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BREAKFAST SERIES

CURRENT ISSUES IN THE CREDIT MARKET

April 30, 2010

Current Issues in Healthcare Lending

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Current Issues in Healthcare Lending

Introduction

Welcome.

We are pleased to be speaking today about current issues in healthcare lending and given the recent passage of healthcare reform and other legislative initiatives, the topics covered by our panel are going to be somewhat broader in scope.

The views expressed in this presentation are designed in part to stimulate discussion and are not necessarily the views of Edwards Angell Palmer & Dodge or our clients.

Firstly, let me introduce my colleagues who will be participating in this presentation today.

Erica Stocker, a public policy advisor in our legislative affairs group based in Washington, D.C.

Susan Siebert, a partner in our Boston office and co-head of our debt finance group.

David Szabo, a partner in our Boston office and a member of our healthcare practice group.

Stuart Brown, resident in Wilmington and head of our bankruptcy and restructuring practice.

And myself, Les Levinson, resident in our New York office in our business law group and head of our healthcare practice group.

The four topics discussed in this program today are:

1. Developments/Updates on Healthcare Legislation
2. Opportunities and Risks Arising from HITECH Act and Stimulus Funding
3. Special Collateral and Other Issues in Healthcare Lending
4. Recent Developments in Restructurings/Healthcare Workouts

One more introductory matter. Our firm has been publishing advisories during the legislative phase which many of you may be receiving and we are also publishing advisories on various parts of the law. If you are not receiving these and would like to, please let us know.

I. Developments/Updates on Healthcare Legislation.
Moderator: Les Levinson; Panelist: Erica Stocker

Question:

Now that the legislation and the related reconciliation bills have been passed, can you give us a brief recap of the key provision which are likely to affect lenders and when you see those provisions coming into effect given that some of the bill has staggered implementation dates as well as rule making to be done by CMS.

Answer:

Here is a brief overview of the key provisions in the new healthcare law (Public Law 111-148), enacted on March 23, 2010, and the reconciliation "sidecar" bill that made additional changes (Public Law 111-152), enacted on March 30, 2010.

A. Over the next 10 years, the new healthcare law will cover up to 32 million currently uninsured individuals – amounting to eventual coverage for 94% of Americans – to the tune of $938 billion.

B. The new law makes significant changes to the private health insurance market, such as eliminating coverage exclusions due to pre-existing conditions, eliminating lifetime and annual limits, covering preventative health services, and extending coverage of dependents to age 26, to name a few.

C. The law also includes many provisions designed to better coordinate care in the government's public programs – Medicare and Medicaid – and to reform their payment systems as well.

D. As you mentioned, Les, the implementation dates are staggered, with some provisions – such as the extension of coverage to young adults up to age 26 and the establishment of a program to cover those currently denied health insurance due to pre-existing conditions – due to be implemented by CMS this year.

E. Over the next several years, the law's major provisions will be phased in – such as the establishment of the health insurance exchanges and government subsidies that will play a major role in covering more Americans, the Medicare and Medicaid payment reforms, and the various tax increases that will offset the costs of increased coverage.

Question:

What is the view as you see it from Washington as to how the legislation is going to impact the hospital, homecare, long term care and medical device sectors -- particularly reimbursement, and how do you see the timing of that playing out?

Answer:

The new law will impact virtually every sector of the healthcare industry. I'd like to respond by breaking down the impacts by industry sector – discussing reimbursement issues and timing in particular.

A. **Hospitals.** Overall, the hospital industry does fairly well under the new healthcare reform law, though they will likely have to make a number of operational changes.

1. Beginning in FY 2013, a new value-based purchasing program for hospitals will require Medicare payments for some common, high cost procedures (such as cardiac, surgical and pneumonia care) to be tied to quality.

Section 3001. Under this program, a percentage of hospital payment would be tied to hospital performance on quality measures related to common and high-cost conditions, such as cardiac, surgical and pneumonia care. Quality measures included in the program (and in all other quality programs in this title) will be developed and chosen with input from external stakeholders. Section 10335 clarifies that the hospital VBP program shall not include measures of hospital readmissions.

2. The majority of the reimbursement cuts that will impact hospitals are in the Disproportionate Share Hospital (DSH) payment system that pays hospitals based on their volume of charity care – though it is important to note that those reductions will not materialize until after the number of insured individuals has improved. Over 10 years, Medicare and Medicaid DSH reductions will equal approximately $36 billion.

Section 2551. DSH impacts begin in FY 2014. The law directs the Secretary to develop a methodology for reducing DSH allotments to all states in order to achieve the mandated reductions, so we will know more when these regulations are proposed.

3. In FY 2012, a new Medicare readmissions policy will subject hospitals with readmission rates over a certain threshold to payment penalties. Expected impact is approximately $7 billion.

