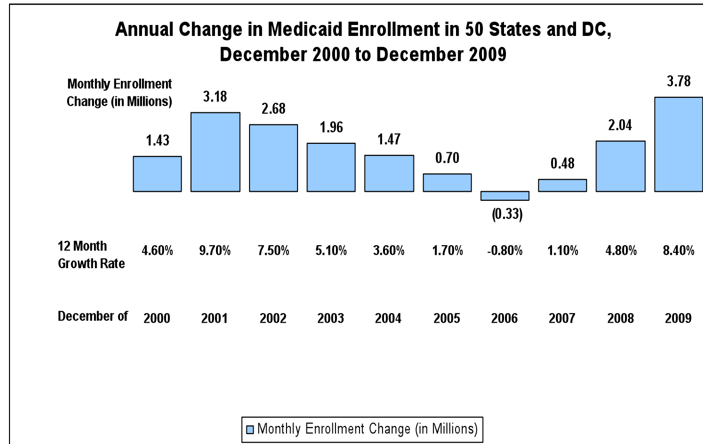
Changes in Medicaid Enrollment



- Medicaid enrollment rose by 3.78 million between December 2008 and December 2009, the program's largest absolute 12-month enrollment increase since the early days of implementation in the late 1960s
- Medicaid enrollment has risen by nearly 6 million (13.6%) since the start of the recession in December 2007. Between that month and December 2009, the nation's unemployment rate doubled from 5.0% to 10%
  - As many Americans lost jobs, incomes, and access to affordable employer coverage, Medicaid enrollment rose to 48.57 million in December 2009
  - Millions more who did not qualify under their state's existing Medicaid eligibility criteria likely joined the ranks of America's now 50 million uninsured

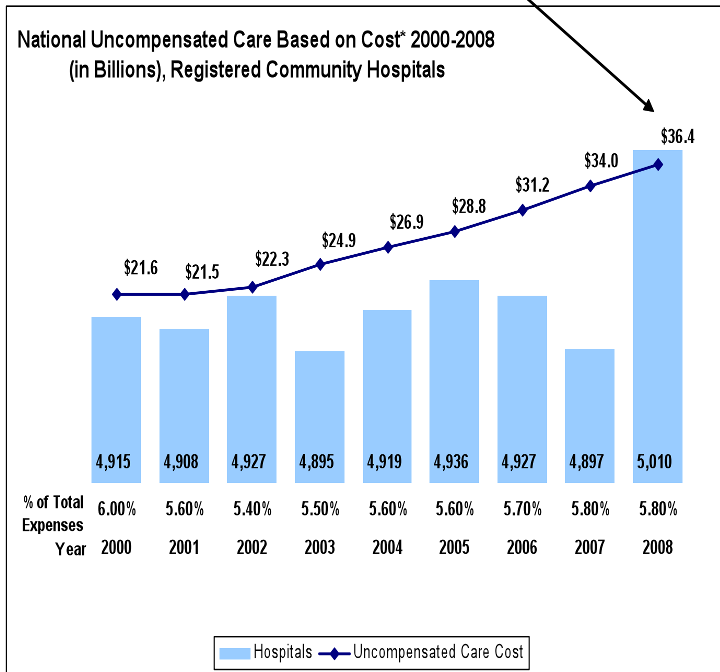
Source: Kaiser Commission on Medicaid Facts, "Medicaid and the Uninsured," September 2010

© 2010 Mesirow Financial Holdings, Inc. All rights reserved.

Rise in National Uncompensated Care

- The uncompensated care figures represent the estimated cost of bad debt and charity care to the hospital
- This figure is calculated for each hospital by multiplying uncompensated care charge data by the ratio of total expenses to gross patient and other operating revenues
- The total uncompensated care cost is arrived at by adding together all individual hospital values. The uncompensated care figure does not include Medicaid or Medicare underpayment costs, or other contractual allowances. Moreover, the figure does not take into account the small number of hospitals that derive the majority of their income from tax appropriations, grants and contributions

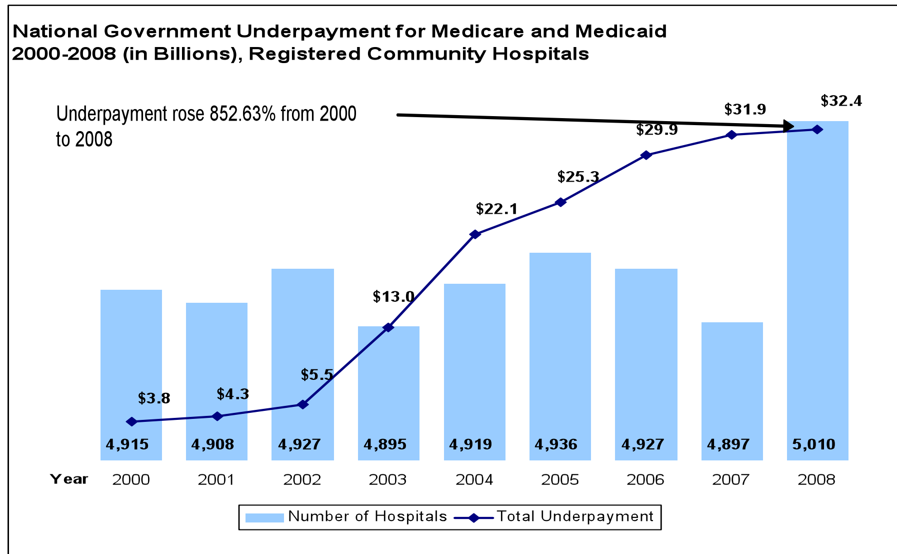
National Uncompensated Care Based on Cost rose a total of $168.52% from 2000 to 2008



