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The Triage and Treatment of Healthcare Institutions in Distress: How to Involve State Regulators in Healthcare Bankruptcies and Receiverships

Honorable Brian P. Stern and Christopher J. Fragomeni*†

INTRODUCTION

As hospitals and other healthcare institutions continue to face a changing landscape in methods of patient care, reimbursement models, and employment practices, some of these institutions will continue to become subject to court supervised insolvency proceedings, including federal bankruptcy and state court receiverships.¹ Financially distressed healthcare institutions pose

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1. See Gus Kallergis & Jean R. Robertson, *The § 363 Miracle Drug?*, 28 AM. BANKR. INST. J. 14, 14 (2009); Deryck A. Palmer & Michele J. Meises, *Collision Course Between Bankruptcy and Health Care Laws: Which Will Ultimately Control?*, 1999 ANN. SURV. OF BANKR. L. 1, 1 (1999); Veronique A. Urban & Ted A. Berkowitz, *Peninsula Hospital: Dissecting a Health Care*

unique and complex public policy concerns when the goals of an insolvency proceeding conflict with a state's responsibility to regulate the public health through state regulatory agencies.² In particular, the purpose of an insolvency proceeding, which is to maximize a monetary recovery for creditors, may conflict with a state regulatory agency's responsibility to ensure adequate and necessary healthcare under its certificate of need and licensing statutes.³ In such instances, due to a regulatory agency's statutory and inherent power, the exercise of its regulatory authority may affect the value of the bankruptcy estate and ultimately the amount and timing of funds distributed to creditors.⁴ This Article explores the goals of bankruptcy, receivership, and state regulation, and considers how courts have reconciled the interests of a healthcare debtor, its creditors, and state regulatory authorities. This Article submits that in the purview of healthcare insolvency, the early and continuous involvement of regulators throughout the insolvency proceeding will streamline the administration of the debtor's estate in a way that advances the state regulator's interests to protect the health, safety, and welfare of its citizens while maximizing recovery for the creditors. It further suggests several ways that regulatory involvement can be achieved, either formally or informally.

Part I of this Article briefly provides an overview of the process and goals of federal bankruptcy, state receivership proceedings, and state regulation of healthcare institutions. Part II identifies the material conflict between the goals of insolvency and governmental healthcare regulation. Part III explains the importance and power of state regulatory agencies and highlights how a regulatory authority can substantially affect an insolvency proceeding. Part IV discusses several recent healthcare

Business Bankruptcy, 32 AM. BANKR. INST. J. 42, 42 (2013); Ayla Ellison, *10 Recent Hospital Bankruptcies, Closures*, BECKER'S HOSP. REV. (Jan. 25, 2016), <http://www.beckershospitalreview.com/finance/10-recent-hospital-bankruptcies-closures-january25.html>.

2. See *In re United Healthcare Sys., Inc.*, No. 97-1159, 1997 WL 176574, at *5 (D.N.J. Mar. 26, 1997) (noting that healthcare institutions should be treated differently in insolvency proceedings).

3. "State agency" refers to any agency that can affect the transfer or sale of a healthcare institution including: (1) a state's department of health in transferring licenses and certificates of need or (2) a state's attorney general in transferring or disposing of a non-profit hospital's charitable assets.

4. See 11 U.S.C.A. § 524(g)(2)(B)(ii)(II) (Westlaw through Pub. L. No. 114-244); *In re United Healthcare*, 1997 WL 176574, at *10.

institutions' insolvencies and highlights the involvement, or lack of involvement, of state regulatory agencies and how such action or inaction affected the insolvency proceeding. Last, Part V will make several recommendations on how state regulators can be involved in bankruptcy and receivership proceedings so that a healthcare institution may successfully navigate through insolvency.

I. INSOLVENCY PROCEEDINGS, STATE REGULATION, AND THEIR GOALS

In order to evaluate the coarse interplay between insolvency and state regulation, it is important to understand the bankruptcy and receivership process as well as the manner in which states regulate healthcare facilities. Further, it is important to understand the goals and purposes of insolvency proceedings and state regulation and how they conflict.

A. *Bankruptcy*

1. *Bankruptcy Process*

If a healthcare institution or its creditors seek to initiate a bankruptcy proceeding, they may do so by filing a voluntary or involuntary petition⁵ under Chapter 7, 9, or 11 of the Bankruptcy Code.⁶ Under a Chapter 7 proceeding, a bankruptcy court takes control of a debtor's assets, liquidates them, and distributes the proceeds from the sale of the assets to the debtor's creditors in a manner consistent with the Code.⁷ In return for this liquidation, the debtor receives a discharge of certain debts.⁸ However, if the healthcare institution is owned or controlled by a "municipality,"⁹

5. See 11 U.S.C.A. §§ 301–303(b) (Westlaw through Pub. L. No. 114–244).

6. See 11 U.S.C.A. § 109(b)–(d) (Westlaw through Pub. L. No. 114–244); ALAN N. RESNICK & HENRY J. SOMMER, *COLLIER ON BANKRUPTCY* § 1.07(2), at 1–31 (16th ed. 2016) ("Chapter 9 is available only to a municipality and only by means of a voluntary petition."); Ellen E. Sward, *Resolving Conflicts Between Bankruptcy Law and the State Police Power*, 1987 WIS. L. REV. 403, 405 (1987).

