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## Corporate Bankruptcy Panel: The Healthcare Industry Post-Affordable Care Act: A Bankruptcy Perspective

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**CORPORATE BANKRUPTCY PANEL**  
**THE HEALTHCARE INDUSTRY POST-AFFORDABLE CARE**  
**ACT: A BANKRUPTCY PERSPECTIVE**

*Samuel Maizel*<sup>\*</sup>  
*Colin Bernardino*<sup>\*\*</sup>  
*Matthew Caine*<sup>\*\*\*</sup>  
*Jeffrey Garfinkle (Moderator)*<sup>\*\*\*\*</sup>

**MR. GOLDMINTZ:** I'd like to welcome everyone back and thank each of you for braving what has clearly been the worst storm of the last decade. It's been tough. We all put on our snowshoes, but we made it here today, so I thank each of you for being flexible with the rescheduling and for donating your time.

I should introduce myself. I'm Gene Goldmintz, the Editor-in-Chief of the *Emory Bankruptcy Developments Journal*. This year our Corporate Panel will be discussing the bankruptcy and restructuring environment in the healthcare industry since the Affordable Care Act was signed into law.

Before we start, I'd like to introduce each of our panelists. First we have Samuel Maizel. Samuel is a Partner at Pachulski Stang Ziehl & Jones. His practice includes bankruptcy matters and financial restructuring with a focus on the healthcare industry. Samuel serves on the Board of Editors of *California Health Law News*, and has previously served as Chair of the American Bar Association Judicial Division Bench-Bar Bankruptcy Council. He was also awarded a Bronze Star Medal for serving in the U.S. Army's The Judge Advocate General's Corps. In 1995, the *Emory Bankruptcy Developments Journal* published his article, *The Medicare Contract in Bankruptcy: In Which Direction Does University Medical Center Lead?*<sup>1</sup>

Second, we have Colin Bernardino. Colin is a Partner at Kilpatrick Townsend & Stockton here in Atlanta, and is a member of its Bankruptcy and

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<sup>1</sup> Elizabeth Swinton Schoen & Samuel R. Maizel, *The Medicare Contract in Bankruptcy: In Which Direction Does University Medical Center Lead?*, 11 EMORY BANKR. DEV. J. 405 (1995).

Financial Restructuring Group. He focuses his practice on bankruptcy and insolvency matters, and frequently represents unsecured creditor committees in chapter 11 hospital bankruptcy cases. Colin is a member of the American Bankruptcy Institute, and, most importantly, serves on the *Emory Bankruptcy Developments Journal* Advisory Board.

Third, we have Matthew Caine. Matthew is a Managing Director at SOLIC Capital Advisors where he is responsible for middle market transactions and industry leadership in a variety of sectors. Matthew earned his M.B.A. from the University of Chicago. He is a certified Restructuring and Insolvency Advisor and is a member of the Association of Insolvency and Restructuring Advisors.

Moderating our panel today is Jeffrey Garfinkle. Jeffrey is a Shareholder and Co-Chair of Buchalter Nemer's Insolvency Practice Group. His practice encompasses the representation of secured creditors, creditor committees, unsecured creditors, debtors, and other parties in a variety of bankruptcy cases. He also serves as the primary national bankruptcy counsel for McKesson, the world's largest healthcare company, and has been doing so for the last fifteen years. As a result of this work, Jeffrey has seen all types of healthcare bankruptcy and restructuring cases. These cases have involved individual doctors, doctor practice groups, senior living facilities, medical equipment companies, and pharmaceutical manufacturers and distributors. Jeffrey is a frequent speaker on bankruptcy, debt financing, and commercial law issues, and is a member of the American Bar Association, the American Bankruptcy Institute, the Financial Lawyers Conference, and the California Bankruptcy Forum, and, most importantly, he also serves on the *Emory Bankruptcy Developments Journal* Advisory Board.

At this time I would like to turn it over to Jeffrey.

**MR. GARFINKLE:** Thank you, Gene. It's always a pleasure to come back here. I'm now celebrating my twenty-fifth anniversary since graduating from Emory, so there is a light at the end of the tunnel for all of you students here.

As I drive down Clifton and I look around at the amazing healthcare complex that I see, it leads me to the question, look around you. Why is Emory, beyond always building something on campus, building this incredible building right next to the Law School? It's a function of the huge business that is healthcare. If you just look at Emory, last year's revenues for Emory Healthcare was \$2.8 billion according to the published data. They just

announced a potential merger with WellStar Health, another healthcare non-profit up in the Perimeter area, which would take, assuming regulatory approval, would take Emory's healthcare system above \$5 billion a year in annual revenue.

But Emory is just part of what is the largest segment of the U.S. economy. Last year, the federal government for its Medicare and Medicaid programs alone spent over \$100 billion on medical services. That does not include discount drug pricing. It does not include many other ancillary expenditures that the federal government alone spent. And with those type of expenditures comes business opportunities and business failures. With the passage of the Affordable Care Act five years ago there has been a lot of discussion about the impact on individuals. You will see people talking about mandates and tax penalties, but there's little public discussion given to the impact of the Affordable Care Act and certain aspects of that very comprehensive law on the businesses that are the day-to-day backbone of the U.S. healthcare system.

On the panel are Matt and Sam, who are going to speak to the different segments of the healthcare market and how the dynamic for those companies is changing on an hour-by-hour, day-by-day, week-by-week basis. Everyday, the Center for Medicare Medicaid Services, termed "CMS" in the industry, is enacting regulations and trying to structure ways to accomplish the primary purpose of the Affordable Care Act. And that is to somehow either reduce or at least slow the growth of federal expenditures for healthcare services. And as a result of those dynamic changes that are going on, there is a ripple effect to the providers. And with that I will turn it over to Matt and Sam.

**MR. CAINE:** Thanks, Jeff. Just a couple of comments as it relates to industry trends, what we're seeing out there. My background is as an investment banker, so a lot of M&A work with facility-based providers. Certainly, consolidation is the thing within the industry, and what's driving that is a complement of several factors including the Affordable Care Act.

But actually before that, just backing up a little bit chronologically, we've got 2007–2008 for the bubble with respect to the debt-financing markets. And that really provided a window for a lot of health systems to access the capital markets to fund expansion, facility-based expansion. Sort of a build-it-and-they-will-come type of strategy. Well, what we quickly found out on the other side of that was a lot of health systems built it and the people did not come. There are a couple of key factors as to why that was.