Source: American Hospital Association, American Hospital Association Uncompensated Hospital Care Cost Fact Sheet, November 2009

© 2010 Mesirow Financial Holdings, Inc. All rights reserved.

National Government Underpayment for Medicare and Medicaid



- Payment rates for Medicare and Medicaid, with the exception of managed care plans, are set by law rather than through a negotiation process as with private insurers. These payment rates are currently set below the costs of providing care resulting in underpayment. Payments made by managed care plans contracting with the Medicare and Medicaid programs are generally negotiated with the hospital
- Hospital participation in Medicare and Medicaid is voluntary. However, as a condition for receiving federal tax exemption for providing health care to the community, not for profit hospitals are required to care for Medicare and Medicaid beneficiaries. Also, Medicare and Medicaid account for 55 percent of all care provided by hospitals. Consequently, very few hospitals can elect not to participate in Medicare and Medicaid

Source: American Hospital Association, American Hospital Association Underpayment by Medicare and Medicaid Fact Sheet, November 2009

© 2010 Mesirow Financial Holdings, Inc. All rights reserved.

Massachusetts Investigation Shows System-Wide Failings

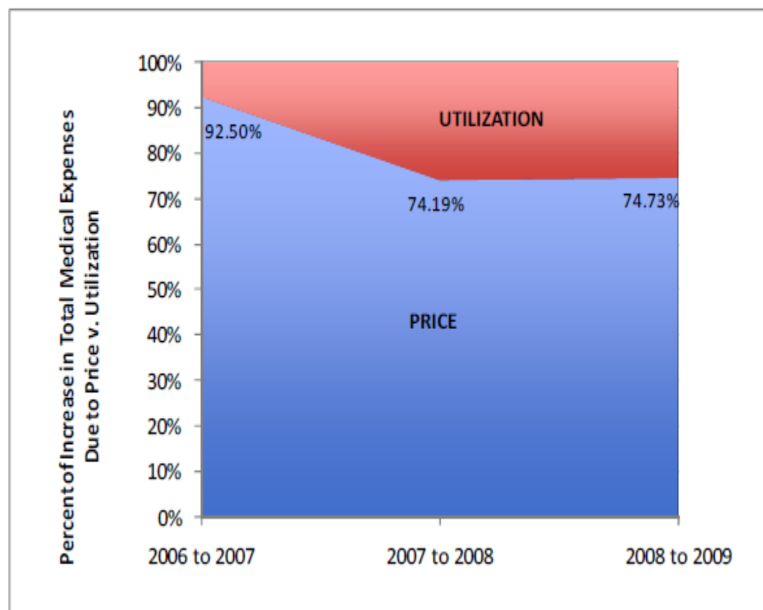
- On January 29, 2010, the Office of the Attorney General of Massachusetts released a preliminary report based on its ongoing investigation of health care cost trends and cost drivers. The investigation concluded:
  - Prices paid by health insurance companies to hospitals and physician groups vary significantly within the same geographic area and amongst providers offering similar levels of service
  - Price variations **are not** correlated to:
    - Quality of care
    - Sickness or complexity of the population being served
    - Extent to which a provider is responsible for caring for a large portion of patients on Medicare or Medicaid
    - Whether a provider is an academic teaching or research facility
  - Price variations **are** correlated to:
    - Market leverage as measured by the relative market position of the hospital or provider group compared with other hospitals or provider groups within a geographic region
    - Certain hospitals are able to negotiate higher rates because of their geographic location, subjective consumer "brand" perceptions, and/or specialty service lines
  - Hospital capital ratios suggest that more highly paid providers are able to build new buildings, purchase new equipment and technology and add to their cost structure. Lower paid providers, in contrast, are unable to put necessary resources into building maintenance or equipment acquisition

Source: Massachusetts AGO Preliminary Report, Investigation of Health Care Cost Trends and Cost Drivers, January 29, 2010

© 2010 Mesirow Financial Holdings, Inc. All rights reserved.