7. See 11 U.S.C.A. §§ 701–784 (Westlaw through Pub. L. No. 114–244); RESNICK & SOMMER, *supra* note 6, § 1.07(1)(a), at 1–25.

8. See 11 U.S.C.A. §§ 523–524, 727(a) (Westlaw through Pub. L. No. 114–244).

9. 11 U.S.C.A. § 101(40) (Westlaw through Pub. L. No. 114–244); RESNICK & SOMMER, *supra* note 6, § 1.07(2), at 1–31 (defining "municipality" broadly as "political subdivisions or public agency or instrumentality of a

it may seek relief under Chapter 9 of the Code, provided that it has specific authorization from the state.¹⁰ Under Chapter 9, the municipality negotiates a plan with its creditors, bondholders, and note holders that enables the municipality to adjust its debt and continue operations.¹¹ If a healthcare institution petitions for bankruptcy under Chapter 11 of the Code, its debt is reorganized in a manner in which the debtor can pay the sum of its creditors' approved claims with its future earnings.¹² Reorganization is a "negotiating process, and Chapter [11] provides the milieu for such negotiation It [] provides . . . a balancing [] tool [] and leverage among the parties involved in the process to foster negotiation and bargaining."¹³

The most important effect of a bankruptcy filing—either under Chapter 7, 9, or 11—is the imposition of an automatic stay on any collection actions or claims against the debtor.¹⁴ The automatic stay serves as,

one of the fundamental debtor protections provided by the bankruptcy laws. It gives the debtor a breathing spell from his creditors. It stops all collection efforts, all harassment, and all foreclosure actions. It permits the debtor to attempt to [formulate a liquidation plan,] reorganization plan, [plan of adjustment,] or simply to be relieved of the financial pressures that drove [it] into bankruptcy.¹⁵

state," including "cities, towns, and counties").

10. 11 U.S.C.A. § 109(c)(2) (Westlaw through Pub. L. No. 114-244); RESNICK & SOMMER, *supra* note 6, § 1.07(2), at 1-31 (Chapter 9 is the only type of bankruptcy available to a municipality.). Such limitation is premised upon the separation of federal and state government:

The Tenth Amendment to the Constitution limits the power of Congress to prescribe for the state or any portion of a state and Chapter 9 reflects this limitation. For example, should a city file a Chapter 9 petition, the bankruptcy judge may not take over the governance of the city, appoint a trustee or otherwise interfere with the affairs of the city.

Id.

11. RESNICK & SOMMER, *supra* note 6, § 1.07(2), at 1-31.

12. *Id.*; see Sward, *supra* note 6, at 405.

13. RESNICK & SOMMER, *supra* note 6, § 1.07(3), at 1-31.

14. See 11 U.S.C.A. § 362 (Westlaw through Pub. L. No. 114-244). Importantly, as discussed *infra*, Part III, the automatic stay does not apply to state regulatory actions.

15. H.R. REP. NO. 95-595, pt. 1, at 340 (1977).

The purpose of the automatic stay is to prevent a creditor remedying its claims against the debtor to the detriment of other creditors.¹⁶ Without the automatic stay, creditors would be in a “race to the courthouse” to ensure a collection of their debts.¹⁷ Rather, the automatic stay provides a bankruptcy court and creditors the opportunity for an orderly liquidation and an equitable distribution of the debtor’s assets according to the priority of the creditors’ claims and rights under the Code.¹⁸ Specifically, the automatic stay prevents a debtor’s creditors from commencing or continuing a lawsuit; enforcing a judgment; controlling any property of the bankruptcy estate; creating, perfecting, or enforcing a lien; collecting debts; or exercising any rights of setoff against the debtor.¹⁹ While broad in its scope, the automatic stay has several exceptions, one of which, as discussed *infra*, specifically exempts state regulatory actions against the debtor.