You've got over-leveraged balance sheets within the healthcare sector, straight out of the gate in 2009, 2010. Healthcare has been pushing payers, and providers have been cognizant about pushing patients to a lower cost setting. So from inpatient to outpatient in terms of providing care. So you had sort of a mixed strategy of building out facilities but also pushing the patient into an outpatient or a lower cost environment. That certainly created a lot of stress in the 2009–2010 period. Coupled now with the Affordable Care Act and passing that comprehensive legislation, it created a ripple effect that is still going on and will be going on for the next four or five years. It certainly is our perspective.

So you've created an environment where there are health systems that are over-leveraged, declining inpatient volumes, albeit typically higher margin patient base. And so what the Affordable Care Act then did, from our perspective, was to serve as an accelerant for a lot of M&A activity or consolidation activity. It created an environment where you have the haves and the have-nots. Why is that? Well, the Affordable Care Act to many of the health systems, sort of the key focus is moving from fee for service to value-based reimbursement. Getting the health systems out of perverse incentives based on the more I click, the more I get paid as opposed to focusing on outcomes, patient quality outcomes, how healthy is that patient upon discharge, and are there readmits?

And so that has put an impetus on health systems to be more cognizant about their quality of care. And so they're going to get reimbursed on a value basis.

So that has created an environment where there's more competition amongst the larger health systems to expand their reach. They're not getting as well reimbursed as they had historically, and so that 25-mile radius now turns into a 50 or 100-mile radius in terms of their reach. And Emory and WellStar are coming together so there's economies of scale there as well.

**MR. GARFINKLE:** Assuming they get regulatory approval and they can clear anti-trust.

**MR. CAINE:** That's the industry logic certainly—that their economies of scale will provide care at a more cost-effective basis.

Second, out-migration. In the secondary markets, at SOLIC we predominantly focus on more middle market transactions. These are community-based providers. Often we'll fly into cities and we'll get in the cars

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and we're driving 50, 100, 150 miles away to these health systems that need to seek a partner. And so those health systems are seeing a lot of out-migration back to the Atlanta's, the Chicago's, wherever the major metropolitan areas, to seek care. So that's creating strain as well in terms of those patient volumes.

**MR. GARFINKLE:** Matt, have you seen the capital requirements to comply with the Affordable Care Act in terms of establishing what are called accountable care organizations or other value-based services, what is the capital structure? How is that kind of impacting, meaning that how much money up front are they having to sink into it beyond their normal operations?

**MR. CAINE:** Great question. It's not even a topic of discussion among the community-based providers. The local health systems, they're not even focused on that—how they can be relevant in an ACA world. Certainly narrow networks, there's a point of discussion they could participate in, but really their focus is how do we survive the next two to three years if they can at all. And so it's not about longer-term strategies with respect to providing that care. I think certainly with the larger systems, capital is key to being able to provide population health management strategies, accountable care organizations, and that requires a lot of capital. It's a new age for them in terms of what the balance sheet is going to look like and their ability to take risks. The Affordable Care Act is pushing these larger systems, those who have access to capital, to deploy that capital in a risk-bearing mode whereby they're almost like a payer taking on the risk of providing care to a large population base and it's capitated in terms of their ability to get reimbursed. And so they're taking on a risk there's a fixed amount.

**MR. MAIZEL:** Do you all understand what he's talking about? So you know how these hospitals get paid or health plans get paid? Capitation. They get paid \$35 per member per month and they take on risk, and they decide a number, and they say to themselves, do we need \$35? That's real numbers. Those aren't made up kind of numbers. And they hope that most of you will stay healthy so that in fact they don't spend \$35 a month providing healthcare to you because someone is going to have cancer and they're going to spend \$500 or \$5000 in a month for that patient, so they need a lot of people who spend less than \$35. That's the risk. That the capitation he's talking about. And that, the inability to price that correctly and figure out what the actual health profile of a population looks like is endemic throughout the industry and a huge source of financial trouble for entities at every level providing every kind of direct service to patients.

**MR. GARFINKLE:** And that population kind of the actuarial basis for that has changed in light of the mandate to acquire health insurance and come into the system. So the earliest players in that process, those that didn't want to pay the fines, were those that were most unhealthy, the ones that were in the population of the greatest risk portfolio. And then hopefully you can convince (this is the mindset behind the Affordable Care Act) the healthy to also subscribe and pay money into the system to counterbalance the very expensive high-risk patients.

**MR. CAINE:** So there is a confluence of several factors here driving the consolidation. And now these health systems, those who are sort of standalone, don't have that access to capital. The debt capital markets are, from a tax-exempt issuer's perspective, really not accessible these days. In 2014, I think there were 105 issuances and that's down from 115 or so in 2013, which was I think a fifteen-year low in terms of access to capital. So these standalone health systems are really out there on their own seeking a partner in one way, shape or form. And there are a lot of different types of strategies and structures that we could talk about, but they get it in terms of the need for consolidation, move now while you have a relative position of strength; otherwise, you face the pending corporate strategy that we certainly help out with from time to time of bankruptcy filing. It's not going to be the end of the world for these hospitals but it's a way to address the legacy liabilities. Ultimately, ideally you have a would-be buyer, a stalking horse purchaser to ultimately acquire those assets to help with the partnership on a post-closing basis. But that is certainly a predominance of a corporate strategy in this environment for the standalone health systems.

**MR. MAIZEL:** I just want to follow up on a couple of things because I think those of us who deal with the industry every day, we tend to use terms and also concepts which if you're not in this cesspool every day it's not going to be familiar to you.

So every time that you hear somebody like Jeff talk about the government reducing saving money, that's the term, I want you to think there's some hospital out there that's already operating on a 1% profit margin with 90% of its patient base coming from Medicare or Medicaid. So if you're on a 1% profit margin and 90% of your patients, the person paying you for the services you're providing says to you: "We're going to save taxpayer money this year. We're going to reduce what we pay you for those services. And you don't have a choice." Your 1% profit margin disappears. And those are real numbers, too.

The average profit margin for a hospital in New Jersey is 1%. The average a healthy hospital in America is a 3% to 5% profit margin. Somewhere between a third and a half depending on the studies you read of the operating hospitals in America, about 5000 operate on a negative EBITDA. That means they're losing money. And we'll talk about some of the ways they make that up, but the shorthand answer as to how they make that up is your taxpayer dollars.

So it's important when you think about, when you hear politicians talk about saving money in the system, that means somebody is not getting paid as much for the same goods or services that they provided yesterday at a different price.

Matt talked about hospitals were "build it you will come." So if you had this conversation in 1955 as the Baby Boomer generation's coming out, people would have drawn projections for how many hospital beds America needed in 2015, it would've been way more hospital beds than we need today. The problem is, they actually built a lot of those hospitals, so we have a lot of competition with less patients to fill the hospital beds. Hospital census is a key number in deciding how healthy your hospital is. So they built the hospitals on an expectation that if you had a heart problem, you would go into a hospital, they would crack your chest open, and then you would spend two weeks recovering in the hospital. The problem is today they run a tube up through your leg into your chest and fix your heart and you're out in twenty-four hours.

