The First Year of the Patient Care Ombudsmen in Review: Part I

Contributing Editor:
Samuel R. Maizel
Pachulski, Stang, Ziehl, Young, Jones & Weintrab; Los Angeles smaizel@pszyjw.com

The Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 (BAPCPA) created the role of a Patient Care Ombudsman (PCO). Under §333 of the Bankruptcy Code, the PCO’s role is “to monitor the quality of patient care and to represent the interests of the patients of the health care business.” In the 16 months since §333 became effective on Oct. 17, 2005, we can see how the role of PCO has evolved from its conception, and review some issues that have arisen with the PCOs who have been appointed. It is, at best, a year characterized by mixed results and a bit of confusion over both the appropriate role for a PCO and the rules to be followed in serving as a PCO.

The Conception of the PCO

To trace the evolution of the PCO role, one must first look at the facts surrounding its conception. The idea of reforming the Bankruptcy Code as it pertained to health care businesses was first raised by Sens. Chuck Grassley (R-Iowa) and Dick Durbin (D-Ill.) after significant negative publicity in at least one failed health care industry bankruptcy case. At their request, Keith Shapiro and Nancy Peterman assisted the staffs of Sens. Grassley and Durbin with drafting the legislation that became the health care provisions of The Business Bankruptcy Reform Act of 1998, Senate Resolution 1914 (S. 1914). Mr. Shapiro testified on June 1, 1998, with regard to S. 1914’s health care provisions, and his testimony is helpful in examining what the role of the PCO was thought to be by the people who drafted those provisions:

1 The author thanks his partner James I. Stang for his patience in reviewing drafts of this article and Rachel E. Caplan, a second-year law student at Boston University School of Law, for her assistance in researching facts for this article.
2 All references in this article to “sections” are to sections of the Bankruptcy Code, 11 U.S.C. §§101-1530, as amended, unless otherwise noted.
3 BAPCPA §1104(a)(1); 11 U.S.C. §333(a)(1).

In view of the increasing frequency of health care bankruptcy cases and the potential risks to innocent patients who involuntarily become involved in these cases, modifications should be made to the Bankruptcy Code to protect patients’ rights and to encourage debtors-in-possession and trustees to consider the patients’ interests when administering a health care bankruptcy case... S. 1914 protects current and former patients by...providing patients with a voice in the bankruptcy case through the appointment of an ombudsman to act as the patients’ advocate concerning the quality of care being provided... In a health care bankruptcy case, patients often are affected by or have concerns about their quality of care during the bankruptcy case. However, the patients have no standing to appear before the bankruptcy court... Section 104 of S. 1914 requires the appointment of an ombudsman within 30 days after the commencement of a bankruptcy case by a health care business. The ombudsman role is extremely limited. The ombudsman’s only duty is to monitor the quality of patient care... The ombudsman will act as the patient’s advocate in the bankruptcy case and will give patients a voice during the bankruptcy case of a health care business. Furthermore, the appointment of an ombudsman will provide the bankruptcy court and all parties in interest with invaluable information regarding the quality of patient care to avoid a crisis... (emphasis added).

The testimony also included two modifications to the existing text of S. 1914: (1) to allow the “mandatory appointment” to be “avoided based on the facts and circumstances of the case,” and (2) that the PCO should be provided with explicit immunity from any liabilities associated with the reports submitted to the court. The final text of §333 reveals that Congress adopted the former recommendation and ignored the latter recommendation.

Additionally, the testimony stated that the PCO provision of S. 1914 was “a natural extension of the concerns which led to the enactment” of what is now known as the State Long-Term Care (SLTC) Ombudsman Program, which required every state to establish an ombudsman program to, “among other things, monitor the quality of care in nursing homes and investigate any complaints.” This is reflected in the final text of §333, which provides that the SLTC ombudsman may be appointed as the PCO in the bankruptcy of a long-term care facility.

Although the testimony included a suggestion that the role of the PCO was to be “extremely limited,” the wording of §333 has led to some debate among attorneys, both private and government, over the appropriate scope of the PCO’s duties. The genesis of this debate was the inclusion of the phrase “represent the interests of the patients of the health care business” (the “advocate role”) in the final text of §333(a)(1), alongside the duty to “monitor the quality of patient care” (the “monitor role”).

The Evolution of the PCO Role

There was a de facto PCO appointed in a bankruptcy case prior to the enactment of §333. In May 2002, the U.S.
Bankruptcy Court for the Northern District of Texas appointed the SLTC ombudsman to act as “resident advocate,” essentially a PCO, during the chapter 11 bankruptcy of Senior Living Properties. The court required the Texas-based facilities to notify the SLTC ombudsman prior to any significant staff reductions or facility closures. The Texas Department of Aging conducted a special training session for 16 members of the SLTC Ombudsman offices with responsibility for the Texas state facilities. The SLTC ombudsman and the debtor’s chief operating officer communicated biweekly by telephone to discuss broader issues that were not addressed by individual ombudsmen visiting the facility. The most significant outcome, as noted by the SLTC ombudsman, was the ability to slow the closing process in certain instances where the patients needed more time to relocate and transition to other facilities.

This case is a good example of the amount of effort required of a PCO in the advocate role. As the effective date of BAPCPA approached, panelists and authors (including this author) expressed concern that the potentially expansive role for a PCO when working in the advocate role, as well as the possible cost of monitoring a large health care business in the monitor role, would create significant issues in the already daunting task of reorganizing a health care business.