Section 3025. This provision would adjust payments for hospitals paid under the inpatient prospective payment system based on the dollar value of each hospital's percentage of potentially preventable Medicare readmissions for the three conditions with risk adjusted readmission measures that are currently endorsed by the National Quality Forum – acute myocardial infarction (AMI), heart failure (HF), and pneumonia (PN). Also, provides the Secretary authority to expand the policy to additional conditions in future years and directs the Secretary to calculate and make publicly available information on all patient hospital readmission rates for certain conditions.

4. In FY 2015, Medicare reimbursement penalties will begin for hospitals with high rates of conditions/infections acquired while in hospital (those in the top 25th percentile). Expected impact is $1.4 billion.

Section 3008. Starting in FY 2015, hospitals in the top 25th percentile of rates of hospital acquired conditions for certain high-cost and common conditions would be subject to a payment penalty under Medicare. This provision also requires the Secretary to submit a report to Congress by January 1, 2012 on the appropriateness of establishing a healthcare acquired condition policy related to other providers participating in Medicare, including nursing homes, inpatient rehabilitation facilities, long-term care hospitals, outpatient hospital departments, ambulatory surgical centers, and health clinics.

5. The Medicare value-based purchasing and infection rates provisions will apply to Ambulatory Surgical Centers (ASCs) as well.

B. **Home Care & Hospice**. Post-acute care providers are arguably the biggest losers under the new healthcare reform law. In a nutshell, they will not see direct expansions but will face Medicare cuts of nearly $40 billion over 10 years.

1. The National Association for Home Care and Hospice believes these cuts are disproportionate to the cuts impacting other providers and will seriously jeopardize a patients' access to care.

2. Home health providers will face a reduction in the home health market basket update by 1 percentage point in 2011 – 2013. In addition, providers face the instatement of a "productivity adjustment" to the market basket update, estimated to be about a 1 percentage point reduction in the market basket update each year beginning in 2015.

Section 3131. This provision would direct the Secretary to improve payment accuracy through rebasing home health payments starting in 2014, as amended by Section 10315, based on an analysis of the current mix of services and intensity of care provided to home health patients. The provision would also establish a 10 percent cap on the amount of reimbursement a home health provider can receive from outlier payments and would reinstate an add-on payment for rural home health providers from April 1, 2010 through 2015. In addition, it would require the Secretary to submit a report to Congress by March 1, 2011 on recommended payment reforms related to serving patients with varying severity of illness or to improve beneficiary access to care. As amended by Section 10315, directs the Secretary to study improving access to home health care for certain patients, including those with high-severity levels of illness, low-income and living in underserved areas, and provides the Secretary authority to conduct a demonstration program based on the results of the study.

Section 3401. Incorporates a productivity adjustment into the market basket update for inpatient hospitals, home health providers, nursing homes, hospice providers, inpatient psychiatric facilities, long-term care hospitals and inpatient rehabilitation facilities beginning in various years and implements additional market basket reductions for certain providers. It would also incorporate a productivity adjustment into payment updates for Part B providers who do not already have such an adjustment. Section 10319 modifies market adjustments for inpatient hospitals, inpatient rehabilitation facilities, inpatient psychiatric hospitals and outpatient hospitals in 2012 and 2013 and for long-term care hospitals in 2011, 2012 and 2013. Also, modifies market basket adjustments for home health providers in 2013 and

hospice providers in 2013 through 2019. Section 1105 of the Reconciliation Act revises the hospital market basket reduction that is in addition to the productivity adjustment as follows: -0.3 in FY 14 and -0.75 in FY 17, FY 18 and FY 19. Removes Senate provision that eliminates the additional market basket for hospitals based on coverage levels. Providers affected are inpatient hospitals, long-term care hospitals, inpatient rehabilitation facilities, psychiatric hospitals and outpatient hospitals.

3. The Secretary of Health and Human Services (HHS) must develop a voluntary pilot program of bundled payment models for a period of five years, including post-acute care providers such as home health agencies, by January 1, 2013.

Section 3023. Directs the Secretary to develop a national, voluntary pilot program encouraging hospitals, doctors, and post-acute care providers to improve patient care and achieve savings for the Medicare program through bundled payment models. Requires the Secretary to establish this program by January 1, 2013 for a period of five years. Before January 1, 2016, the Secretary is also required to submit a plan to Congress to expand the pilot program if doing so will improve patient care and reduce spending. Section 10308 provides the Secretary of HHS authority to expand the payment bundling pilot if it is found to improve quality and reduce costs. Also, directs the Secretary to test bundled payment arrangements involving continuing care hospitals within the bundling pilot program.

4. On a more positive note, the new law establishes the Independence at Home demonstration program, which will allow for chronically ill Medicare beneficiaries to test a payment incentive and service delivery system that utilizes physician-directed home-based primary care teams that aim to reduce expenditures and improve health outcomes.

