file Schedules, etc. and thus pushing out the § 341 Meeting.
- If a quick sale or quick confirmation is anticipated, meeting with the U.S. Trustee enables the Debtor and its professionals to set a timeline of the case.

Identify necessary contracts, indispensable leases, and vendors critical to operate

- Certain leases, contracts, and vendors are critical to the ongoing operations of the healthcare business.

BANKRUPTCY: PRE-FILING CONSIDERATIONS

Patient Confidentiality	• HIPAA creates a duty for healthcare providers (and their "business associates") to maintain the confidentiality of patient information. HIPAA regulations impose strict standards on "covered entities" and set forth penalties if patient information is improperly used or disclosed. 45 C.F.R. § 160, 162, 164. • To comply with HIPAA and the noticing requirements of the Code, a healthcare debtor should file a Motion Authorizing Implementation of Procedures to Maintain and Protect Confidential Patient Information.
Medical Records	• No HIPAA requirement, it's state-specific. • Texas: Hospitals 10 years after last treatment or patient's death if during stay (minors: the later of 10 years after last treatment or until patient turns 21). • If a trustee has insufficient funds to pay for the storage of patient records, Section 351 of the Code and Bankruptcy Rule 6011 provide specific requirements for the disposal of patient records.

BANKRUPTCY: PRE-FILING CONSIDERATIONS

Patient Care Ombudsman (PCO)

- § 333 of the Code provides for the appointment of a patient care ombudsman (PCO) within 30 days after commencement of a healthcare business bankruptcy case. Bankruptcy Rule 2007.2 sets forth the procedure to appoint.
- PCO is a "patient advocate," entrusted with monitoring the quality of patient care, representing the interests of patients.
- PCO is required to report to the bankruptcy court every 60 days, pursuant to Bankruptcy Rule 2015.1.
- PCO fees and counsel (including local counsel, if retained) are paid by the Estate; budget for the PCO in the DIP and cash collateral budgets.

BANKRUPTCY: PRE-FILING CONSIDERATIONS

Communication Planning for Physicians, Nursing Staff, Employees, and the Public

- It is essential for hospitals and healthcare providers to maintain good community relations.
- Especially in times of financial distress, when operations need to run smoothly, it is in the best interests of all constituencies (provider, creditors, employees, physicians, patients, regulatory agencies, and the public) for the Debtor to have a coordinated communications and public relations program to ensure coherent and consistent communications to the various constituencies.

FIRST-DAY MOTIONS: DIP/CASH COLLATERAL & CASH MANAGEMENT

DIP Financing and/or Cash Collateral

"Notwithstanding any provision in the underlying motion or this order to the contrary, nothing shall impair the Texas Health and Human Services Commission's rights of recoupment under the Medicaid Program, which shall remain unaffected. The Bankruptcy Estate (Debtor-in-Possession or any subsequently appointed Trustee) shall retain its right to contest the amount of any recoupment after exhausting its administrative remedies to challenge such amount.

Notwithstanding any other provision in the underlying motion or this order to the contrary, there shall be carved out from the liens, replacement liens, security interests, and superpriority claims of the Debtor's secured lenders granted in this final order or otherwise, the actual, necessary costs associated with closing the Debtor's facilities, including the maintenance, retention and disposition of patient medical records as required by applicable state law or the alternative provisions of 11 U.S.C. § 351, and costs in connection with transferring patients to another facility."

FIRST-DAY MOTIONS: PATIENT CONFIDENTIALITY & MEDICAL RECORDS

Patient Confidentiality	• HIPAA creates a duty for healthcare providers (and their "business associates") to maintain the confidentiality of patient information. HIPAA regulations impose strict standards on "covered entities" and set forth penalties if patient information is improperly used or disclosed. 45 C.F.R. § 160, 162, 164. • To comply with HIPAA and the noticing requirements of the Code, a healthcare debtor should file a Motion Authorizing Implementation of Procedures to Maintain and Protect Confidential Patient Information.
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PROVIDER AGREEMENTS & THE AUTOMATIC STAY

The Automatic Stay prohibits the immediate termination of:

- Provider Agreements, both federal and state
- Medicare
- Physician contracts
- Radiology and other specialized service agreements
- Ambulatory service contracts
- Contracts to supply or for the supply of blood

The Automatic Stay DOES NOT PROHIBIT exclusion from Medicare and Medicaid:

•There is an exception to the automatic stay to allow a governmental entity to enforce its police and regulatory power. Some courts have held that attempts to exclude a debtor from a federal health care program for nonpayment of Medicare overpayments, False Claims Act liability, or civil penalties are not proper efforts to enforce police and regulatory powers.

•HOWEVER, in 2005 BAPCPA added § 362(b)(28), which provides that the automatic stay does NOT prevent HHS (Health & Human Services) from excluding a health care business "from participation in the Medicare program or any other federal health care program."