**MR. GARFINKLE:** That's the problem.

**MR. MAIZEL:** That's the problem. If you're running a hospital, you just lost thirteen patient bed days and the income that comes with that.

One of the other things about sort of "build it they will come" that Matt talked about is equipment. So there's an arms race among hospitals. If you're a hospital and the hospital down the street has the fancy MRI machine or CAT scan, well you have to have one too, because otherwise all those high speed processes and all the doctors that do that work will go to the competing hospital. So you have to buy your own MRI machine.

Now in a perfect world, the world we don't live in, someone would say, okay, Cobb County needs, based on this population size, one MRI and one CAT scan, or two, or three or whatever number it is. But that isn't how our world works. So each hospital competing for those high dollar value procedures is going to want that, and they're going to raise money or they're



going to take on debt. And then they're going to find out that they built this MRI and nobody came. And then they're going to have to service the \$2 million in debt they incurred to get that new CAT scan machine.

The other issue is the ambulatory surgical stuff. I mean, there was a period where if you needed surgery, you went to a hospital and you had the surgery. Well, then doctors realized because they're smart—

**MR. GARFINKLE:** And economically rational.

**MR. MAIZEL:** —and economically rational. They're not as smart as they think they are, but they're pretty smart. They decided well, look, why should we do low-risk, high-profit procedures in a standalone hospital where we have to support the emergency room, for example, which is a huge black hole for money, why would we do those easy low-risk, high-dollar value procedures in a hospital? Let's do them in an ambulatory surgical center where the patients come in and out in a day. And so all those procedures moved to ambulatory surgical centers, a lot of which were owned by doctors, so that they could get the facility fee in addition to their own fees.

**MR. GARFINKLE:** And it's their profit center.

**MR. MAIZEL:** Right. So what happened is your hospitals were left with the really knotty, not-so-good compensation procedures, and all the other stuff disappeared. And the ambulatory surgical center, if they have a problem with a patient, they call 911 and get an ambulance and take them to the ER, which is supported by that hospital that they siphoned off all the procedures from. And which by the way, we'll talk about, is supported by your taxpayer dollars. That may be a repeating theme here.

One of the things that Matt talked about is capital. So what we're seeing in America in the healthcare industry is a lot of investment in healthcare. I mean 20% of the GDP is spent in healthcare, so you would imagine that big corporate equity funds, venture capital funds, they want to invest here, and the demographics are good. They really are not as good as people think but if you are superficial with this you go, look, people are getting older in America and older people need more healthcare, so X plus Y equals Z. We should have more healthcare stuff and we should invest our money there. So you see huge funds like Cerberus spending, what, a billion dollars acquiring hospitals in Massachusetts. A large fund called Leonard Green backs a company called Prospect, which is buying hospitals all over the country. Blue Wolf Capital, a fund which had no investment in healthcare just made, depending on who you

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talk to, a \$700 million offer to buy six major hospitals in California. They have no experience in healthcare but they see it as a place to invest their money.

**MR. GARFINKLE:** They're looking for a return, some return.

**MR. MAIZEL:** Okay. So there's two things I'd say about this capital flow that Matt described. One is, we've seen this before. Funds like Bruckmann, Rosser, Sherrill & Co., which also owned Au Bon Pain, California Pizza Kitchen and EZ Lube, bought four hospitals because they wanted to diversify their portfolio, and then I helped them sell those four hospitals later when they realized it isn't all the same thing.

Bain Capital. Many of you might have heard of Bain Capital in the last Romney election cycle. They had a huge investment in HCA, which is the largest hospital chain in America, and they've now divested themselves of that. Why? Because one of the things these funds expect is return on investment, "ROI." And you cannot get the return on investment they expect from their investments in an industry where the people that you sell your services or products to tells you what they're going to pay you for those goods or services, and that's how the system works. And Medicare and Medicaid are the 800-pound gorilla in this industry and they tell you what they will pay you. That's hard if you're an equity fund to get the return on investment under those circumstances.

Just three other points about the Affordable Care Act. First of all, just to reveal my prejudices, I'm a one-payer system guy. I was in the Army for a long time. May not be the best healthcare system, but you know what? If you're one of the 50 million people or 40 million people in America that had no health insurance, it's way better than that.

**MR. GARFINKLE:** And I misspoke before. I meant to say it's over a trillion dollars a year just on Medicare and Medicaid, and it's covering 30% of the population today. And then when you add on the people that are subsidizing through the ACA, at this point why don't we just have a single pay?

**MR. MAIZEL:** Okay, but I just want to reveal my prejudices. So one of the things that Matt also touched on is the rich are getting richer and the poor are getting poorer. Now some of that is probably because of the Affordable Care Act. Some of it is just how it's working out. So what you're seeing is the rich hospitals, Cedar-Sinai in Los Angeles for examples, are doing very well, and then the one hundred-bed rural hospitals, they are literally dying. And by the way, when hospitals die, people die because that means instead of going

twenty minutes to the nearest emergency room, you go forty-five minutes, and we can do the statistical modeling to tell you how many people will not make that additional twenty-five-minute trip.

So a couple of things about the Affordable Care Act from my view looking at the bottom 20% of the hospital industry, for example. They cut \$155 billion out of Medicare over the next ten years. So if Medicare is the 800-pound gorilla that pays something like 40% of hospital visits in America right now, it's not a huge amount because I think they spend \$560 billion a year, and they're only cutting \$155 billion over ten years. It's not a huge cut, but when you're operating on a razor-thin profit margin or actually operating in the red, every cut counts a lot.

The second thing is, they recalibrated something called the "disproportionate share payments." So when you hear politicians talk about how we don't want the government involved in the healthcare system because it'll screw it up, you should just take that with a grain of salt because in fact the hospitals in America, the vast majority of hospitals in America survive on government payments, whether for goods or services, Medicare-Medicaid, or handouts. So that may be "disproportionate share payments," distressed hospital funds, or quality assurance fees in California, which actually operates in about thirty states now called different things.

**MR. GARFINKLE:** Or the 340B program.<sup>2</sup>

**MR. MAIZEL:** Yeah, I mean, there's just all these government programs—

**MR. GARFINKLE:** Right. Drug, reduced drug pricing programs, which basically have become a central profit center for most hospitals.