Section 3024 contains these provisions.

C. **Medical Device Manufacturers**. The outcome for device manufacturers improved throughout the healthcare reform debate.

1. The proposed annual excise tax on medical devices was originally about $40 billion and came down to approximately $20 billion. In addition, the onset of the tax was postponed from 2011 to 2013.

Section 9009. As amended by Section 1405 of the Reconciliation Act, this section imposes an excise tax on the sale of medical devices by the manufacturer or importer equal to 2.3 percent of the sales price. The tax is deductible for federal income tax purposes. The excise tax does not apply to any sale of eyeglasses, contact lenses, hearing aids, or any medical device of a type generally purchased by the public at retail. In addition, sales for export and sales of devices for use in further manufacturing are exempt from the excise tax.

D. **PhRMA/Biotech**. Considering the hit they could have taken, pharmaceutical and biotechnology companies fared well by negotiating concessions early in the healthcare reform debate.

1. A new industry fee on pharmaceutical manufacturers will cost the industry $27 billion over 10 years. The fees begin in earnest in 2011.

Section 9008. As amended by Section 1404 of the Reconciliation Act, imposes an annual fee on the pharmaceutical manufacturing sector. The amount of the fee is $2.5 billion in 2011, $2.8 billion in years 2012-2013, $3.0 billion in 2014-2016, $4.0 billion in 2017, $4.1 billion in 2018 and $2.8 billion in 2019 and years thereafter. This non-deductible fee is allocated across the industry according to market share with a reduction in share for companies with annual sales of branded pharmaceuticals of less than $400 million.

2. Increased Medicare and Medicaid drug rebates will cost the industry more than $38 billion.

Section 2501. The flat rebate for single source and innovator multiple source outpatient prescription drugs would increase from 15.1 percent to 23.1 percent, except the rebate for clotting factors and outpatient drugs approved by the Food and Drug Administration exclusively for pediatric indications would increase to 17.1 percent. The basic rebate percentage for multi-source, non-innovator drugs would increase from 11 percent to 13 percent. Drug manufacturers would also be required to pay rebates for drugs dispensed to Medicaid beneficiaries who receive care from a Medicaid managed care organization (MCO). Total rebate liability would be limited to 100 percent of the average manufacturer price (AMP). Additional revenue generated by these increases will be remitted to the federal government. As amended by Section 1206 of the Reconciliation Act, for purposes of applying the additional rebate, narrows the definition of a new formulation of a drug to a line extension of a single source or innovator multiple source drug that is an oral solid dosage form of the drug.

3. In order to close the Medicare Part D "donut hole" (the gap in prescription drug coverage that impacts many seniors), manufacturers will be required to offer 50% discounts (increasing to 75% by 2020) for drugs in that coverage gap.

Section 1101 (Reconciliation Act). Provides a $250 rebate for all Medicare Part D enrollees who enter the donut hole in 2010. Builds on pharmaceutical manufacturers' 50 percent discount on brand-name drugs beginning in 2011 to provide 75 percent coverage for brand-name and generic drugs by 2020 to fill the donut hole.

4. The new healthcare law includes the Pathway for Biosimilars Act – language to provide the Food and Drug Administration a pathway to approve biosimilars (often called biogenerics, or follow-on biologics). The biotech industry won 12 years of exclusivity before such biosimilars could enter the market – a longer period than many Democratic healthcare leaders wanted.

Sections 7001-7002 contain these provisions.

5. Pharmaceutical companies also won concessions from lawmakers on language expanding the 340B Drug Pricing Program, when a provision to expand the program to inpatient drugs was removed in final negotiations.

Sections 7101-7103 contain these provisions.

E. **Labs**. Lab companies avoided an industry tax in healthcare reform due to their up front agreement on Medicare payment reductions, which can be seen as a positive for this industry sector.

1. Clinical labs will see a 1.75% reduction in their payments over the next five years.

Section 3401. Section on market basket contains this reduction.

From the American Clinical Laboratory Association:

Productivity Adjustment. Repeals the .5% payment reduction in the clinical lab fee schedule effective 2011-2013 and replaces it with a full productivity adjustment for the calendar year 2011 and subsequent years. The productivity adjustment could not reduce the fee schedule update below zero.

Additional Adjustment to Lab Fee Schedule. Applies an additional 1.75% decrease in the CPI update for the calendar years 2011-2015. This adjustment could reduce the fee schedule update below zero.

2. However, the increase in the newly-insured visiting physicians for the first time will likely result in an increased volume of tests being performed – an outcome that will likely bode well for lab companies.

3. Further, lab companies will see a one year exemption from the recommendations of the newly-established Independent Payment Advisory Board (see below).