TERMINATION FROM PROVIDER AGREEMENTS & THE AUTOMATIC STAY

"Termination from Participation in" Medicare or Medicaid is a less serious remedy than Exclusion. Termination is the refusal to renew or a discontinuation of a Provider's contract. Termination is NOT permanent, and the Provider can immediately apply for a new contract.

- 11 USC § 362(b)(28) only refers to "exclusion" and not "termination."
- If the factors for exclusion are not met, HHS cannot use § 362(b)(28) to terminate a contract.
- To terminate, HHS must seek relief from the automatic stay before it can terminate a Provider's participation in Medicare or other federal programs.
- After termination and application for a new contract, CMS should grant a new contract if the reasons for termination are remedied and the Provider gives reasonable assurance that that those reasons will not recur.

SECTION 525(A) & THE AUTOMATIC STAY

Exclusion and termination are prohibited by § 525(a) if the government's action is motivated **solely** because the Debtor is in bankruptcy or has not paid a pre-petition debt.

Even if the government offers non-bankruptcy related reasons to terminate or exclude a Provider, bankruptcy courts routinely look beyond the government's stated reasons to determine whether the government is improperly discriminating under § 525(a).

. . . governmental unit may not deny, revoke, suspend, or refuse to renew a license, permit, charter, franchise, or other similar grant to, condition such a grant to, discriminate with respect to such a grant against, . . . a person that is or has been a debtor under this title . . . solely because such bankrupt or debtor is or has been a debtor under this title . . ., has been insolvent before the commencement of the case under this title, or during the case but before the debtor is granted or denied a discharge, or has not paid a debt that is dischargeable in the case under this title or that was discharged under the Bankruptcy Act.

SETOFF, RECOUPMENT, & THE AUTOMATIC STAY

Can the government recover pre-petition Medicare or Medicaid overpayments by offsetting against payments coming to the Provider during the bankruptcy case under the same provider agreement?

- The government argues it may recover such payments via "Recoupment."
- "Recoupment is the setting up of a demand arising from the same transaction as the plaintiff's claim or case of action, strictly for the purpose of abatement or reduction of such claim." Univ. Med. Ctr. v. Sullivan (In re Univ. Med. Ctr.), 973 F.2d 1065, 1079-80 (3d Cir. 1992).
- The equitable doctrine of Recoupment is an exception to the automatic stay, because the funds subject to recoupment are not the Debtor's property and recoupment is based on a single transaction.
- Setoff is barred by the automatic stay since it may involve multiple debts arising from separate transactions.

SETOFF, RECOUPMENT, & THE AUTOMATIC STAY

Court Split:

- Third Circuit held recoupment of pre-petition overpayments is not permitted because there are separate transactions.
- First, Ninth & D.C. Circuits hold recoupment of pre-petition overpayments is permitted because the Medicare system provides for a single, on-going, integrated transaction for recoupment analyses purposes.
- NO Fifth Circuit Decision

TEXAS BANKRUPTCY COURT DECISION:

- In re AHN Homecare, LLC, 222 B.R. 804 (Bankr. N.D. Tex. 1998)
- Healthcare entity received Medicare overpayments pre-petition.
- HHS commenced recoupment pre-petition.
- Debtor files Ch. 11.
- HHS continued to recoup (post-petition) for the pre-petition overpayment.
- Court looked at the circuit split to determine whether a pre-petition payment and post-petition re-payment constituted “one transaction” to satisfy recoupment.
- Held: Medicare contract between Debtor and HHS constituted “one transaction.”
- Held: HHS was entitled to recoup from Debtor and did so without violating the stay.

JURISDICTION & REIMBURSEMENT CLAIM

42 U.S.C. § 405(h)

"no action against the United States, the [Secretary of HHS] . . . shall be brought under section 1331 or 1346 of Title 28 to recover on any claim under [the Medicare Act]."

Outside of bankruptcy: any provider contesting a reimbursement decision or pay suspension must exhaust the HHS administrative appeals process prior to litigating.

In bankruptcy: majority of courts hold that 42 U.S.C. § 405(h) bars bankruptcy courts from exercising jurisdiction over a Medicare claim dispute until the provider has completed the HHS administrative appeal process.

SALE: ASSUMPTION & ASSIGNMENT OF PROVIDER AGREEMENTS

Medicare and Medicaid Provider Agreements are generally classified as executory contracts.

If a healthcare entity reorganizes in bankruptcy, the provider agreement(s) must be assumed to allow the entity to continue as a reorganized healthcare entity or to allow for the transfer of the provider agreements as part of a sale.

A purchaser who assumes a provider agreement acquires those assets subject to the government's right to seek recoupment and subject to governmental liabilities attached to the provider agreement (overpayments, audits, etc.).