**MR. MAIZEL:** Yeah. So there's just various ways that the government hands money to facilities to keep them afloat because Medicare pays about eighty cents on the dollar for a patient. So if the hospital spends a dollar on a Medicare patient, they probably can expect to get paid about seventy-five to eighty cents of that cost, and Medicaid is a little less. And how do they make up that delta? Yes, volume, exactly. Some of my hospitals think that. But they make it up by charging—so you read these stories about how people who show up without health insurance are getting billed \$25,000 for a suture? It's to make up that delta because the vast majority of patients are not—they're not even getting compensated what they spend to treat the patient.

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<sup>2</sup> Veterans Health Care Act of 1992, Pub. L. No. 102-585, § 602, 106 Stat. 4943, 4967–71 (1991).

So there's a thing called disproportionate share payment, and this was a recognition that hospitals in urban areas, poor hospitals, treat a disproportionate share of uninsured poor people. And so the government handed out about \$20 billion a year to hospitals to compensate them for not paying them enough under Medicare-Medicaid, so they could say we're keeping costs down on Medicare-Medicaid, but then they would give them these disproportionate share payments to make up some of the difference. Under the Affordable Care Act, there's a presumption that everyone is going to be insured. So you don't need to have these disproportionate share payments anymore because we're not going to have uninsured people showing up in the emergency room. And in theory that works. In reality you've got places—I wrote an article about this and they made copies I think, or they were trying to make copies maybe. If you're really incredibly bored with your lives and you want it, I'll send you the article if you ask me afterwards.

So they said we're going to do away with—we're cutting these by like 75% over the next five to ten years, and a lot of these poor hospitals survive on these disproportionate share payments. So the problem is, you go to places like California where it turns out a significant percentage, maybe the majority, of the uninsured are uninsurable even under the Affordable Care Act because they're not here legally. So you have counties in New York City, counties in California which are going to be completely hammered when this takes place because their percentage of uninsured patients is not going to change even under the Affordable Care Act. It's a huge problem.

Two other points about the Affordable Care Act. One is the idea, as Matt mentioned, they're trying to move you away from paying you for procedures to paying you for outcomes, which is why you're seeing this integration that I know Jeff is going to talk about more. Because if you have to control the outcome, if you're a hospital and you're paid for a procedure, you do the procedure, they leave, you're done. But if you have to worry about the actual outcome of the patient's health, then you want to control more variables, right? You want to make sure that you not only control the procedure, but the visiting nurses who come to the house afterwards to make sure they do their follow-up care or take their meds or whatever. So under the Affordable Care Act, the stick for this is penalties of up to 1.25% are going to be imposed on hospitals that have—I'm sorry. I'm getting my penalties mixed up. I think this is like 1% for readmission rates.

So what's going to happen is now if you have people who get readmitted within thirty days of your departure from the hospital for whatever reason, it doesn't have to be for the same reason you originally went into the hospital, that hospital will be penalized by Medicare for that readmission.

**MR. GARFINKLE:** That goes to the post-acute care and also some skilled nursing facilities issues. Let's quickly move off of hospitals if you can.

**MR. MAIZEL:** Let me just do one more point. So what happens is not surprising when you survey the population, the people who are more likely to get readmitted are poor, uneducated people. That's just statistically the way it works. And so this is a huge problem for the hospitals that treat that population. Nothing they do is going to change the profile of their population. Their readmission rates are not really reliant on their quality of care, but they're stuck.

And one other thing is patient surveys. So hospitals that don't do well in patient surveys, there's this value-based purchasing program. It's to get some feedback to hospitals as to how well they're doing. If you do poorly on patient surveys, you'll be penalized up to 1.25% of your income from Medicare. They've done surveys. What is the thing that is most likely to be evaluated in the patient survey? Most of us are not capable of evaluating the doctor's quality of care. We don't really know if he's a good doctor. So what you're seeing is companies like Disney that are now developing patient interface programs that they sell to hospitals because that's what actually gets rated in the surveys. It's like, what was the quality of your interaction? And the other thing is, poor hospitals always look like dumps because the first thing they—sorry. That's inartfully put, but it's true, because the first thing they cut is capital expenditures, because you can't cut personnel in a hospital. You can't cut medical supplies. What can you cut? You don't replace the carpet, you don't repaint this year.

What is showing up in the surveys is people react to the quality of the capital, the building around them. If it looks like a dump, they're going to rate the hospital more poorly than if it was a nice looking hospital even if the quality of care is exactly the same.

**MR. GARFINKLE:** With that, we've spent a lot of time talking about hospitals but some of the same financial pressures are on other aspects. There's skilled nursing facilities, post-acute care treatment centers, home healthcare. You're seeing it impact all the way down the cycle from the hospital all the

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way down the line. The Affordable Care Act is also having a dramatic effect on physician practice groups and standalone physicians. I grew up in an era, and many of my generation grew up in an era where you went to your local doctor and then maybe your doctor had relationships with two or three hospitals. Not anymore. In the next ten years from now, the existence of standalone medical practices is going to be the exception, not the rule. I am convinced of that and I will talk a little bit later about that, but I'm going to move on. We've spent a lot of time talking about this to the *In re Bayou Shores* case<sup>3</sup> and Colin will address that and I think Sam has some input on that.

**MR. BERNARDINO:** You were talking about skilled nursing facilities, or starting to, and *Bayou Shores* is a case that filed in August 2014 in the Middle District of Florida. It was, and still is, a 159-bed skilled nursing facility in St. Petersburg doing business as the Rehabilitation Center of St. Petersburg. One of the courts found that it was one of the few facilities in the area that caters to patients with serious psychiatric conditions, so the vast majority of its patients suffered from depression, bipolar affected disorder, schizophrenia, as well as Alzheimer's and other types of dementia.

This type of facility is also I think very significantly impacted by these changes that we've been talking about. Historically over 91% of this particular facility's revenue were derived directly from Medicare Part A, Medicare Part B and Medicaid.<sup>4</sup> And this facility we have to assume probably had its usual issues dealing with its particular population that it catered to, but ran into several or deemed to be significant issues in 2014. Starting in February it was cited for immediate jeopardy to its patients by the Center for Medicare & Medicaid Services, or CMS, for noncompliance with its recordkeeping. I did some digging. The recordkeeping issue in order was non-resuscitation orders. There were conflicting orders in each of the patients' records here. So if a particular resident, as they're called, was having an issue, the doctor wouldn't be able to tell whether he was supposed to call in people if he was going to try to resuscitate him or just basically let him go. CMS views that to be a pretty significant issue. In fairness to the debtor, they believe it occurred because of their electronic records transition that basically all healthcare providers are now having to go towards. And so they were notified of the issue, they cured it immediately. Apparently went through and did an audit of all of their residents

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<sup>3</sup> 525 B.R. 160 (Bankr. M.D. Fla. 2014).

