The Evolving Standards for the Appointment of a Patient Care Ombudsman: §333 in "Operation"

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Nearly two and one-half years after the effective date of §333 of the Bankruptcy Code, providing for the appointment of a patient care ombudsman (PCO) in the bankruptcy of a health care business, only recently are bankruptcy courts beginning to offer some clarity and qualifications on the conditions and circumstances under which PCOs must or should be appointed. The first part of this article will review the statistics related to the appointment of a PCO, with some surprising results. The second part of this article will examine the evolving precedent regarding when bankruptcy courts will either find that the appointment of a PCO is inappropriate, because the case is simply not the bankruptcy of a "health care business" despite the health care-related services that the business provides, or that the appointment of the PCO is unnecessary "under the facts of the case."

Statistics Regarding the Appointment of PCOs


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The U.S. Trustee Program has tracked the disposition of cases that have implicated the issue of PCO appointments pursuant to §333. This section, which was enacted as part of the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 (BAPCPA) and applies to health care business cases commenced on or after Oct. 17, 2005, states:

> If the debtor in a case under chapter 7, 9 or 11 is a health care business, the 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.

Thus, the language of the statute appears to make the appointment of a PCO mandatory, unless the bankruptcy court finds that "the appointment...is not necessary for the protection of the [debtor's] patients under the specific facts of the case." Despite this seemingly mandatory language, more often than not a PCO is not appointed in cases that would seem to fall within the ambit of the statute.

As of September 2007, there had been 208 cases filed after BAPCA's effective date that implicated the appointment of a PCO. Of those cases, 29 involved debtors that were hospitals, 45 involved debtors that were skilled nursing facilities (SNFs), and 134 involved debtors that were another form of health care provider or business, including debtors that were individual practitioners, groups of practitioners and/or their professional corporations, clinics, home health care services and various miscellaneous health-related entities.

Those cases in which the appointment of a PCO was most likely were the 45 involving SNFs. In these cases, PCOs were appointed in 29 of the 45 cases or 64 percent of cases, while in the remaining 16 cases the appointment of a PCO was deemed unnecessary. Of the 16 cases in which a PCO was not appointed, 5 of the debtors were no longer operating SNFs, having either closed or sold the facilities. In the remaining cases, the bankruptcy court determined that the appointment of a PCO was not necessary for the protection of the patients.


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The next category in which the appointment of a PCO was most likely were those cases concerning hospitals. PCOs were appointed in 18 out of the 29 hospital cases or 62 percent of cases. In the remaining 11 cases in which PCOs were not appointed, 9 facilities were no longer operating, while in the remainder, the appointment of a PCO was found unnecessary for the protection of the patients.

The category of cases in which the appointment of a PCO was least likely to occur was that in which debtors were neither nursing homes nor hospitals, but instead were among a variety of health care-related entities. In this category, which includes 134 cases, PCOs were appointed in only 10 cases or 7.4 percent of cases. In the remaining 124 cases, debtors were found not to be health care businesses in 11 cases, and were found to have been non-operating in 11 other cases. In the remaining cases, the courts generally declined to reach the issue of whether the debtor was a health care business, determining only that given the circumstances of the case the appointment of a PCO was unnecessary.[2]

Thus, despite the seemingly mandatory language of §333, it is apparent that in more than half of the health care related bankruptcy cases filed since its enactment, no PCO was appointed.

PCO Statute in "Practice"

Courts seem to have concluded that §333 requires two discrete inquiries for determining whether the appointment of a patient care ombudsman is necessary: first, determining whether the debtor

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Intensive Care

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[2] *See, e.g., In re Total Woman Healthcare Center P.C.*, 2006 WL 3708164, at *3.

qualifies as a health care business, and second, determining whether the specific facts of the case make the appointment of an ombudsman unnecessary.

Is Debtor a "Health Care Business"?

Section 101(27A) of the Bankruptcy Code, which was also added to the Code as part of BAPCPA, defines a "health care business" as follows:

> (A) 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—
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> (i) the diagnosis or treatment of injury, deformity or disease; and
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> (ii) surgical, drug treatment, psychiatric, or obstetric care; and
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> (B) includes—
>
> (i) any—
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> (I) generalized or specialized hospital;
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> (II) ancillary, ambultatory, emergency, or surgical treatment facility;
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> (III) hospice;
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> (IV) home health agency; and
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> (V) other health care institution that is similar to an entity referred to in subclasses (I), (II), (III), or (IV); and
>
> (ii) any long-term care facility, including any—
>
> (I) skilled nursing facility;
>
> (II) intermediate care facility;
>
> (IV) home for the aged;
>
> (V) domiciliary care facility; and
>
> (VI) health care institution that is related to a facility referred to in subclasses (I), (II), (III), (IV), or (V), if that institution is primarily engaged in offering room, board, laundry, or personal assistance with activities of daily living and incidentals to activities of daily living. While this definition would seem to be quite broad, in practice bankruptcy courts have narrowed its scope.