Massachusetts Investigation Shows System-Wide Failings

A Major Health Plan's Cost Drivers From 2006-2009: Price as a Driver of Total Medical Expenses



NOTES

(1) Cost drivers are expressed as a percent of unadjusted Allowed Medical Claims trend.

(2) The 2006-2008 data reflects 6 month re-forecasted analysis; the 2009 data is based on an initial projection.

- Price increases, not increases in utilization, caused most of the increases in health care costs during the past few years in Massachusetts

Source: Massachusetts AGO Preliminary Report, Investigation of Health Care Cost Trends and Cost Drivers, January 29, 2010

© 2010 Mesirow Financial Holdings, Inc. All rights reserved.

Perfect Solution—Just Ask House

Source: Fox.com/House

© 2010 Mesirow Financial Holdings, Inc. All rights reserved.

PPACA AND A HOSPITAL IN BANKRUPTCY

By Carol E. Jendrzey, Partner, Cox/Smith

In 2005, the Bankruptcy Abuse Prevention and Consumer Protection Act ("BAPCPA") went into effect. Some of the more striking changes that came about with BAPCPA related to health care bankruptcies. Although there continue to be disagreements as to the need for and the interpretation of certain of the new BAPCPA provisions relating to health care bankruptcies, there was compelling testimony about patients and/or nursing home residents virtually abandoned when facilities were abruptly closed in support of having such provisions during the congressional hearings. Thus, in an effort to curtail these nightmares, provisions relating to the appointment of patient care ombudsman and the disposition of medical records were enacted. Five years later, on March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (P.L. 111-148) ("PPACA") into law. The following is a discussion of certain provisions of the United States Bankruptcy Code (the "Bankruptcy Code") and the Federal Rules of Bankruptcy Procedures (the "Bankruptcy Rules") and how PPACA may relate to them in health care bankruptcy proceedings.

Medicare Reimbursements Down, Medicare Reimbursements Up

Under PPACA, there is going to be an increasing emphasis on preventive outpatient care. Even public or not for profits hospitals are looking to develop more outpatient clinics in light of the change of focus from acute care to preventive care. Under PPACA, Medicare reimbursements are expected to decrease, while Medicaid payments are suppose to increase and be more in line with Medicare reimbursements. Specifically, beginning in 2013, Medicaid payments will increase for fee-for-service and managed care for services provided by primary care physicians. However, the known decrease in reimbursements to Medicare is only part of the story.

In a bankruptcy, the debtor's ability to accurately project cash flow will affect its ability to obtain post petition financing during the case. Certain provisions of PPACE will impact the reimbursements to the debtor from the government. In the past, the debtor's concern related to recoupments due to alleged overpayments by the Medicare and Medicaid. Beginning in 2012, Medicare payments will be reduced by specified percentages to account for excess, allegedly, preventable hospital readmissions. Sec 3025 Although it is easy to fault the facility, especially one who is financially stretched, for the patient's readmission it is often the patient's non-compliance that results in the readmission. Indeed, one of the criticisms regarding PPACA is that the hospitals should not be penalized for readmission of patients when it is the patient who failed to follow instructions. Thus, hospital debtor may want to consider a case manager who monitors the patients and makes sure that they are complying with health care instructions, which may reduce the readmissions.

In 2015, hospital Medicare payments may also be reduced due to hospital acquired conditions. Sec. 3008 Additionally, beginning in 2011, states will not be permitted to receive Medicaid services for health care acquired conditions. Although on its face it would appear that the government is moving towards an outcome as opposed to procedure based payment system, it does create a great deal of uncertainty in connection with cash flow during a bankruptcy. This coupled with the fact that physicians, which are the patient generators, are already uncertain about referring patients to a hospital in bankruptcy, may make them less likely to refer.

Another area where there will be reductions is in the area of disproportionate share hospitals ("DSH"). In addition to the other amounts payable under the Medicare and Medicaid programs, the DSH program makes payments to certain qualifying hospitals serving a disproportionate share of low-income patients. *In re Cha Hawaii, LLC*, 426 B.R. 828 (Bankr. Haw. 2010). The purpose behind DSH payments was to

supplement hospitals that were strained by taking a disproportionate share of low income patients; thus, this will impact cash flow during the bankruptcy and possibly the Debtor's ability to obtain financing during the case.

Under PPACA, payments under Medicaid for primary care will be increased to Medicare rates. Unfortunately, the increase in rate is not a panacea for physicians. Medicare reimbursements are not that high, so the rate increase may not make that much difference. Also, PPACA does not address care for illegal immigrants. Thus, the treatment of illegal immigrants will continue to be an issue for the public hospital sector.

Involuntary Cases

Section 303 of the United States Bankruptcy Code states that a creditor may not commence a case against "a corporation that is not a moneyed, business, or commercial corporation." As discussed above, under PPACA, there will be a reduction in the amounts paid to providers under Medicare and Medicaid. The anticipated result of such reduction is fewer providers, physicians and other health care entities will accept patients covered under Medicare and Medicaid. This in turn would mean that more patients will turn to not for profit or charitable facilities for their care. Although non-profits, unlike their for profit counterparts, do not need to worry that their creditors will commence an involuntary against them if the non-profit fails to pay its debts, it does have to worry that the creditor will cease to supply it if it does not continue to pay its debts.