<sup>4</sup> *Id.* at 162.

and were able to get that issue squared away, and CMS found that they were in substantial compliance.

Then, in March of 2014, they had another issue which CMS deemed to be something that caused their residents to be in immediate jeopardy. In this case an individual with a history of sexual exploitation or abuse was admitted and placed into a room with another resident. Now while there was no evidence that anything happened during the twenty-four hours that that resident was with the already occupying resident, this is an issue that could have led to some pretty significant problems, and CMS said we can't have this happening and declared that they were not in compliance. Again, the debtor, to its credit, immediately rectified the situation and confirmed that nothing had actually happened. They were deemed to again be back in compliance.

Then, in May of 2014, CMS did in fact inform the debtor, it wasn't a debtor at the time but the facility that, yeah, okay, those issues were fine with what you did. You're in substantial compliance. In July 2014, a resident was found to have left the facility. The resident had been on the second floor in a secure area with controlled access and had left with some visitors and was found by himself fifteen minutes later down the street. Nothing happened to that person. They were found. Someone must have—the facility figured out that, hey, we've lost one or someone found this person and brought him back to the facility. But again, this was deemed to be an issue of immediate jeopardy, and CMS said you are not in compliance.

In response, the facility took remedial steps to ensure that there wouldn't be any more patients walking out that were suffering from dementia or whatever, and they also hired a third-party consultant that coincidentally found that their remedial steps were, in fact, sufficient and the debtor actually then told CMS here are the steps we've taken to fix this. CMS decided not to revisit the facility, and instead elected to terminate their Medicare provider agreement. And so on July—

**MR. GARFINKLE:** To put that in context, when you terminate a provider agreement, the facility loses its reimbursement rights which effectively shuts down the facility.

**MR. BERNARDINO:** I guess in acknowledgement of that, they were kind enough to say we will pay you for another thirty days—

**MR. GARFINKLE:** Yes.

**MR. BERNARDINO:** —in order to help out with the transition of payments, but they did deny that there would be any payment for new admissions. They also instituted a civil monetary penalty of, I think, around \$3000 a day that they were then going to be recouping by the way. So while they're—

**MR. GARFINKLE:** And just for the—recoupment is a concept in bankruptcy particularly in the Medicare-Medicaid scenario where the government just deducts amounts it would otherwise pay you. So, sorry to—

**MR. BERNARDINO:** So the facility decides we can't have this; we're going to be shut down. We've only got thirty days of partial payments coming in and then at that point 91% of your revenue is about to be cut off. They will have to shut down. Theoretically patients could be on the street. They begin their administrative appeals process through CMS. At the same time or very shortly thereafter they go and seek an injunction in the U.S. District Court and the District Court says, okay, fine, I'll give you a temporary restraining order for basically two weeks, but will shut it off, though, at 3:00 p.m. on August 15.<sup>5</sup> And then they hold a hearing, the U.S. District Court realizes "I don't have jurisdiction because you haven't completed your administrative remedies. You haven't gone through the Medicare appeals process which could take years." And so, sorry that you're going to lose your funding in another week or so, the court dissolves the temporary restraining order. Within an hour, the facility has filed for chapter 11.

One of the first things the facility then does is they realize they have this issue. They're still going to run out of payment if in fact the provider agreement had been terminated prepetition—it's not an executory contract; it's a terminated contract. And so they go in and ask the Bankruptcy Court to find that in fact the Medicare provider agreement has not been terminated and that CMS cannot terminate the agreement, find that the automatic stay does apply, and that the police powers under § 362(d)(4)<sup>6</sup> do not apply here. And so the court holds a hearing on this.

Basically, what ends up happening is that the court finds that, because CMS only sought to terminate the reimbursement, that the government was

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<sup>5</sup> *Bayou Shores SNF, LLC v. Burwell*, No. 8:14-cv-1849-T-33MAP, 2014 U.S. Dist. LEXIS 113614 (M.D. Fla. Aug. 15, 2014) *injunction denied by Bayou Shores SNF, LLC v. Burwell*, No. 8:14-cv-1849-T-33MAP, 2014 U.S. Dist. LEXIS 116038 (M.D. Fla., Aug. 20, 2014).

<sup>6</sup> 11 U.S.C. § 362(d)(4) (2012) (permitting the court to grant relief from the automatic stay with respect to an act against real property if the court finds that the filing of the bankruptcy petition was an attempt to delay, hinder, or defraud creditors.)



acting with its pecuniary interests only in mind and not for any other type of regulatory patient care reason, notwithstanding the basis of why they were cutting off reimbursement in the first place. And so the Bankruptcy Court says, sorry, no police power exception. You have to continue to reimburse and continue to make payments under the Medicare-Medicaid provider agreements.

Basically, the case moves very quickly and the debtor, I think the idea here was to stay ahead of the federal government before they can get an appeal lodged up to the District Court, goes to the Court with a plan and presents a plan that treats all creditor classes as unimpaired. The only real issue here is, can the debtor assume the Medicare provider agreement? And so the Court takes a look at whether in fact that Medicare provider agreement had been terminated prepetition or not. And the HHS, Health and Human Services, argues that actually it terminated on the date that they specified in their notice prepetition which was August 3, 2014. Remember the case was filed on August 15. So no live executory contract, nothing to assume here. Can't confirm a case if the whole basis for the case is that you're going to continue to get revenue from this assumed contract.

Debtor in turn argues, well, that's nice but we still had a right to appeal, and we had not exhausted all of our appeals, and so not only that, but we had brought our facility back into substantial compliance. Remember we had that consultant and he went and did an audit and he determined, yes, in fact they were in substantial compliance and HHS did not challenge this. They also didn't challenge whether the debtor was going to be able to provide adequate assurance for future performance which they probably could have done. So maybe that's one of the takeaways here.

But they end up . . . the Court says I'm going to allow you to assume this contract, and so it confirms the plan.<sup>7</sup> By the way, it does this notwithstanding the fact that the Florida Agency for Healthcare Administration had already announced that they're not going to renew the debtor's nursing license. So somehow, notwithstanding the fact that one of the state regulatory agencies has already said that this can't be a nursing facility, and that's what this business is, the court said, you know, that's okay. You might be able to mitigate.

**MR. GARFINKLE:** I didn't look at the—was there a confirmation date, found a feasible plan under the confirmation—

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<sup>7</sup> *Bayou Shores SNF, LLC*, 525 B.R. at 173.

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**MR. MAIZEL:** Yes, absolutely.

**MR. BERNARDINO:** Yes.

**MR. GARFINKLE:** —finding of fact on that?

**MR. BERNARDINO:** Yes, there is a Memorandum Opinion, twenty pages or so, where this whole issue is—

**MR. GARFINKLE:** Does he address and how does he address the fact that they don't have regulatory approval for the coming year?