In the *7-Hills Radiology LLC*[3] case, which was the first reported decision declining to appoint a PCO, the bankruptcy court focused on the issue of whether the debtor qualified as a health care business pursuant to §101(27A). The *7-Hills* court focused on the statutory text set forth in §101(27A)(A), defining a "health care business" as a business "that is primarily engaged in offering to the general public" health care services and facilities.[4] The court found that the debtor, which performed radiological tests only for patients referred by treating physicians, did not offer its services to the general public. The debtor did not advise the patients after the tests were performed, nor did it keep the patients' records. The *7-Hills* court chose to focus on §101(27A) and whether the debtor qualified as a health care business because, as the court remarked in footnote, "[o]ther consequences follow from the designation of a debtor as a health care business," including, *inter alia,* restrictions on the disposal of patient records[5] and the transfer of patients[6] and a special administrative priority granted to the expenses of winding up a health care business.[7] In other words, the designation of a debtor as a health care business has implications beyond simply the appointment of a PCO.

Another aspect of the *7-Hills* decision is noteworthy, particularly because other courts have considered the question also. In *dicta,* the court wrote:

> [the] language [of subparagraph (B) of §101(27A)] indicates that the type of health care businesses that were the primary targets of the definition were businesses that had some form of direct and ongoing contact with patients to the point of providing them shelter and sustenance in addition to medical treatment. That is the almost inescapable conclusion one draws from the focus on institutions in which patients are housed and treated.[8]

Citing *7-Hills Radiology,* the court in *In re Medical Associates of Pinellas LLC (Pinellas)*[9] in January 2007 set out a formal four-part test (which has since been followed by other courts[10]) for determining whether a debtor qualifies as a health care business pursuant to §101(27A)(A) such that the appointment of a PCO would be required pursuant to §333 (unless such ombudsman is found not necessary under the specific facts of the case): (1) the debtor must be a private or public entity, (2) the debtor must be primarily engaged in offering to the general public facilities and services, (3) the facilities and services must be for the diagnosis or treatment of injury, deformation, or disease, and (4) the facilities must be for surgical care, drug treatment, psychiatric care or obstetric care. The *Pinellas* court determined that the debtor, which provided support services of a largely administrative nature to doctors, including billing, insurance, human resources and related financial services, as well as some laboratory support, was not a health care business because it did not offer its services generally to the public. The *Pinellas* court found that the debtor did not advertise to procure patients for the doctors, and the doctors did business in their own names or the names of their individual professional associations.

The *Pinellas* court, in *dicta* of its own, cited legislative history from efforts in 1999 and 2000 to amend the Bankruptcy Code that seemed to be consistent with "the concept that a health care business was intended to refer to inpatient care facilities such as hospitals and nursing homes and not most outpatient facilities such as a doctor's office."[11]

> [I]n Senate discussions...of the health care amendments that appeared in the Bankruptcy Reform Act of 1999 (which are virtually the same as the BAPCPA amendments), Senator Grassley stated, "I was shocked to realize that the Bankruptcy Code doesn't require bankruptcy trustees and creditor committees to consider the welfare of patients *when closing down or reorganizing a hospital or nursing home.*'"(emphasis in the original)[12]

The *Pinellas* court cited additional statements by Sen. Grassley also suggesting that the PCO provisions were intended to apply mostly to health care businesses "such as hospitals or nursing homes." Similarly, in another 2006 case in the Middle District of North Carolina

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

4 350 B.R. at 904.

5 11 U.S.C. §351.

6 11 U.S.C. §704(a)(12).

7 11 U.S.C. §503(b)(8).

8 *In re 7-Hills,* at 905.

9 *In re Medical Associates of Pinellas L.L.C.,* 360 B.R. 356 (Bankr. M.D. Fla. 2007).

10 *See, infra, In re Alternate Family Care,* 377 B.R. 754, 757-758 (Bankr. S.D. Fla. 2007), and *In re William L. Saber, M.D., P.C.,* 369 B.R. 631, 635-637 (Bankr. D. Colo. 2007).