If a group of creditors do elect to commence an involuntary case against a health care provider or entity, there should be some consideration as to the effect of commencing a chapter 11 versus a chapter 7. Most chapter 7 trustees do not want the responsibility for operating a health care facility and may not have the necessary experience. Closing down an operating facility can take weeks to months to accomplish. An abrupt closure of a health care entity can be like bungee jumping without knowing the

length of the cord. Issues related to the transfer of patients and records are of the utmost concern. However, depending on the type of facility, there are additional concerns about securing and disposal of controlled substances, radioactive materials and other hazardous materials. Closure of a health care facility always makes the press, so is closing a facility the type of press the creditor wants for his company.

Other Issues with Government Receivables

Although it appears that there may be new issues with government receivables under PPACA, the past issues seem to be resolved. In the past, the issues related to government receivables revolved around whether a lender could have a lien against government receivables. Financing that utilizes government receivables as collateral is often done. However, an issue arose over the provision in the Social Security Act which stated that "[n]o payment which may be made to a provider of services under this subsection for any service furnished to an individual shall be made to any other person under an assignment or power of attorney." 42 U.S.C. § 1395g. A similar regulation is in place as to Medicaid receivables. 42 U.S.C. § 1396a(32). Thus, it appeared that a lien against government receivables was not enforceable. However, the Fifth Circuit in *Wilson v. First National Bank (In re Missionary Baptist Found. of Am, Inc.)*, 796 F.2d 752 (5th Cir. 1986), held that the debtor's use of Medicare and Medicaid reimbursement payments to collateralize a bank loan did not violate the Social Security Act.

Events Following the Filing of a Voluntary Case

The commencement of a voluntary case, regardless of whether it is under chapter 7, chapter 9 or chapter 11 will trigger certain events in a health care bankruptcy. Specifically, the appointment of a Patient Care Ombudsman under Section 333 of the Bankruptcy Code and possibly the appointment of a Consumer Privacy Ombudsman under Section 332. I have not seen any health care bankruptcies where the United States Trustee has appointed both a Patient Care Ombudsman and a Consumer Privacy

Ombudsman. The need for the appointment of a Consumer Privacy Ombudsman arises in the case where there is a sale under Section 363 of the Bankruptcy Code that involves the sale of personally identifiable information under section 363(b)(1)(B). In the sale of a health care entity or the sale of its receivables, the issue of disclosure of personally identifiable information is apparent and will need to be addressed. These issues are well within the scope of the role of the Patient Care Ombudsman.

A health care entity that files for bankruptcy may also need to take extra steps in providing notice under Section 342 of the Bankruptcy Code. Under Section 342 of the Bankruptcy Code and Rule 2002 of the Bankruptcy Rules the notice of relief and of the creditors meeting must be provided to the debtor, the trustee, all creditors and indenture trustees. Providing notice to vendors is not an issue; however, notice to current and previous patients is more problematic. One of the most daunting issues in a healthcare bankruptcy case is maintaining patient privacy and confidentiality.

Generally, hospitals and long term care providers must comply with HIPAA because they or a retained service provider electronically transmit health care information for purposes of billings. The Privacy Rule protects all "individually identifiable health information." 45 C.F.R. § 160.103. Individually identifiable health information includes, but is not limited to, the name and address of the individual. Providing notice of the bankruptcy to patients who could have claims, be it for patient refunds or for tort claims should be done in compliance with HIPAA.

The bankruptcy courts are also sensitive to this issue. In the past, courts[1] have allowed the debtors to file portions of the debtors' schedules and statements under seal. In both cases, the debtors filed motions with the bankruptcy court prior to the date that

---

[1] *In re Shreveport Doctors Hospital 2003, Ltd*, Case No. 07-10415, pending in the United States Bankruptcy Court for the Western District of Louisiana – Shreveport Division; *In re Moore Medical Center, LLC*, Case No. 06-12867, pending in the United States Bankruptcy Court for the Western District of Oklahoma.

schedules and statements were due. In these cases the debtors requested authorization to file separate schedules for potential non-public patient claims (the "Patient Schedules"), and authorization to exclude these names from the published creditors' matrix. The Patient Schedules are then filed under seal. Unfortunately, this undertaking then imposes additional burdens on the debtor going forward. For one, the debtor is now responsible for sending out the notice of bankruptcy, which in most jurisdictions is handled by the clerk's office. Also, any other notices or pleadings that a particular jurisdiction's clerk's office would normally distribute, now must be done by the debtor.