**MR. MAIZEL:** The state had said they were going to terminate the state agreements because they're required to by statute. If you lose the Medicare provider agreement, the state is required to terminate the state agreement. And the court said, I have effectively taken away the grounds that the state cited for terminating this facility, so I think it's at least a colorable argument that the facility will be licensed by the state.

**MR. BERNARDINO:** And the other thing the court pointed out was, yeah, I've already ruled Medicare is going to continue here, but Florida Medicaid statutes, unlike Medicare statutes, do provide for the debtor to be allowed to try to mitigate and basically reinstate through an appeal process. And so he said, that's fine but since we're talking about Florida Medicaid here, there is a chance. I don't know what that chance is but there's apparently enough of a chance that the debtor will be able to mitigate and reinstate, notwithstanding that at least the regulatory agency has already said a year from now this will not be in business.

One of the things here, and I think this affects, at least in my experience in representing creditors committees in hospital cases, is that the courts don't want to shut down these facilities, and one of the factors the court cited to was transfer trauma concerns of the patients. What will happen if I shut this thing down? There were over one hundred residents in this facility at the time. They have to go somewhere. These are people with serious issues. And there are studies that say if you transfer these patients to new places, it is a stressful event that will negatively impact their health. People die when they are removed from these surroundings, and the court cited to that as another reason why it could not basically shut this case down.

**MR. GARFINKLE:** But isn't that—isn't it a dangerous slope to go down? I mean we've all faced issues where there are critical vendors to hospitals who

are being forced into a situation that's involuntary where they're being, basically at little to no compensation, forced to provide goods and services to a very defunct underwater hospital.

**MR. MAIZEL:** Yes. Yes, and the sun comes up in the morning.

**MR. GARFINKLE:** How should the court deal with that?

**MR. MAIZEL:** With apologies to bankruptcy judges who are present, bankruptcy judges are loathe to have people die in their cases. It is one thing to have a shoe store shut down. It is another thing to read in the morning newspaper over your coffee that someone died. The headline is: Patients Die. The smaller headline is: Bankruptcy Judge Shuts Facility. I do a lot of debtor work and I'll have this conversation with secured creditors. I mean, you may have a security interest in the hospital, but nobody is going to allow you to foreclose and padlock the doors. People are alive here and need care. It is just a different world. It is just a different kind of case than you'll get anywhere else. I mean, this case is a microcosm of what makes these healthcare bankruptcy cases so fascinating, because you've got this incredibly regulated industry matching up with this unique set of laws that control the bankruptcy world. So it's irresistible force meets immovable object. And this case is a microcosm of the issues that come up in these cases, the same issues that Judge Bonapfel and I were litigating against each other twenty years.

So look at the issues that were raised here. There is in the Medicare Act a prohibition against federal courts taking jurisdiction over Medicare disputes unless and until the provider exhausts their administrative remedies. Let me explain to you how exhausting that process is.

First, you submit your claim and it gets denied. You have to ask for a redetermination. Those are always denied. Then you send it up to the next level and they always deny your claim as well, but you've got to do it.

**MR. GARFINKLE:** The third level. It's the third level. That's another two years.

**MR. MAIZEL:** That takes about eight months generally to get that level. Then you get to go to the Office of Medicare Hearing and Appeals, which is an organization of thousands of administrative law judges spread throughout the country. The system is currently capable of handling about 70 to 80,000 claims a year. It currently has 800,000 claims pending, and it gets about 70,000 more claims every four to six weeks because there's so much emphasis on claim

review and denials and they've hired these quality assurance people to review claims and deny them. Because there's a presumption that everybody's a crook in this system, you can spend years waiting for your appeal to be heard at the this level. Then you go to the Medicare Appeals Council. Then you get to go to a federal court. That jurisdictional bar was rewritten in 1984, and previously it barred all federal court jurisdiction. In 1984 they rewrote it. They rewrote it because at the same time the U.S. Code was revised and it broke federal jurisdiction into a lot of different grants. Section 28 U.S.C. § 1334 is the bankruptcy jurisdictional grant.<sup>8</sup> When they rewrote the Medicare Act, they didn't list § 1334. When they listed out all the jurisdictional grants that were barred by this exhaustion remedy requirement, they didn't put § 1334 in there.

Now it's over thirty years ago and they haven't fixed it. When I was a government lawyer, I argued pretty successfully that this was a scrivener's error. I mean, the legislative history says they didn't mean to change anyone's rights; it's just a mistake. That was twenty years ago. Apparently nobody's bothered to correct it. Here in this case the court said, you know what? I'm a judge. I can read the Supreme Court. The Supreme Court says plain language of the statute. The statute doesn't bar bankruptcy court jurisdiction. If it's not vague or ambiguous I don't even look at the legislative history, so I don't care what the legislative history said. Bankruptcy jurisdiction is not barred. And courts are all over the place on this. Circuit courts are all over. The bankruptcy courts are all over there.

Another issue that was mentioned: this idea of the provider agreement being an executory contract. So outside of bankruptcy, the government argues that providers get no contractual rights by entering into a provider agreement, because they don't want you to go to the Court of Federal Claims and have the contract rights that all government contractors have. And if you ever see the agreement, it doesn't actually look like a government contract, which are usually delivered in wheelbarrows. It's a two-page document that says, congratulations, you're enrolled. Bill according to the number we gave you in the upper right hand corner and follow the rules, which we will change regularly. That's it.

Inside of bankruptcy, the government argues with equal success that it's an executory contract. I'm not sure what about filing a bankruptcy petition

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<sup>8</sup> 28 U.S.C. § 1334 (2012).

changes a non-government contract into a government contract, but that's subject to debate.

The issue of the impact of the automatic stay, the police powers exception, so in most of these cases the government is seeking to recover monies, pecuniary interest. But they will always argue that this is exempt from the automatic stay because it's a police or regulatory act, which generally in bankruptcy means you're supposed to be protecting the public welfare. In this case, they stopped paying but they didn't require the facility to close. So the bankruptcy judge said, well, if this is really about public welfare, public safety, why didn't you make the place close? All you did is say we're not going to pay you anymore. You can stay open. You can keep treating patients. That's okay; we're just not going to pay you. Made it sound like they were more interested in the money than patient welfare, which they basically were.

And also this issue of recoupment that was mentioned. This is a huge problem in bankruptcy courts. Recoupment is not subject to the automatic stay. The government argues with a lot of success that their rights to take money out of the stream of payments is a right of recoupment not subject really to the bankruptcy court's control in most cases. Obviously we want to argue it's set-off which is subject to the automatic stay and subject to bankruptcy court control.