11 *Pinellas, supra* at 361.

12 *Id.*

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involving a "defunct" dental practice, the court stated that "the types of businesses listed [in §101(27A)(B)] are all of such a similar nature in that they provide both housing and treatment...that it is difficult to imagine that the legislature would have intended a business that is so fundamentally different, such as an outpatient dental practice, to be read into the definition."[13]

Distinctions in the (Limited) Case Law

The court in *In re William L. Saber, M.D., P.C.* noted in response to the debtor's argument that it performed only "minor surgeries with a local anesthesia" that the statute does not differentiate between minor and major surgeries. Indeed, the *Saber* court noted that §101(27)(B) uses the word "includes," which is not a limiting word under the Code, meaning that the list of entities contained in subsection (B) is not exhaustive and that there could therefore be other entities that meet the definition of a health care business other than those listed.[14] Contrary to the *dicta* in *Pinellas,* the court in *Saber* declined to look at the statute's underlying legislative history, because it found the statute unambiguous.[15] Thus, it appears at present that this issue is still subject to some interpretation.[16]

Necessity of Appointing PCO

The *Alternate Family Care*[17] case, decided in October 2007, introduced a totality-of-the-circumstances test for evaluating whether the specific facts of a case made the appointment of a PCO unnecessary. The court set forth a list of nine (nonexclusive) factors surrounding the bankruptcy filing and debtor's operations to be examined in considering the totality of the circumstances:

1. the cause of the bankruptcy;
2. the presence and role of licensing or supervising entities;
3. the debtor's past history of patient care;
4. the ability of the patients to protect their rights;
5. the level of dependency of the patients of the facility;
6. the likelihood of tension between the interests of the patients and debtor;
7. the potential injury to the patients if the debtor drastically reduced its level of patient care;
8. the presence and sufficiency of internal safeguards to ensure appropriate level of care; and
9. the impact of the cost of an ombudsman on the likelihood of a successful reorganization.

The *Alternate Family Care* court found that only two of the nine factors weighed in favor of the appointment of an ombudsman, while the other seven factors, including particularly the fact that the debtor was under significant supervision and oversight from other state and private entities and the debtor's "remarkable track record of excellence" in caring for its patients (emotionally disturbed children receiving psychiatric residential treatment services and foster children receiving temporary care) over the course of 20 years, weighed against the appointment of an ombudsman.[18]

Two other cases decided prior to the *Alternate Family Care* case are also worthy of note for declining to order the appointment of an ombudsman based on the circumstances of the case (although, of course, these cases did not employ a formal totality-of-the-circumstances test). Both focused on the cause of the filing of the bankruptcy petition and the fact that the debtors testified that they understood their responsibilities with respect to patient records as the reasons for declining to order the appointment of an ombudsman. The first case is *In re Saber,* discussed above, in which the court found that the debtor qualified as a health care business under §101(27A), but then found that the appointment of a patient care ombudsman was unnecessary because the debtor's "bankruptcy filing was not precipitated by concerns relating to the quality of patient care or patient privacy matters but to the entry of a state court judgment based on a contractual dispute between the debtor and a physician formerly employed by the debtor."[19] The *Saber* court seemed to be principally concerned with the role that a PCO might play in protecting the privacy of patient records. In summing up its recitation of the circumstances that made the appointment of an ombudsman unnecessary in the case, the court stated that it was "satisfied the debtor has sufficient procedures in place to enable it to continue to protect the privacy of its patients."[20]

Similarly, in *In re Total Woman Healthcare Center, P.C.,*[21] a case involving a sole practitioner, board certified in obstetrics and gynecology, who performed physical exams, ultrasounds and biopsies at her offices and surgeries, deliveries and outpatient services at two local hospitals, the court emphasized that tax obligations, not deficient patient care, were the cause of the bankruptcy filing.[22] The court also found that the debtor's "financial distress had not affected patient care" and that the debtor "understands her obligation to maintain patient records and to provide copies of the records to patients who decide to see another physician."[23] Having determined that the appointment of an ombudsman was unnecessary under the

13 *In re Anne C. Banes, D.D.S. P.L.L.C.,* 355 B.R. 532, 535 (Bankr. M.D.N.C. 2006). The court declined to order the appointment of a patient care ombudsman in this case because the debtor, who had no active patients, failed to qualify as a health care business. The *Banes* court wrote: "The plain language of the statute states that it applies to any entity that 'is primarily engaged in offering' health care services to the general public. Congress chose to write this statutory definition in the present tense, indicating that it was concerned with appointing patient care ombudsmen in cases where health care businesses seeking bankruptcy protection are currently engaged in the ongoing care of patients." *Id.*

14 *In re William L. Saber, M.D., P.C.,* 369 B.R. 631, 635-637 (Bankr. D. Colo. 2007).