In physician operated health care entities or practices, there also are often state rules related to physicians' duties to notify their patients when the practice or clinic is closed. For example, in Texas the Chapter 165 of Medical Board Rules require that "[w]hen a physician retires, terminates employment or otherwise leaves a medical practice, he or she is responsible for … ensuring that patients receive reasonable notification." Notification is accomplished under the Medical Board Rules by (a) publishing notice in the newspaper; (b) placing written notice in the physician's office; and (c) sending letters to patients seen in the last two years. Failure to comply with these notice requirements could subject the physician to disciplinary actions. Serious thought when filing health care cases should be given to the notice of relief in chapter 7 cases including a provision that notifies patients that the health care entity has or will cease to operate and instructions on the disposition of medical records.

Section 351, Disposal of Patient Records

The disposition of patient records is a difficult area for practitioners. Generally, if the health care entity is going to be reorganized or sold, the reorganized or purchasing entity assumes custody of the medical records. If that is not the case, Section 351 of the

Bankruptcy Code provides explicit instructions on how the disposal is to take place. Specifically, Section 351 states that:

> If a health care business commences a case under chapter 7, 9, or 11, and the trustee does not have a sufficient amount of funds to pay for the storage of patient records in the manner required under applicable Federal or State law, the following requirement shall apply:
>
> (1) The trustee shall—
>
> (A) promptly publish notice, in 1 or more appropriate newspapers, that if patient records are not claimed by the patient or an insurance provider (if applicable law permits the insurance provider to make that claim) by the date that is 365 days after the date of that notification, the trustee will destroy the patient records; and
>
> (B) during the first 180 days of the 365-day period described in subparagraph (A), promptly attempt to notify directly each patient that is the subject of the patient records and appropriate insurance carrier concerning the patient records by mailing to the most recent known address for that patient, or a family member or contact person for that patient, and to the appropriate insurance carrier an appropriate notice regarding the claiming or disposing of patient records.
>
> (2) If, after providing the notification under paragraph (1), patient records are not claimed during the 365-day period described under that paragraph, the trustee shall mail, by certified mail, at the end of such 365-day period a written request to each appropriate Federal agency to request permission from that agency to deposit the patient records with that agency, except that no Federal agency is required to accept patient records under this paragraph.
>
> (3) If, following the 365-day period described in paragraph (2) and providing the notification under paragraph (1), patient records are not claimed by a patient or insurance provider, or request is not granted by a Federal agency to deposit such records with that agency, the trustee shall destroy those records by-
>
> (A) if the records are written, shredding or burning the records; or
>
> (B) if the records are magnetic, optical, or other electronic records, by otherwise destroying those records so that those records cannot be retrieved.

Clearly, this is an expensive process. The provisions under PPACA that relate to the transition to electronic medical records ("EMR") will go a long way in mitigating the expense in this area. The American Recovery and Reinvestment Act of 2009 (the "Stimulus Package") that went into effect in February provides for grants to assist hospital and health care providers implement and use electronic health records. Unfortunately, at this time hospitals and other health care facilities are in a transition

period and due to the medical record retention laws of the various states, the problem of storage and disposal of medical records continues to be an expensive and difficult issue for debtors and trustees.

Conclusion

At this juncture, it is not completely clear how the Patient Protection and Affordable Care Act will affect health care entities that file for bankruptcy protection. The most significant effect will be the new law's effect on reimbursements. The debtor's ability to project cash flow and its constituent's ability to rely on those projections will influence the debtor's ability to obtain financing, buy supplies, retain staff, and attract physicians to refer patients to the health care entity. In the end, it will affect the health care entity's ability to deliver medical care.

16th ANNUAL ROCKY MOUNTAIN BANKRUPTCY CONFERENCE

Analysis of Patient Ombudsman Case Law Related to Healthcare Bill

November 15, 2010

Duane H. Gillman
Jessica G. Peterson
Lena Cetvei
DURHAM JONES & PINEGAR

I. Patient Care Ombudsman Statute

In 2005, Congress enacted § 333 of the Bankruptcy Code[2] addressing the appointment of a Patient Care Ombudsman. Although different types of ombudsmen are used in different situations,[3] this article will focus solely on the patient care ombudsman appointed to protect patients in bankruptcies of health care businesses.

Section 333 provides that if a debtor in a case under Chapter 7, 9, or 11 is a health care business,[4] the court is required to appoint an ombudsman no later than 30 days after the commencement of the case.[5] The ombudsman's purpose is to monitor the quality of patient care and represent the interests of the patients of the health care business.[6] The court does not have to appoint an ombudsman if under the specific facts of the case, the court finds that the appointment of such ombudsman is not necessary for the protection of patients.[7]

Section 333 outlines specific duties an ombudsman is required to perform. First, the ombudsman must monitor the quality of the patient care provided to the debtor's patients to the extent necessary, including interviewing patients and physicians.[8] Second, the ombudsman no later than sixty days after appointment and at sixty day intervals

---

[2] Title 11 of the United States Code.