F. **Establishment of Independent Payment Advisory Board**.

1. 2015 will see the establishment of an Independent Payment Advisory Board to develop and submit proposals to Congress aimed at reducing excess cost growth and improving quality of care for Medicare beneficiaries.

Section 3403 contains these provisions.

2. In years when Medicare costs are projected to be unsustainable, the Board's proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. Congress would be allowed to consider an alternative provision on a fast-track basis.

3. Once established, the recommendations of this board will clearly have implications throughout the various sectors of the healthcare industry, as reimbursement reductions will likely be recommended in order to keep the Medicare program on a sustainable course.

II. Opportunities and Risks Arising from HITECH Act and Stimulus Funding
Moderator: Les Levinson; Panelist: David Szabo

Question:

Please give us a brief overview of HIT and related IT stimulus measures, and why is this meaningful to lenders.

Answer:

The Health Information Technology for Clinical and Economic Health (HITECH) Act was part of the stimulus law passed in the early days of the Obama Administration. HITECH made billions of dollars in new Medicare and Medicaid funding available to physicians and hospitals for the implementation of health information technology (HIT). It also provided millions in grants for states and state-designated entities for the purpose of assisting physicians with the implementation of HIT and for the purpose of developing health information exchange networks.

Question:

What is the economic impact on healthcare companies (and thus indirectly lenders) from failing to comply with HIT and related initiatives?

Answer:

The impact will be felt in different ways. First, there will be Medicare reimbursement penalties that will be imposed on providers starting in 2015. Second, I think these entities will find themselves at a competitive disadvantage in the marketplace, and ultimately may have to make the same investments their competitors made, but without the benefit of federal stimulus funds to offset against the cost. Third, in some states, Massachusetts among them, having electronic records will become a condition of hospital licensure, so really, there is no choice, but to comply at least in part.

In a broader sense, hospitals and other providers that are not making these investments are at risk of falling behind the curve in a more fundamental way. Would you open an account at a bank that did not have an ATM network and on line banking?

Question:

Which types of companies are going to benefit most from HIT and stimulus funding form a lender's perspective, both as to improved credit quality, but also industry growth?

Answer:

Clearly, electronic medical records vendors, such as eClinicalworks, Athena health, and many others are primary beneficiaries. IT integration vendors and consultants, such as CSC consulting, also are in a very good position, as "meaningful use' requires interoperability between information systems.

Providers with strong IT systems should perform better in the revenue cycle, have lower administrative expense associated with claims collections and better control over contractual allowances and denials.

If accountable care organizations emerge as a competitive force, only organizations with strong clinical IT and ability to merger clinical and administrative information will be able to manage the demands to integrated payment and outcomes based payment metrics.

Hospitals with a powerful IT strategy should have better relationships with doctors and patients over time, and be stronger in the marketplace.

III. Special Collateral and Other Issues in Healthcare Lending
Moderator: Les Levinson; Panelist: Susan Siebert

Erica and Dave spoke about the impact of legislative reform and IT on healthcare lending. Susan and Stuart are going to turn to more traditional subjects and discuss issues in documenting and enforcing loans to healthcare borrowers.

Question:

What are some of the issues facing lenders in dealing with collateral in entities providing healthcare services and specifically in valuing healthcare accounts receivables?

Answer:

In any other business a $100 account receivable usually means $100 … in the healthcare industry, it does not necessarily mean $100. Adjustments are constants. Healthcare lenders, therefore, need to look at the historical payment picture for a borrower, knowing that the government will recoup or setoff for what it views as various forms of "overpayment".

Question:

Are there any particular concerns about valuing healthcare accounts receivable for borrowing base purposes?

Answer:

Yes, a healthcare lender needs to decide whether the borrowing base will be based on gross or net accounts receivable. With net accounts receivable, contractual adjustments from the

government and other third party payors are taken at the time of billing. This results in a higher liquidity factor for your borrowing base. If the accounts receivable are valued on a gross basis, contractual adjustments are taken at the time of payment, resulting in lower liquidity. A lender needs to assume the appropriate adjustments in each case so that the collateral availability is correct.

What factors go into whether a borrower bills and records charges on a gross or net billing basis? Some view it as easier to have one charge structure and write contractual adjustments off at the time of payment, rather than estimating those adjustments at the time of the billing. Some third party commercial payors may pay at a higher rate if the account is billed on a gross rather than a net basis. On the other hand, some providers bill and record charges on a net billing basis because it gives a truer picture of the net collectible value of the account receivable.

In any event, from a lender perspective, it is preferable for the lender to advance on a net accounts receivable basis.

Question:

Any special inventory issues, such as when dealing with pharmaceuticals?