15 *Id.* Ultimately, the *Saber* court concluded that the debtor fit squarely under the definitional requirements of §101(27A)(B) as a "surgical treatment facility."

16 **Nancy Peterman**, who assisted in drafting the health care provisions of BAPCPA, **Sherri Morissette** and **Suzanne Koenig** have written that "in drafting the definition of heath care business, the intent of the legislators was to make the definition as broad as possible; thus, ensuring a broad application of BAPCPA's health care provisions for the protection of patients." *See* "Why So Many Excuses to Avoid Appointment of a Patient Care Ombudsman?," *ABI Health Care Committee eNewsletter* (August 2007).

17 *In re Alternate Family Care,* 377 B.R. 754 (S.D. Fla., 2007); *Pinellas,* 360 B.R at 360 (also recognizing that "includes" is not a limiting term).

18 It might be argued that some of the nine articulated factors do not appear to be very closely related to the language of the statute and are therefore not particularly relevant to the appointment of a patient care ombudsman, especially the "the cause of the bankruptcy filing" and the cost of the PCO on the ability of the debtor to reorganize. On the other hand, the history of the debtor's patient care, the presence of other inspectors or regulators, and the presence and sufficiency of internal safeguards seem to be the kind of factors courts should consider. The statute says that the court must determine whether a PCO is necessary to protect the patients under the facts of the case. If a facility is awash in state or federal regulators, has good internal controls and quality control systems and has a history of good care (which may be inconsistent with being awash in state and federal regulators as a practical matter), then it would seem a fair bet that a court could find that there was no need to appoint yet another inspector to review the patient care.

19 *In re Saber,* at 637.

20 *Id.* at 638.

21 2006 WL 3708164 (Bankr. M.D. Ga., 2006).

22 The debtor's "obligations do not arise from deficient patient care." *Id.* at *2.

23 *Id.* Peterman, et al. have argued that the question of whether issues of patient care precipitated a debtor's bankruptcy filing should not be determinative in deciding whether a PCO should be appointed given the fact that "patient care issues can arise at any time," and, in fact, may be more likely to arise after a bankruptcy filing because post-petition events can often affect a debtor's priorities in unanticipated ways. *See* "Why So Many Excuses to Avoid the Appointment of a Patient Care Ombudsman?," *supra* note 16.

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circumstances of the case, the court declined to decide whether the debtor was a health care business.

Recent Representative Challenge to a PCO

In re Pleasant Care Corporation, et al.[24] illustrates some other means and nuances that have been used to challenge the appointment and continued service of a PCO. In that case, the debtors and the official committee of unsecured creditors joined forces to have a PCO removed from a case almost immediately after his appointment, arguing that he failed to make disclosures as required by Bankruptcy Rule 2007, he was not disinterested as required by §333 and because, generally, a PCO was not necessary for the protection of the patients in this case pursuant to Bankruptcy Rule 2007.2.

Disinterestedness. The motion was based, in part, on the fact that the PCO submitted a Bankruptcy Rule 2007 statement, which required disclosures of "connections" with, among other things, creditors, but failed to disclose a connection to the secured creditor in the case. The PCO's disclosure made no mention of his involvement in and assistance to the pre-petition effort by the debtors' secured lender to appoint a state court receiver over the debtors—the act that precipitated the filing of the bankruptcy by the debtors. In the week prior to the petition being filed, the PCO had worked with counsel for the secured lender regarding the receivership, provided comments on at least one draft document related to the receivership effort, had his law firm expressly named as counsel in the proposed order appointing the receiver, and was present in state court as part of the secured lender's "team" when the receivership effort was halted by the filing of the bankruptcy petition. Despite these connections to the secured lender and its possible connection to the bankruptcy case, in his disclosure statement the PCO failed to disclose this connection with the debtors' major secured creditor. This failure, it was argued, provided an independent ground to terminate the appointment of this particular PCO, without regard to whether the connection itself rendered him not a disinterested person, or whether a PCO was generally required.