[3] Two other types of ombudsmen are consumer privacy ombudsmen and long term care ombudsmen. A consumer privacy ombudsman is governed by 11 U.S.C. §§ 363(b) and 332. Consumer privacy ombudsmen are appointed by a U.S. Trustee to provide the court information regarding the proposed sale or lease of personally identifiable consumer information by the debtor business. 11 U.S.C § 332(b). Long term care ombudsmen are governed by the federal Older Americans Act, which requires every state to have an ombudsman program that addresses complaints and advocates for improvements in the long term care system. *National Ombudsman Recourse Center*, Nov. 2007. Long term care ombudsmen are advocates for residents of nursing homes, board and care homes, and assisted living facilities, and they provide information about how to find a facility and how to get quality care in addition to assisting with complaints and resolving problems confidentially.

[4] "Any public or private entity…that is primarily engaged in offering to the general public facilities and services for – (i) the diagnosis or treatment of injury, deformity, or disease; and (ii) surgical, drug treatment, psychiatric, or obstetric care…." 11 U.S.C. § 101(27A).

[5] 11 U.S.C. § 333(a)(1).

[6] *Id.*

[7] *Id.*

[8] *Id.* at § 333(b)(1).

thereafter shall report to the court regarding the quality of patient care provided to the debtor's patients.[9] Finally, if the ombudsman determines that the quality of patient care provided to the debtor's patients is declining significantly or is being materially compromised, he or she must file a motion or written report with the court with notice to the parties in interest immediately upon making such a determination.[10]

II. Litigated Issues Surrounding Patient Care Ombudsman Statute

Since Congress enacted § 333 in 2005, there have been only a handful of cases discussing the patient care ombudsman statute. The majority of the case law addresses the issue of how to determine when it is necessary for a U.S. Trustee to appoint a patient care ombudsman (PCO). Another issue that will likely be contested in the future, with only a few cases discussing it so far, is the issue of whether a patient care ombudsman can or must have legal counsel.

A. Is an Ombudsman Necessary?

In determining whether to appoint a PCO, a court must perform a two part test.[11] First, the court must decide if the debtor is a health care business under 11 U.S.C. § 101(27A).[12] If the court finds that the debtor is a health care business, the court must appoint an ombudsman unless it finds that such an ombudsman is not necessary for the protection of patients.[13] Most of the courts that have interpreted the issue of whether an ombudsman is necessary to protect patients have determined that an ombudsman is not necessary.[14]

In analyzing whether a debtor is a health care business, courts look to several factors, which some courts have distilled into a four part test.[15] First, the debtor must be a private or public entity. Second, the debtor must be primarily engaged in offering facilities and services to the general public. Third, the facilities and services must be for the diagnosis or treatment of injury, deformity or disease. And finally, the facilities must be for surgical care, drug treatment, psychiatric care or obstetric care.

In the *In re Alternate Family Care* case, the court found that a facility that provides care for emotionally troubled children was considered a health care business.[16]

---

[9] *Id.* at § 333(b)(2).
[10] *Id.* at § 333(b)(3).
[11] *In re Alternate Family Care*, 377 B.R. 754, 756 (Bankr. S.D.Fla.,2007).
[12] *Id.*
[13] *Id.*
[14] *See In re Alternate Family Care*, 377 B.R. at 756 (holding that although debtor was a health care business, an ombudsman was not necessary under the facts of the case because there was enough external oversight to ensure quality of patient care); *In re North Shore Hematology-Oncology Associates, P.C.*, 400 B.R. 7, 11 (Bankr. E.D.N.Y. 2008) (holding that although debtor was a health care business, appointment of a patient care ombudsman was not required because debtor did not provide any in-patient care and had an extremely low patient complaint rate); *In re William L. Saber, M.D., P.C.*, 369 B.R. 631 (Bankr. D. Colo. 2007) (holding that although doctor's office qualified as a health care business, appointment of an ombudsman was unnecessary because debtor had successful track record of patient care); *In re Valley Health System*, 381 B.R. 756 (Bankr. C.D. Cal. 2008) (holding that internal controls and extensive oversight of the health care district made appointment of an ombudsman unnecessary).
[15] *In re Alternate Family Care*, 377 B.R. at 756.
[16] *Id.* at 756–58.