Answer:

With pharmaceuticals a healthcare lender has to remember that, although it can get a security interest in the inventory, it will not be able to sell the pharmaceutical inventory in a meltdown situation to just any third party. The list of those to whom the lender may sell will be limited to other licensed pharmaceutical companies.

Although a UCC filing may be sufficient to perfect a security interest in pharmaceutical inventory and records, additional steps under HIPAA may be required to get the full value of that inventory such as private patient prescription information subject to HIPAA. If the healthcare lender wants access to such information, it needs to enter into a type of HIPAA "business associate agreement" with the borrower concerning such information. This agreement would impose HIPAA restrictions on the healthcare lender with respect to patient information. The loan documents would require frequent updating of escrowed patient information.

Question:

How about other collateral danger issues?

Answer:

The clinical performance of the borrower can effect a healthcare lender's collateral. For skilled nursing facilities, poor annual or interim compliance survey results, can (a) result in severe monetary penalties or a lump sum payment that can offset future payments on government receivable, (b) prevent Medicare and Medicaid payments on new admissions

while the non-compliance exists, (c) lead to a reduction in future patients due to the fact that historical survey results may be publicly accessed, and (d) result in a termination of the borrower's Medicare/Medicaid provider agreement resulting in the existing Medicare/Medicaid collateral being worthless.

Question:

Perfecting a security interest in, and collecting healthcare accounts receivable is different than traditional accounts receivable. What type of solutions can lenders create to protect their collateral while remaining compliant with applicable legal guidelines?

Answer:

When a lender takes a security interest in healthcare receivables, it will file a financing statement covering all such receivables. In the case of non-government healthcare insurance receivables, under the Uniform Commercial Code it gives the healthcare lender a right to notify account debtors to make payments directly to the healthcare lender in the event of default. However, where healthcare insurance receivables are payable by the government, the anti-assignment provisions prohibit healthcare lenders from stepping into the shoes of the debtors in order to receive payments directly from the government. Because the healthcare lender cannot do this, it needs to explore a different way to collect such receivables.

Normally, a lender would also perfect its security interest in the deposit account into which the debtor deposits payments on accounts receivable. This is done by putting a control agreement in place which is a tri-party agreement among the borrower, the healthcare lender and the depositary bank, allowing the lender to block withdrawals and control cash – either at all times or at least upon notice after an event of default. However, for government healthcare receivables, a healthcare lender cannot take away the borrower's ultimate right to control the disposition of funds in its deposit account. For this reason, healthcare lenders have come up with a "double lockbox" or at least "double deposit account" approach when the borrower is required to have two separate deposit accounts (and if applicable, lockboxes) – one for government receivables and one for non-government receivables. The account with non-government receivables is perfected with a typical deposit account control agreement, either activated at the time of closing or upon an event of default. The lender would therefore have the right to completely control amounts in that deposit account. As for government receivables in the other account, the healthcare lender could be perfected in identifiable cash proceeds of the government receivables, even though it lacks sole control of that account. The borrower also could provide a standing order to the healthcare lender, directing that the amounts in the government receivables account be swept daily into the blocked account containing other receivables which are in the control of the healthcare lender. Under the anti-assignment provisions, the standing order could not be irrevocable and the borrower will have the ability to revoke it or divert funds from that account before the sweep. For more protection, healthcare lenders could provide in the loan documentation that if the standing order for the daily sweep is changed, such action would constitute an event of default.

Question:

Given the public policy considerations that permeate the healthcare system, what are some of the current issues that lenders deal with in lending to licensed healthcare facilities and how does a lender protect its collateral interest in such licenses?

Answer:

A license to operate a healthcare facility is different of course than holding a Medicare or Medicaid provider agreement. A license is a state or local law issue and to lose a healthcare license of course can shut down a facility immediately. While a healthcare lender may be able to obtain a security interest in a license as a general intangible, transferring that license in a workout or default sale will be restricted. A state agency will need to approve the transferee and great scrutiny will be given as to a transferee's suitability and character. In our experience, this scrutiny is the same whether an existing license is being transferred or a new license is being sought. Another issue is how to determine the value of an existing license in light of such consent rights to transfer it.

IV. Recent Developments in Restructurings/Healthcare Workouts
Moderator: Les Levinson; Panelist: Stuart Brown

Question:

The Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 ("BAPCPA") modified certain provisions of the Bankruptcy Code and are implicated when the debtor is a health care business. Can you give us a brief overview of these provisions and now they impact lenders?

Answer:

Mention new St. Vincent's cases pending in SDNY.

The Bankruptcy Code amendments from 2005, not surprisingly, address many of the same concerns referenced by my colleagues - protection of private information and attention to patient care.

Section 101 of the Bankruptcy Code. BAPCPA amended Section 101 to add definitions of "health care business," "patient" and "patient records."