SALE: NON-PROFIT

BAPCPA added 3 amendments relating to the transfer/sale of non-profit assets:

- 11 U.S.C. § 363(d): trustee may only sell or lease property under subsections (b) and (c) in accordance with applicable non-bankruptcy law that governs the transfer of property by a nonprofit entity.
- 11 U.S.C. § 1129(a)(16): in confirming a plan, the court must find that all transfers of property under the plan are made in accordance with applicable non-bankruptcy law that governs the transfer of property by a nonprofit entity.
- 11 U.S.C. § 541(f) a debtor's property that is a tax-exempt, nonprofit charitable corporation under § 501(c)(3) of the Internal Revenue Code may be transferred to an entity that is not such a corporation, but only under the same conditions as would apply if the debtor had not filed bankruptcy.

SALE: NON-PROFIT

Duty of Obedience

- Generally, Section 363 sales are analyzed on whether it is the highest and best offer so as to maximize recovery to the estate.
- Non-Profit sales are analyzed on whether the charitable mission is carried out.
- Board and Directors of non-profits have a fiduciary duty to further the health care entity's mission. Thus, the decision regarding the best bid should not be based solely on price.

Entire sales process—from marketing to potential buyers to timing to certainty of closure—is guided by regulatory approvals.

SALE CONSIDERATIONS

Sales of hospitals require compliance with:

- Change of ownership procedures for provider agreements
- Accreditation by the Joint Commission (or others)
- Licensing requirements
- Transfer of U.S. Drug Enforcement Agency registration
- Transfer of pharmacy permits
- Regulations regarding radioactive materials and radiation machines
- Federal and local environmental compliance

PATIENT CARE & BUSINESS WIND-DOWN

Duty to Transfer Patients & Closing a Healthcare Business

- Sections 704(a)(12) and 1106(a)(1) obligate the trustee to use "all reasonable and best efforts" to transfer patients from a healthcare business that is to be closed to an "appropriate" healthcare business in the vicinity that provides substantially similar services and a reasonable quality of care.

- Bankruptcy Rule 2015.2 provides that, unless the court orders otherwise, the trustee may not transfer any patient to another healthcare business under section 704(a)(12) without providing 14-days' notice of the transfer to the patient, the patient's contacts (subject to patient privacy laws), and the PCO.

- Section 503(b)(8) grants special administrative expense priority for expenses incurred in winding up a healthcare business.

CHAPTER NINE: PUBLIC HEALTHCARE RESTRUCTURING

Requirements to file under Chapter 9 are more strict than Chapter 11

- Only a "municipality" may file for relief under chapter 9. 11 U.S.C. § 109(c).

  The term "municipality" is defined in the Bankruptcy Code as a "political subdivision or public agency or instrumentality of a State" 11 U.S.C. § 101(40). Includes cities, counties, townships, school districts, public improvement districts, and revenue-producing bodies that provide services which are paid for by users rather than by general taxes, such as bridge authorities, highway authorities, and gas authorities.

- The municipality must be specifically authorized to be a debtor by state law or by a governmental officer or organization empowered by State law to authorize the municipality to be a debtor;
- The municipality must be insolvent, as defined in 11 U.S.C. § 101(32)(C);
- The municipality must desire to effect a plan to adjust its debts; and
- The municipality must either:
  - obtain the agreement of creditors holding at least a majority in amount of the claims of each class that the debtor intends to impair under a plan in a case under chapter 9; or
  - negotiate in good faith with creditors and fail to obtain the agreement of creditors holding at least a majority in amount of the claims of each class that the debtor intends to impair under a plan; or
  - be unable to negotiate with creditors because such negotiation is impracticable; or
  - reasonably believe that a creditor may attempt to obtain a preference.

CHAPTER NINE: PUBLIC HEALTHCARE RESTRUCTURING

- Once deemed eligible to file under Chapter 9, healthcare businesses have more latitude and receives more deference from the bankruptcy court.
- Creditors cannot file a competing plan.
- Because a main purpose of Chapter 9 is to allow a public entity to continue to offer public services, plan confirmation requirements are more flexible.
- Role of the U.S. trustee is more limited, i.e. the U.S. trustee does not examine the debtor at a meeting of creditors (and there is no meeting of creditors), does not have the authority to move for appointment of a trustee or examiner, does not have the authority to move for conversion of the case, does not supervise the administration of the case, does not monitor the financial operations of the debtor, and does not review the fees of professionals retained in the case.
- A municipality has the authority to borrow money during a chapter 9 case as an administrative expense. 11 U.S.C. §§ 364, 901(a). This is essential to the survival of a municipality that has exhausted all other resources.
- A municipality may employ professionals without court approval, and professional fees are reviewed only within the context of plan confirmation.

Questions?