The court found that even though most of the patients were referred to the facility from other doctors, some parents of children found the facility on their own, and as such the facility provided service to the public. The court compared two other cases, one in which services were provided to doctors, and second of a radiology clinic that only provided testing to referred patients, both of which were found not to serve the general public, and as such were not considered health care businesses for purposes of the patient care ombudsman statute.[17] In the *In re Alternate Family Care* case, the court found that the facilities provided treatment for a disease through psychiatric and medical treatment of severe emotional conditions in children, and therefore the debtor was considered a health care business. Other courts have found that a single physician plastic surgeon's office, a large public agency providing comprehensive health care services, an organization providing cancer and blood disorder treatment, are all considered health care businesses under § 101(27A).[18]

Once a court determines that the debtor is a health care business, the court must appoint an ombudsman unless it determines that the appointment is not necessary under the facts of the case.[19] Whether the appointment of an ombudsman is unnecessary appears to be the most litigated issue surrounding the patient care ombudsman statute currently. The court in *In re Alternate Family Care* looked to nine salient but non-exclusive factors surrounding the circumstances of the bankruptcy filing and the operations of the debtor to determine whether the appointment of an ombudsman was unnecessary.[20] The nine factors are: the cause of the bankruptcy, the presence and role of licensing or supervising entities, debtor's past history of patient care, the ability of the patients to protect their rights, the level of dependency of the patients on the facility, the likelihood of tension between the interests of the patients and the debtor, the potential injury to the patients if debtor drastically reduced its level of patient care, the presence and sufficiency of internal safeguards to ensure appropriate level of care, the impact of the cost of an ombudsman on the likelihood of a successful reorganization.[21] The weight to be accorded to each of the factors when making a determination of whether to appoint an ombudsman is left to the discretion of the reviewing court.[22]

The court analyzed each of the nine factors in the *In re Alternate Family Care* case, and determined that the number of factors weighing against the appointment of an ombudsman outweighed the number of factors weighing for such an appointment. First, the cause of the bankruptcy was not related in any way to the quality of patient care, but instead was the result of a fire in one of their most profitable centers.[23] Second, several governmental agencies were in charge of supervising the level of patient care at AFC

---

[17] *Id.*
[18] *In re North Shore Hematology-Oncology Associates., P.C.*, 400 B.R. 7, 11 (Bankr. E.D.N.Y. 2008); *In re William L. Saber, M.D., P.C.*, 369 B.R. 631 (Bankr. D. Colo. 2007); *In re Valley Health System*, 381 B.R. 756 (Bankr. C.D. Cal. 2008).
[19] *In re Alternate Family Care*, 377 B.R. at 758.
[20] *Id.*
[21] *Id.*
[22] *In re North Shore Hematology-Oncology Associates., P.C.*, 400 B.R. 7, 11 (Bankr. E.D.N.Y. 2008).
[23] *In re Alternate Family Care*, 377 B.R. at 758; s*ee also In re William L. Saber, M.D., P.C.*, 369 B.R. 631 (Bankr. D. Colo. 2007) (finding that the cause of the bankruptcy was an employment contract dispute with another physician, and did not stem from the quality of patient care); *In re Valley Health System*, 381 B.R. 756 (Bankr. C.D. Cal. 2008) (finding that the cause of bankruptcy was contractual problems, not the quality of patient care).

because they provided services for emotionally disturbed children, many of whom were in the state's foster care system. Moreover, the debtor had a 20 year track record providing excellent patient care. There was also no tension between the interests of the patient and the debtor: the care of the patients was in the best interests of AFC and reducing the number of patients would not benefit the facility. In addition, there were many internal safeguards to ensure an adequate level of care for the children, including licensed doctors and trained staff at the facility and supervision by numerous government agencies. Finally, the cost of an ombudsman would severely limit AFC's reorganizational ability because of the facility's lack of cash and inability to afford financing. These factors were compared with factors in favor of appointing an ombudsman. Those factors included the inability of the patients, who are children, to protect their rights, the high level of dependency of the patients on the facility, and the potential for injury to the patients if the debtor reduced its level of patient care. However, because AFC was already very well regulated and supervised by the state government, and adding an ombudsman would be financially very burdensome and would add an additional layer of bureaucracy, the court decided that the appointment of an ombudsman was unwarranted.

In other cases, courts look to additional, but similar factors to determine whether appointing an ombudsman is necessary, such as: "(1) the high quality of the debtor's existing patient care; (2) the debtor's financial ability to maintain high quality patient care; (3) the existence of an internal ombudsman program to protect the rights of patients, and/or (4) the level of monitoring and oversight by federal, state, local, or professional association programs which renders the services of an ombudsman redundant."[24] In addition, even though courts may determine that appointment of an ombudsman would be unnecessary at a given moment in the bankruptcy process, they should be willing to reevaluate immediately if there occurs a change in circumstances or if newly discovered evidence shows that an ombudsman would be necessary.[25]

B. Is an Ombudsman entitled to legal counsel?

Another issue that is anticipated to be litigated is whether an ombudsman can represent patients' interests in court, and if he cannot, whether he is allowed to retain legal counsel. Since the enactment of § 333 of the Bankruptcy Code, the Patient Care Ombudsman (PCO) serves two roles: one as the monitor of the patient care that the health care debtor delivers, and the other as an advocate for the patients of the health care debtor.[26]

The problem of whether PCOs can represent patients' interests arises because most PCOs are not attorneys but they are appointed to serve in an advocate role. Although individuals who are not licensed to practice law are entitled to represent themselves in a court room *pro se*, they are not entitled to represent the rights or interests of anyone else.[27] In a recent Tenth Circuit Court of Appeals decision by the Bankruptcy Appellate Panel, a non-attorney state court receiver filed a motion to dismiss a bankruptcy case, and the debtors moved to strike arguing that only *pro se* individual