Further, the PCO failed to disclose a connection with a competitor of the debtor's current management—a relationship which, it was argued, might well have provided a financial motive for the PCO to try to ensure that the debtors were unsuccessful in their efforts to reorganize, and might have rendered the PCO to be nondisinterested. The PCO allegedly had a long and financially important relationship with a company that had a near monopoly on health care receiverships in California, having been paid nearly 75 percent of all the State of California's funds expended for such receiverships since 2001 (more than $10 million in total). It was argued that if the debtors successfully reorganized, they might present a competitor to the company with which the PCO had had a long relationship in future health care receivership work, and thus, the PCO had an economic incentive to work against the debtors and their efforts to reorganize the debtors' operations. Additionally, it was argued that the state was a major party in interest in the case and the PCO should have disclosed his financial relationship to it. None of this was disclosed by the PCO in his Rule 2007 statement and, it was argued, that rule provides an independent ground to terminate the appointment of this particular PCO, without regard to whether the connection itself rendered him not a disinterested person, or whether a PCO was generally required.

Appointment Unnecessary. The debtors and the committee also argued that Bankruptcy Rule 2007.2 provides that the court may terminate the appointment of the PCO if a party in interest shows that the appointment is not necessary to protect the patients. Here, they argued, there were more than adequate grounds to make that finding: (1) the debtors' pre-petition management had been replaced completely by a highly respected operator and "turnaround" specialist of SNFs; (2) the debtors had retained the services of a trained nurse, licensed skilled nursing facility administrator and former SNF owner to serve as the Chief Clinical Officer with a responsibility to improve patient care; (3) the debtors' management had supplemented the debtors' existing staff with numerous quality-assurance clinical nurses who were directly responsible for overseeing and improving the quality of patient care at the debtors' facilities; (4) the debtors were subject to an Independent Quality Monitor under a Corporate Integrity Agreement with the U.S. Department of Health and Human Services, under which they are closely monitored and under which regular reports on the quality of patient care are provided to, at least, the federal government, and which cost the estate $17,000 per week; (5) the debtors were subject to regular oversight by the State Long Term Care Ombudsman, which monitors the quality of patient care; (6) the debtors were subject to frequent inspections by the State of California Department of Health Services; (7) the PCO was an attorney who expressed some intent to discharge his duties by merely hiring additional nurses who would have duplicated the existing efforts to monitor and improve patient care; and (8) the debtors' Financing Order, which allowed them to obtain post-petition financing and use of cash collateral pursuant to a pre-approved budget, did not include the PCO's estimated fees of $170,000 for the first two months of his employment and, therefore, payment of those fees might result in an event of default causing the termination of the debtors' post-petition financing.

> *[T]he case law relating to the definition of what constitutes a health care business for purposes of appointing a PCO pursuant to §333 remains somewhat unsettled.*

The bankruptcy court granted the motion of the debtors and the committee in the *Pleasant Care* case, finding that under the facts of the case, no further protection for the patients was required. Therefore, the court in that case never addressed the issue of whether the PCO

[24] Chapter 11 Case No.: LA 07-12312-EC, Jointly Administered with Cases Nos.: LA 07-12316-EC, LA 07-12319-EC; LA 07-12322-EC; and Case No. LA 07-12326-EC. These cases are still pending the Central District of California, Los Angeles Division.

had not been disinterested.

Conclusion

While the *Pinellas* case offered a four-part test for determining whether a debtor is a health care business, the case law relating to the definition of what constitutes a health care business for purposes of appointing a PCO pursuant to §333 remains somewhat unsettled. It does appear that based on the language of §101(27A)(A), a debtor must provide health care services to the general public. *Dicta* in certain cases, however, has raised the issue of whether only institutional debtors providing both treatment and housing to patients should be considered health care businesses for purposes of appointing PCOs. As noted above, in the vast majority of cases in which the debtor was neither a hospital nor a nursing home, the courts have declined to order the appointment of a PCO, and in those cases, the courts have generally avoided deciding the issue of whether the debtor was a health care business, content instead to determine only that the appointment of a PCO was unnecessary.

With respect to debtors generally, the factual circumstances impacting the decisions not to order the appointment of a PCO do not lend themselves to easy categorization. The only constant appears to be that the courts made their determinations based on an examination of the totality of the facts. The recent decision by the court in the *Alternate Family Care* case suggested a nonexclusive nine-part test for weighing the totality of the circumstances, although some of the factors set forth in that decision seem not altogether relevant for making the determination to appoint a PCO. Even so, in health care cases, the debtor, if it seeks to avoid the appointment of an ombudsman, has the burden of establishing a solid evidentiary basis from which to argue that the appointment of a PCO in its case is unnecessary to protect the patients at the facility or debtor. ■