**MR. GARFINKLE:** And prepetition, postpetition set-off rules that apply.

**MR. MAIZEL:** So all these issues this case has, it's worth reading the twenty-page opinion confirming the plan because it really summarizes pretty neatly a lot of these issues that have been litigated regularly for twenty years in these cases.

**MR. GARFINKLE:** And to finish up the story because we've got to move on to the next topic, after the plan was confirmed in *Bayou Shores*, they went effective almost immediately substantially consummated the plan which for the purposes of hopefully mooting the government's appeal which is now being litigated.

So we then move over back to the Affordable Care Act and a new concept but old concept that has come back to life. They're called accountable care organizations. This goes to the concept of value added services as opposed to incident pricing. And under § 3022 of the Patient Protection and Affordable

Care Act,<sup>9</sup> the CMS is directed to create Medicare-Medicaid shared savings programs. Very similar to HMO's which came into really functional existence in the late 1980's, early '90s, and as it's described by CMS, an ACO is an organization of healthcare providers that agree to be accountable for quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee for service programs who are assigned to it.

So basically you're taking a population of patients and putting them into a controlled service for all services, be it your primary care physician, be it your oncologist, be it your gastroenterologist, even all the way up to who your hospital is, one of the indications that Emory as its merger with WellStar was that this will help us create a more functional ACO program, and that's what's driving the proposed merger at least according to public press releases.

The ACO concept emerged in some discussions in the mid-2000's and then kept going and going until it was finally incorporated in the Affordable Care Act. It's very similar in purpose, again, to HMO's. There are well over 600 ACO's already created today around the country in every state. The earliest from 2012 to 2013 were termed pioneer ACO's. There were thirty-two of them. Eight of them have already been dissolved. The hope for expected benefits have yet to materialize for those earliest innovators, partly because the payment and reimbursement model that was initially created for the pioneer ACO's really didn't compensate the providers for the services that they were providing and the risk they were taking.

Under these ACO structures, the ACO is a separate legal entity. It contracts with CMS. In the materials that were handed out, I have provided the form ACO organization participation agreement that CMS requires. It's two pages, and it is signed by the Accountable Care Organization. From there, the Accountable Care Organization subcontracts with the various participating members, be they physicians, physician practice groups. Even suppliers of good and services can be members of an ACO. And why does this matter? Because there is a shared basically profit and loss structure, and under the initial structure of the ACO's, the first two years there were basically what I'm going to call loss leaders. There's no bearing of the loss. To the extent there were losses, CMS would step up and cover the losses according to certain formulas created.

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<sup>9</sup> Pub. L. No. 111-148, § 3022, 124 Stat. 119 (2010).

In year three, which we're now entering, those losses are now borne by the ACO. And so if one can be predictive as to what happened using the HMO model in the late '80's, early '90's, one can expect over the next five years to see ACO's enter into financial trouble and potentially bankruptcy court, which raises a whole host of issues.

Here are the basic structures as we think about ACO's and what CMS is now requiring of them. First, an ACO must be a separate legal entity. Typically what we're seeing is limited liability companies. An ACO must have its own separate and unique tax identification number; again, separate entity. Here's an interesting aspect, and it's going to be interesting how this plays out in the bankruptcy case: the governing body of an ACO must be separate and unique to the ACO. It may not be the same as the governing body of any ACO participant. And the ACO governing board owes a fiduciary duty to the ACO and not to any member.

So you have an ACO that's in trouble. Financial wherewithal is going down, and that ACO is made up of large physician groups. Who are they going to protect? Are they going to protect the ACO or are they going to protect their own physician groups or perhaps if they're standalone physicians, themselves? Who do they owe the duty to?

**MR. MAIZEL:** Jeff, why is that any different than a holding company that files, where we file, you know, a holding company and then a bunch of subs?

**MR. GARFINKLE:** Because in this instance, the ACO's, the physician practice groups are going to have to make decisions that make themselves sustainable as opposed to the ACO sustainable. And so in terms of taking acts during the course of the bankruptcy case, I want to get out of this relationship. I want to have you sequester and segregate and account for the funds that are coming into, which I'll get to because the flow of funds is very important here. I want you to do that and advocate for that in the bankruptcy case.

Are they insiders? Yes, they are. And so how is the court going to scrutinize the independent acts that the participant members of an ACO are taking to protect their own interests at the expense of the entity for which they owe the fiduciary duty to, the ACO entity.

And there must be a written agreement between each participating member in the ACO. I've given you a sample practice agreement that I found on the Internet from 2012. I've redacted the names. I'm sure somebody can find this on the internet, but it speaks to what all the duties of participating physicians

are, relative to each other, and the participation agreement must allow the ACO to take a remedial action against the ACO participant and vice versa.

The current legal structures—again, this is a very evolving concept, similar to what we had for LLC's as they emerged and we deal with LLC issues in bankruptcy. You can have physician-only ACO's. You can have nonprofit tax-exempt ACO's such as Emory is creating with I think Blue Cross Blue Shield and some other entities. For profit corporate models, and basic LLC, I've summarized them in the material.

The first question from a bankruptcy perspective is, is an ACO bankruptcy-eligible? Under § 109 of the Bankruptcy Code, entities are entitled to file bankruptcies unless they are a domestic insurance company.<sup>10</sup> Domestic insurance company is a term that's not defined in the Bankruptcy Code, and in the late '80s or during the 1980's, early 1990's, there was considerable litigation over HMO bankruptcy eligibility. All told, there were ten decisions issued during that period and they were split 50/50. They were done on a state-by-state basis. I mentioned them in the materials: Louisiana, Arizona, Illinois, Texas upheld the eligibility in certain court decisions, mostly arising out of a case in Los Angeles. That same court found that Wisconsin's system, their HMO system was so regulated at that time that an HMO was not eligible.

On the flip side, there are decisions from 1993 and 1989 holding that Illinois, New Jersey, and Oregon's HMO's were not bankruptcy eligible because they qualified as domestic insurance companies.

The National Association of Insurance Commissioners, termed NAIC, recognized this dilemma. The state insurance commissioners did not like having their HMO's in their states filing bankruptcy and so they quickly on a state-by-state basis passed legislation deeming HMO's to be a domestic insurance company and thereby eliminating this issue they hoped from the books.