To understand how the role of the PCO has evolved during the past year, one must understand these concerns.

The Costs of the Monitor Role

Dealing with the PCO’s costs to monitor and report on the quality of health care provided by a large, multi-state health care business has concerned everyone. To evaluate the quality of patient care requires the PCO or his or her representatives to, among other things, inspect the facility or facilities, review records and prior evaluations, interview staff, including nurses and doctors, and interview patients. This would be a formidable task, involving the deployment of considerable staff with significant experience and training to prepare a comprehensive and useful report. Many health care businesses are already operating on a very small margin (a recent report on New Jersey hospitals showed that they average an operating margin of only 1.6 percent), and any additional cost may make reorganization impossible. And the costs could be significant. A national advisory firm with a significant health care practice estimated informally for the author the cost of serving as the PCO—just for the monitor role—for a home health care business that recently emerged from bankruptcy, with 128 facilities in 27 states, employing 600 caregivers, 300 staffing personnel, and a roster of approximately 3,200 part-time or per diem employees, with the vast majority of sites being located in suburban areas and small cities. The estimated cost of completing just the required initial 60-day report on the quality of patient care was between $2.1 million and $3.28 million—which would have been almost as much as the total of legal fees awarded in the case for the debtor’s and creditors’ committee’s counsels combined. And while this case was large, it was nowhere near the largest health care bankruptcy case in recent

7 www.ltcombudsman.org/ampublic/49_352_4374.cfm.
8 id.
9 id.
10 id.
memory. In 1999, a string of bankruptcy cases involving skilled nursing facilities began, including Vencor (129 related debtor entities providing care to 35,000 patients daily through 55,000 employees), Sun Healthcare Group (85 related debtor entities providing care to tens of thousands of patients through over 60,000 employees) and Mariner Post Acute Network (more than 181 related debtor entities operating approximately 400 long-term care facilities with over 39,000 beds, 54,000 employees and 32,000 patients). Obviously, the cost of doing even a cursory review of the quality of patient care provided by health care businesses of this size would be significant.

Naturally, the easiest way to avoid these costs is to appoint the SLTC ombudsman, who is already paid by the state and does not charge the estate for his or her services. However, as discussed below, other issues arise in using the SLTC ombudsman to fulfill the PCO role, even in cases where the health care business is a long-term care facility. Another way to control costs is to limit the role of the PCO, which can be done in several ways. One way that has been used is to have the PCO perform only a limited review of the quality of patient care, perhaps visiting only a few of the facilities and extrapolating from those to draw conclusions about the entire operation of the debtor, or not even visiting any of the facilities, and only doing a “desktop” review of selected records. Another way that has been proposed to control costs is to limit the role of the PCO by having the court or the U.S. Trustee order the PCO to ignore the advocate role and focus only on the monitor role. However, all of these options adversely affect the role of the PCO, effectively rewriting §333 in an effort to reduce costs.

The Advocate Role

While one could imagine a very limited role for a PCO whose only duty is to act as a monitor of patient care, one can also imagine a very expansive role for a PCO whose duty is to “act as the patient’s advocate...and...give patients a voice during the bankruptcy case of a health care business.” In theory, as discussed below, in the advocate role, the PCO could be a important player in the debtor’s reorganization effort, including, among other things, offering opinions on financing, sales, resolution of executory contracts or unexpired leases, and even hiring and firing decisions. All of these common bankruptcy events could impact the ability of a health care business to maintain the quality of care provided to its patients. As such, when acting in the advocate role, the PCO would be acting within the scope of his or her authority to take a position on those events, and to inform the judge of the possible impact of any particular course of action on the quality of patient care being provided.

How the PCO will behave when acting in the advocate role is significantly different than when the PCO is acting in the monitoring role. For example, take the situation of a state taxing authority filing a motion to lift the automatic stay to set off a tax refund to a health care business to recover a prior Medicaid overpayment. In his or her monitor role, the PCO would wait and watch to see if, after

13 Lupisacci and Pruitt, supra note 11 at 57.

14 This is not a fanciful scenario, as there are many reported cases involving such efforts by governmental entities, and numerous unrelated decisions. See, e.g., In re Cheltenham Corp., 94 F.3d 772, 779 (2d Cir. 1996) (discussing common law right to offset tax refunds against claims of federal agencies); WAM Inc. v. Mass. Dep’t of Pub. Welfare, 840 F.2d 996 (1st Cir. 1988) (discussing effort by state agency to offset between nursing homes under common ownership); In re Doctors Hospital of Hyde Park Inc., 272 B.R. 677, 683 (Bankr. N.D. Ill. 2002) (discussing state agencies seeking to setoff Medicaid reimbursements to recover unpaid taxes); In re Nuclear Imaging Systems Inc., 260 B.R. 724, 733-34 (Bankr. E.D. Pa. 2000) (discussing setoff between IRS and the Health Care Financing Administration); In re Lakeside Community Hosp., 139 B.R. 886 (Bankr. N.D. Ill. 1992) (discussing state agencies seeking to set off funds owed to health care business to recover unpaid taxes), aff’d, 151 B.R. 887 (N.D. Ill. 1993).