A "health care business" is any public or private entity, for profit or not for profit, primarily engaged in offering the public facilities and services for diagnosis or treatment of injury, deformity or disease and surgical, drug treatment, psychiatric or obstetric care. "Health care businesses" include any general or specialized hospital, ambulatory, emergency or surgical treatment facility, hospice, home health agency or similar health care institution and any long-term care facility.

A "patient" is any individual who obtains or receives services from a health care business.

"Patient records" are any written document or magnetic, optical or electronic record relating to a patient.

- Some courts have considered "health care businesses" to only include those that provide facilities and services in an institutional, in-patient setting such as a hospital or nursing home and not out-patient facilities,[1] but at least one court has endorsed a broader definition that extends to an individual doctor's office.[2] The question of whether the debtor qualifies as a "health care business" is an important one, as it affects the appointment of an ombudsman, restrictions on disposal of patient records, transfer of patients and administrative priority of expenses of winding-up.[3] Some courts have suggested that the concept of a "health care business" is aimed at debtors that have direct and ongoing contact with patients, providing shelter and sustenance in addition to medical treatment,[4] and formulated a four-part test requiring that (i) the debtor is a private or public entity, (ii) the debtor is primarily engaged in offering to the general public facilities and services, (iii) the facilities and services are for diagnosis or treatment of injury, deformation or disease and (iv) the facilities are for surgical care, drug treatment, psychiatric care or obstetric care.[5]

Question:

So how do these new definitions play out in a bankruptcy case?

Answer:

Section 333 of the Bankruptcy Code. BAPCPA added new Section 333, under which, in cases under chapter 7, 9 or 11 involving a debtor "health care business," the court **shall** order the appointment of an ombudsman by the United States trustee, to monitor the quality of patient care and to represent the interests of patients, **unless** the court finds such an appointment unnecessary on the facts of a particular case. The patient care ombudsman

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[1] *In re Banes*, 355 B.R. 532, 535 (Bankr. M.D.N.C. 2006); *In re 7-Hills Radiology LLC*, 350 B. R. 902, 905 (Bankr. D. Nev. 2006) (focusing on the statutory language defining a health care business as one primarily engaged in offering services and facilities to the general public and declining to appoint a PCO in the case of a debtor that performed radiological tests for patients referred by treating physicians). *See also In re Medical Associates of Pinellas L.L.C.*, 360 B.R. 356 (Bankr. M.D. Fla. 2007) (finding that the debtor, which provided administrative support services and laboratory support to doctors, was not a health care business because it did not offer services generally to the public).

[2] *In re William L. Saber, M.D., P.C.*, 369 B.R. 631 (Bankr. D. Colo. 2007) (noting that, by its use of the word includes, the listing of entities in the statute is not exhaustive and that the statute does not distinguish between major and minor surgeries).

[3] *In re 7-Hills Radiology LLC*, 350 B. R. 902 (Bankr. D. Nev. 2006).

[4] *Id* at 905. *See also In re Anne C. Banes, D.D.S. P.L.L.C.*, 355 B.R. 532 (Bankr. M.D.N.C. 2006) (declining to characterize an outpatient dental practice as a health care business).

[5] *In re Medical Associates of Pinellas L.L.C.*, 360 B.R. 356 (Bankr. M.D. Fla. 2007). *See also In re Alternate Family Care*, 377 B.R. 754 (Bankr. S.D. Fla. 2007); *In re William L. Saber, M.D., P.C.*, 369 B.R. 631 (Bankr. D. Colo. 2007).

("PCO") must be disinterested and a State Long-Term Care Ombudsman appointed under the Older Americans Act of 1965 may serve in a dual capacity as the PCO.

- Courts have just begun to offer clarity and qualifications on the conditions and circumstances under which a PCO will be appointed and the relevant inquiries appear to be (i) the status of the debtor as a health care business and (ii) the specific facts of the case making the appointment of an ombudsman necessary. As suggested above, the appointment of a PCO may be found to be inappropriate because, despite the provision of health care-related services, the debtor is not a health care business. BAPCPA requires that the court make a case-specific assessment of the need for a PCO and courts have applied a totality-of-the-circumstances test that considers the following (nonexclusive) factors: (i) the cause of the bankruptcy, (ii) the presence and role of licensing or supervising authorities, (iii) the debtor's history of patient care, (iv) the ability of patients to protect their rights, (v) the level of patients' dependence on the debtor, (vi) the likelihood of tension between the interests of the debtor and patients, (vii) the potential injury to patients if the debtor drastically reduced its level of patient care, (viii) the presence and sufficiency of internal safeguards to ensure appropriate level of care and (ix) the impact of the cost of an ombudsman on the likelihood of a successful reorganization.[6] Determinates in whether or not to appoint a PCO have included concerns as to independence of the debtor's quality assurance personnel and the need for a medically trained person to aid the court in reviewing pleadings[7] and other questions relating to the debtor's operations, including the reasons for its bankruptcy filing, quality of its patient care and understanding of responsibilities with respect to maintenance and disposition of patient records.[8]