---

[24] *In re North Shore Hematology-Oncology Associates*, 400 B.R. at 11.
[25] *Id.*
[26] Samuel R. Maizel, *Patient Care Ombudsman: What about Consel?*, ABI Journal 14 (Feb. 2010).
[27] *Id.* at 14.

parties and members of the bar may appear or sign pleadings.[28] The court found the receiver had no personal claims being asserted against the debtors through the motion nor was he exclusively advocating his own personal rights or interests, and as such he was not allowed to appear in a representative capacity for the receivership because he was not allowed to practice law.[29]

A U.S. Trustee can appoint a corporation as a PCO, however because an artificial entity can never appear *pro se*, a corporation serving as a PCO must retain counsel in the bankruptcy case to which it is appointed.[30] In addition, when PCOs are serving in the advocate role in which they are representing the interests of the patients of the health care business debtor, they also must be represented by counsel because § 1654 of the U.S. code requires that the party appearing *pro se* must be the actual beneficial owner of the claims being asserted, as *In re Shattuck* made clear, unless the PCO is also a patient of the health care business.[31]

The issue, however, appears less clear when PCOs are serving in their monitoring role, as opposed to their advocate role. Some argue that as long as the PCO merely reports on the quality of patient care, similar to an expert witness in a bankruptcy proceeding, without advocating a side and thereby representing the rights of the patients, a PCO proceeding may not violate § 1654.[32]

Even though in certain situations, such as those discussed above, a PCO must retain counsel, it is unclear whether such an appointment is authorized by Congress. The bankruptcy code clearly allows the debtor, trustee, and creditors' committee to retain counsel, but the bankruptcy code does not expressly allow a PCO to employ a professional, such as a lawyer, at the expense of the estate.[33] It has been suggested that the duties of a PCO are analogous to the duties of an examiner in traditional bankruptcy cases, who are appointed to investigate the acts, conduct, liabilities, financial condition, and operations of the debtor and are allowed to employ professionals for such actions.[34] Although the authority of examiners to appoint legal counsel is also not statutorily specified, historically courts have allowed examiners to appoint legal counsel based on section 105(a) of the Bankruptcy Code which states that the court may issue any order, process, or judgment that is necessary or appropriate to carry out the provisions of this title.[35] Since the role of the PCO is similar in investigating acts, conduct, financial condition and operations of the health care business debtor as to those areas that affect patient care, an analogy can be drawn between the PCO and the examiner, and it can be suggested that PCOs can hire professionals, such as attorneys, to assist with these tasks as well under 105(a).[36]

The counterargument, however, is that there is a long standing rule that examiners are allowed to appoint counsel, but Congress failed to deal with the issue in 2005 with

---

[28] *Id.* (discussing *In re Shattuck*, 411 B.R.378 (B.A.P. 10th Cir. 2009)).
[29] *Id.*
[30] *Id.*
[31] *Id.* at 76.
[32] *Id.*
[33] *Id.*; *see In re Synergy Hematology-Oncology Medical Associates, Inc*, 433 B.R. 316, 318 (Bankr. C.D. Cal. 2010).
[34] Maizel, *supra* note 24, at 76.
[35] *In re Synergy Hematology-Oncology Medical Associates, Inc*, 433 B.R. at 319.
[36] *Id.*

regard to PCOs. Moreover, when Congress enacted the PCO legislation in 2005, it also enacted Consumer Privacy Ombudsman legislation, which also fails to address whether an ombudsman can appoint legal counsel.[37] Regardless of the current state of the law, many PCOs appear in cases without counsel, which may be because the U.S. Trustee or the courts discourage hiring counsel to keep down administrative costs and expenses. However, some argue that PCOs acting without counsel tend to ignore applicable requirements of the bankruptcy code, Federal Rules of Bankruptcy Procedure and/or the applicable court rules.[38] Because of the confusion of whether counsel is allowed and/or required on behalf of PCOs, and Congress' apparent silence on the issue, it is likely that we will see more cases addressing this issue litigated in the courts in the near future.

III. Conclusion

In summary, the fairly new patient care ombudsman legislation appears to provide important safeguards for protecting patients of debtor health care businesses in bankruptcy proceedings. However, as with any new legislation, courts will likely stay occupied with fact specific inquiries surrounding PCOs, such as which debtors constitute health care businesses and in what circumstances an ombudsman is unnecessary, in addition to more substantive questions of law relating to whether a PCO can represent the interests of patients without counsel, and if not, how the Bankruptcy Code authorizes the appointment of counsel for ombudsmen.

[37] *In re Synergy Hematology-Oncology Medical Associates, Inc*, 433 B.R. at 318.
[38] *Id.*