But we go full circle. We're now twenty years later and we have ACO's, and we have some model acts that NAIC has propounded but it doesn't address accountable care organizations. So one can expect as these ACO's fail, and some will. We know that statistically. If you have 600 entities, probably like a restaurant or anyone else, any business, you have start-ups, we have best of intentions but there will be failures. And the first question out of the box is are

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<sup>10</sup> 11 U.S.C. § 109.



they bankruptcy eligible? And that's going to determine does federal preemption apply, given that CMS has promulgated the regulations by which these entities operate? And if there is no preemption argument then we look to the states and how they may going forward regulate them. And I guess we'll just have to wait and see how that develops on a state-by-state basis.

The next issue which of course arises when you're dealing with a healthcare bankruptcy case is, is an ACO a healthcare business? As part of BAPCPA,<sup>11</sup> this is the changes to the Bankruptcy Code that were enacted about ten years ago, the Code was amended to include a defined term called a healthcare business. And why do we have a healthcare business? Because of a concern that because of the unique nature of healthcare bankruptcy cases, the bankruptcy judges really needed to have eyes on the ground to make sure that patient care wasn't being jeopardized. And so we have § 333 of the Bankruptcy Code coming into play,<sup>12</sup> being enacted as part of BAPCPA which created the concept of a healthcare ombudsman that applies in all cases, 7's, 13's, 9's, and 11's. It's across the board. It does apply to 9's. Where you have a healthcare ombudsman to make sure patient care is being properly provided.

Is an ACO a healthcare business? The definition of a healthcare business is in § 101(27A) of the Code.<sup>13</sup> It says a private entity that is primarily engaged in offering diagnosis or treatment of injury, surgical, drug treatment, psychiatric or obstetric medicine, and includes other healthcare institutes similar to the listed entities. So is an ACO a healthcare business? The court found there's no answer to that question but it's going to have to be addressed.

And then the next level analysis, let's assume it's a healthcare business, let's assume there's an ombudsman appointed. What's the scope of the ombudsman's duties? Can it go down into the non-debtor participants' care level? Or is it just limited to what the ACO is doing? Bankruptcy judges around the country are going to have to struggle with this problem when these ACO's file. Again, I'm just raising issues. There are no answers yet because it hasn't come to the forefront.

Then we turn to what is kind of a hot button issue for me is the contracting issues. As you see these ACO's being formed, my healthcare partners keep

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<sup>11</sup> Pub. L. No. 109-8, 119 Stat. 23 (2005) (codified as amended in scattered sections of 11 U.S.C.). BAPCPA became fully effective for cases filed on or after Oct. 17, 2005.

<sup>12</sup> 11 U.S.C. § 333.

<sup>13</sup> *Id.* § 101(27A).

coming to me as well as my primary client McKesson keep coming to me and asking, how do we protect ourselves if an ACO has financial trouble? And of course from a credit risk analysis which is critical when you're negotiating these type of contracts, everyone has the best of intentions when they enter into a contract. We're all going to make money. It's going to be a great situation. We're going to be able to control the costs, get all the incentives that CMS is promising us. Little thought is given to what happens when it fails. From my perspective, having reviewed thousands of contracts over my career, that is the most important purpose of a contract. The most is to ask yourself how are the rights and remedies in that contract set forth and defined. And what's critical here is to think about the flow of money because everything comes down to money in these situations.

The participating entities in an ACO are billing through the ACO. CMS is paying the ACO which in turn pays the participants, be they whomever they are at the participating level. How do you protect yourself if you are the participant for those inflowing funds? If an ACO files bankruptcy, the monies that have already come in and long since spent are gone. You're never going to get them. Forget it. But there's still going to be cash coming in during the earliest stages of the case, which are attributable to the services provided by participating entities. And so again, not very well tested is to put in what we're suggesting is constructive trust language within the documentation to say that in the event an ACO files bankruptcy, any postpetition funds are held in constructive trust for the participants.

Now Sam is scoffing because he knows how—

**MR. MAIZEL:** I do debtor work. I mean, this is grist for the mill.

**MR. GARFINKLE:** —how skeptical most bankruptcy courts are to constructive trust theories. But the participants in this multi-party system need to be protected or you're going to see not only the bankruptcy filing of the ACO, but you're going to see the bankruptcy filings of the participants, and that's a lose-lose situation for all concerned, because now you've taken away the contracting entity with CMS but you're jeopardizing at the lower level the patient care entities that are actually providing the day-to-day services.

I wish I could say that there is a clean Bankruptcy Code answer to this problem; there isn't. So all we can do is try to build in structures into the agreements that we have that account for that credit risk that exists should an ACO enter bankruptcy.

So I think that fairly summarizes where we are, and I think we're right at four o'clock.

**MR. MAIZEL:** I think we have a couple of minutes for questions. Any questions about your health plans? Thank you all for making the time today. We appreciate it.

**AUDIENCE MEMBER:** In *Bayou Shores* the bankruptcy judge apparently enjoined the termination of the CMS agreement. And I was curious, the argument at appeal—

**MR. GARFINKLE:** You mean the District Court. The District Court enjoined it so it was federal district court litigation.

**MR. MAIZEL:** The District Court entered a TRO and then just to keep the parties in place until it could decide what to do, the District Court looked at the exhaustion of administrative remedies requirement, said that it was barred by it because its jurisdiction at that point, even though technically it's the bankruptcy court, the lawsuit wasn't brought under 28 U.S.C. § 1334, so it said I'm barred sitting as a district court, and it, I guess, voided or vacated the TRO order, right? And that's when they filed bankruptcy.

**AUDIENCE MEMBER:** My question generally then if it's not applicable in *Bayou Shores* is, would a bankruptcy judge in bankruptcy court have the authority to enjoin a kind of agreement like that?

**MR. MAIZEL:** Sure.

**MR. GARFINKLE:** I think probably if they had brought that TRO as an adversary proceeding under Rule 7001<sup>14</sup> and sought injunctive relief, the bankruptcy court could've done so.

**MR. MAIZEL:** Yeah.

**AUDIENCE MEMBER:** I was just reading the appellate brief. It said the argument was that they didn't have the authority under the Constitution, like Article III.

**MR. MAIZEL:** But then the District Court is operating under a different grant of jurisdiction and it has . . . I mean the thing about reading appellate briefs and briefs generally is lawyers get paid to make arguments, and I can assure you

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<sup>14</sup> FED. R. BANKR. P. 7001.

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the government lawyers will have arguments and the other side will have arguments. The trick is to figure out who's actually telling the truth.

**MR. GARFINKLE:** And not only who's telling the truth; which arguments are worthy of consideration. Some arguments, the judge will just say that's not worth my time.

**MR. MAIZEL:** I don't have any doubt that a bankruptcy court can enter an injunction to bar the federal government from taking an act under the right facts.

**MR. GOLDMINTZ:** Are there any other questions? That concludes today's Symposium. Let's give a round of applause to the panel. Thank you.