- The continued service of a PCO, once appointed, has been successfully challenged (by the debtors and official committee of unsecured creditors) in at least one case.[9]

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[6] *In re Alternate Family Care*, 377 B.R. 754 (Bankr. S.D. Fla. 2007) (introducing the totality-of the circumstances test and determining that appointment of a PCO was not necessary, given the significant supervision and oversight from other state and private entities and the debtor's excellent record of providing emotionally disturbed children with psychiatric residential treatment services and foster children with temporary care). *See also In re Valley Health Systems*, 381 B.R. 756, 761 (Bankr. C.D. Cal. 2008).

[7] *In re Brotman Medical Center Inc.*, Case No. 07-19705 (Bankr. C.D. Cal.).

[8] *See In re William L. Saber, M.D., P.C.*, 369 B.R. 631 (Bankr. D. Colo. 2007) (finding an ombudsman unnecessary, as the bankruptcy was precipitated by a judgment on a contractual dispute with a physician formerly employed by the debtor and not concerns relating to quality of patient care or privacy matters and the debtor had sufficient procedures in place to continue to protect patient privacy); *In re Total Woman Healthcare Center, P.C.*, 2006 WL 3708164 (Bankr. M.D. Ga. 2006) (declining to appoint an ombudsman in the case of a solo practitioner who performed physical exams, ultrasounds and biopsies at her office and surgeries, deliveries and outpatient services at local hospitals, because tax obligations and not deficient patient care led to the bankruptcy and the debtor understood her obligations with respect to patient records). *See also In re Sequoia Community Health Foundation Inc.*, Case No. 08-13653 (Bankr. E.D. Cal.).

[9] *In re Pleasant Care Corporation, et al.*, Case. No. LA 07-12312-EC (Bankr. C. D. Cal.) (finding that under the facts of the case, no further protection of patients was required (without reaching the challenge to the PCO's disinterestedness based on his failures to disclose his assistance to the secured creditor in pre-

- BAPCPA also amended Section 330 of the Bankruptcy Code to add ombudsmans appointed under Section 333 to the persons to whom a court may award reasonable compensation for actual, necessary services rendered. A PCO is, therefore, compensated in the same manner as professionals retained by the trustee, debtor or committee. Under Section 330, the amount of compensation to a PCO is within the discretion of the court and in determining reasonable compensation, factors to be considered include time spent, rates charged, reasonableness of time spent given the complexity or importance of the service and customary rates of similar professionals in similar cases. Compensation for unnecessary duplicative services or services that were unnecessary or unlikely to benefit the debtor's estate is not authorized, which is odd and at odds with the role of such an ombudsman, whose role is to assure patient care, while the estate's interest involves both health and economic concerns.

- PCOs were not added as persons entitled to interim compensation under Section 331 of the Bankruptcy Code; however, some bankruptcy courts have used their equitable powers to grant interim fee applications by PCOs.[10]

- PCOs were not added to Section 327 of the Bankruptcy Code and Section 330 does not contain express authorization for the retention of professionals by a PCO. At least one court declined to use Section 330 as authority for a PCO to retain counsel.[11] Yet other courts have granted employment applications citing Section 330,[12] while some have referenced Section 330 in allowing a PCO to seek reimbursement for compensation of its counsel without directly deciding the retention issue.[13] Certain courts have reasoned that Section 330(a)(1)(A), which permits reasonable compensation to a PCO for actual, necessary expenses, applies to any professionals authorized by the court under Rule 2014 and that the PCO and any professionals employed by the PCO are to be compensated from the debtor's estate.[14] Other courts have considered Section 330(a)(1)(B) to be the operative provision and found that the Bankruptcy Code does not provide for direct compensation from the

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petition efforts to appoint a state court receiver and his connection with a competitor to the debtor's management)).

[10] *In re Haven Eldercare LLC*, 382 B.R. 180, 183 (Bankr. D. Conn. 2008) (noting that PCOs are "conspicuously absent" from inclusion under Section 331). The court initially rejected the PCO's interim compensation application but subsequently allowed it (Order for Compensation, *Haven Eldercare*, Case No. 07-32720, Docket Nos. 822 and 1350 (Bankr. D. Conn.). *See also Our Lady of Mercy Medical, et. al.*, Case No. 07-10609 (Bankr. S.D.N.Y.); *TSG Inc.*, Case No. 06-80899 (Bankr. E.D. Ok.); *Parker Hughes Clinics*, Case No. 07-30238 (Bankr. D. Minn.).

[11] *In re Renaissance Hospital – Grand Prairie Inc.*, 2008 WL 5746904, *3 (Bankr. N.D. Tex. Dec. 31, 2000).

[12] *See, e.g.*, Application for Order Pursuant to Section 330(a) of the Bankruptcy Code Authorizing the Employment of Saul Ewing LLP as Counsel for Patient Care Ombudsman, filed in *In re Atlantic Health Services Inc.*, Chapter 11 Case No. 06-10356 (PM) (Bankr. D. Md.).

[13] *See, e.g., In re Haven Eldercare LLC*, 382 B.R. 180, 183 (Bankr. D. Conn. 2008).

[14] *See generally Our Lady of Mercy Medical, et al.*, Case No. 07-10609 (Bankr. S.D.N.Y.); *Atlantic Health Services Inc.*, Case No. 06-10356 (Bankr. D. Md.); *Illinois Skin Inc.*, Case No. 06-16098 (Bankr. N.D. Ill.); *Dari Ann Ungaretti*, Case No. 06-16094 (Bankr. N.D. Ill.).

debtor's estate for professionals, so the PCO must compensate such professionals in the first instance and then seek reimbursement.[15]

Question:

Other than the appointment of an ombudsman, are there other provisions that may tend to increase the costs of a bankruptcy case?

Answer:

Section 351 of the Bankruptcy Code. BAPCPA added new Section 351, which provides for greater patient protections in the maintenance and disposal of records of a health care business.

Section 503(b) of the Bankruptcy Code. BAPCPA amended Section 503(b) to classify the actual and necessary costs and expenses of closing a health care business incurred by a trustee or governmental agency, including expenses of disposing of patient records and transferring patients to another health care business, as administrative expenses, despite that these expenses are hardly beneficial to the estate and creditors' recoveries.

Section 362 of the Bankruptcy Code. BAPCPA amended Section 362 – the automatic stay provisions - to provide that debtor health care business' exclusion by the Secretary of Health and Human Services from participation in the Medicare program or any other federal health care program is not subject to the automatic stay.

Section 704 of the Bankruptcy Code. BAPCPA amended Section 704 to require the trustee to use reasonable and best efforts to transfer patients from a debtor health care business in the process of being closed to an appropriate health care business that (i) is in the vicinity of the debtor, (ii) provides substantially the same patient services and (iii) maintains a reasonable quality of care.

Question:

In addition to those provisions, did Congress also modify the workings of consumer bankruptcy cases?

Answer:

In addition, certain provisions of Titles II and XII of BAPCPA concerning consumers may also affect health care businesses.

Section 107 of the Bankruptcy Code. BAPCPA amended Section 107, pertaining to public access to papers filed in a bankruptcy case, to permit the court to enter an order protecting

[15] See *In re Haven Eldercare LLC,* 382 B.R. 180, 183 (Bankr. D. Conn. 2008); *Parker Hughes Clinics,* Case No. 07-30238 (Bankr. D. Minn.).

an individual from disclosure of information that would create an undue risk of identity theft or other unlawful injury to person or property, including name, social security number, date of birth, driver's license or identification number, alien registration number, passport number, employer or tax identification number or other information filed or to be filed with the court; provided that the United States trustee, trustee, bankruptcy administrator and any auditor shall have access to filings and submissions in the case.

Section 332 of the Bankruptcy Code. BAPCPA added new Section 332, under which, if a hearing is required with respect to a debtor's transfer of personally identifiable information, the court shall order the appointment of an ombudsman, separate and apart from the PCO, a consumer privacy ombudsman (CPO) by the United States trustee, to appear and be heard at any hearing concerning the transfer and provide certain information to aid the court. The ombudsman must be disinterested and is compensated from the estate.

Section 363 of the Bankruptcy Code. BAPCPA amended Section 363 to define "personally identifiable information" and allow for the transfer of such information only after (i) a consumer privacy ombudsman is appointed and (ii) the court approves the transfer as not violating applicable non-bankruptcy law. "Personally identifiable information" includes an individual's name, residential address, electronic address, residential telephone number, social security number, or credit card account number when given to a debtor in connection with obtaining products or services from the debtor for personal use, or any other information that if disclosed would result in contacting or identifying an individual physically or electronically. The amendments also require that the transfer of such information about individuals unaffiliated with a debtor be consistent with the debtor's disclosed policies for the disclosure of such information as in effect on the petition date.

BAPCPA further amended Section 363 to require a nonprofit entity selling assets pursuant to Section 363 or transferring assets pursuant to a plan to comply with applicable non-bankruptcy law with respect to transfers of property by nonprofit entities. In addition, attorneys general of the states in which the nonprofit debtor is incorporated or doing business have standing to be heard in the bankruptcy court on issues relating to sale or transfer of assets. This section is not, however, to be construed to require approval of any court other than the bankruptcy court for the transfer of property by a nonprofit debtor.