2. Bankruptcy Goals

While the goals of the Code vary and are far reaching, the two main fundamental purposes of bankruptcy are (1) “either to rehabilitate financially a distressed debtor or to assemble and liquidate his assets for distribution to creditors,”²⁰ and (2) “to give the [debtor] a fresh start.”²¹ In achieving either goal, “the nature of bankruptcy is to sort out all of the debtor’s legal relationships with others, and to apply the principles and rules of the

16. See HON. NANCY C. DREHER & HON. JOAN N. FEENEY, BANKRUPTCY LAW MANUAL § 2:1, at 2 (5th ed. 2008).

17. See *In re Alyucan Interstate Corp.*, 12 B.R. 803, 806 (Bankr. D. Utah 1981). “The automatic stay . . . is designed ‘to prevent a chaotic and uncontrolled scramble for the debtor’s [assets] in a variety of uncoordinated proceedings in different courts.’” *Id.* (quoting *Fid. Mortg. Inv’rs v. Camelia Builders, Inc.*, 550 F.2d 47, 55 (2d Cir. 1976)). “Such procedural safeguard ‘shields creditors from one another by replacing ‘race’ and other preferential systems of debt collection with a more equitable and orderly distribution of assets.’” *Id.*

18. DREHER & FEENEY, *supra* note 16, § 2:1, at 2.

19. See 11 U.S.C.A. § 362(a)(1–7) (Westlaw through Pub. L. No. 114–244).

20. H.R. REP. NO. 95–595, pt. 1, at 10 (1977); see *In re Saint Vincents Catholic Med. Ctrs. of N.Y.*, 429 B.R. 139, 146 (Bankr. S.D.N.Y. 2010) (“One of the Bankruptcy Code’s main purposes . . . ‘is to convert the bankrupt’s estate . . . and distribute it among creditors.’”).

21. *Burlingham v. Crouse*, 228 U.S. 459, 473 (1913); see also RESNICK & SOMMER, *supra* note 6, § 1.01(1), at 1–4.

bankruptcy laws to those relationships.”²²

The first fundamental goal of bankruptcy—to either reorganize debts or liquidate assets for the benefit of creditors—is advantageous because it “secure[s] a prompt and effectual administration and settlement of the estate of all bankrupts within a limited period.”²³ However, in a Chapter 7 liquidation of assets, the distribution of the proceeds may not be done in an equal way; a creditor’s priorities determine the amount of their claim they will recover and whether they will receive that money before or after other creditors.²⁴ This hierarchical structure “protects the rights of senior creditors against dilution either by junior creditors or equity interests.”²⁵

Furthermore, the second goal of bankruptcy—to give a debtor a fresh start—“gives to the honest but unfortunate debtor . . . a new opportunity in life and a clear field for future effort, unhampered by the pressure and discouragement of preexisting debt.”²⁶ Thus, “[t]he essence of [bankruptcy] is to provide a mechanism for the reorganization of a financially distressed business . . . in the hope that a profitable and productive member of its economic community can one again emerge.”²⁷

B. *Receivership*

1. *Receivership Proceedings*

While there are many different types of receivership proceedings,²⁸ this Article will focus on state receivership in the

22. H.R. REP. NO. 95-595, pt. 1, at 10 (1977).

23. RESNICK & SOMMER, *supra* note 6, § 1.01(1) at 1-4 (quoting *Katchen v. Landy*, 382 U.S. 323, 328 (1966)).

24. *Id.*

25. *Id.* at § 1.01(1) at 1-5 (quoting *Marine Harbor Props. v. Mfrs. Tr. Co.*, 317 U.S. 78, 87 (1942)).

26. *Local Loan Co. v. Hunt*, 292 U.S. 234, 244 (1934) (citation omitted). This goal can be accomplished through Chapter 7 discharge of debts or a restructure of debts under Chapter 11 into a practicable and feasible future repayment plan. RESNICK & SOMMER, *supra* note 6, § 1.01(1), at 1-4. It can further be achieved by the Code’s allowance of debtors to withdraw assets from the bankruptcy estate up to a certain value. See 11 U.S.C.A. § 522(b)(1)-(2), (d) (Westlaw through Pub. L. No. 114-244).

27. RESNICK & SOMMER, *supra* note 6, § 1.07(3)(a), at 1-31 (alteration in original).

28. See 65 AM. JUR. 2D *Receivers* §§ 2, 3 (2011); see also WILLIAM MEADE FLETCHER, *FLETCHER CYCLOPEDIA OF THE LAW OF CORPORATIONS*, § 7708, at 168-69 (perm. ed., rev. 2015).

purview of insolvency. Due to its equitable nature, receivership serves as a practical, flexible, and more adaptable alternative to bankruptcy.²⁹ As an equitable remedy, receivership proceedings can “be tailored to the circumstances of the case to a much finer degree than a bankruptcy.”³⁰ For instance, in receivership, a court has the ability to set out procedures, rules, or any other mechanisms that are appropriate to the specific insolvency.³¹ Parties to a receivership proceeding may benefit from it because,

assets are sold or disposed of more quickly, and the secured lender’s collateral is more quickly adjudicated, [] notification of creditors is simplified, [] the lender has greater control over the disposition of assets and management of the case since the lender compensates the receiver, [] distributions to secured creditors generally proceed faster since subordinate classes of creditors typically receive no distribution, [] the lender is shielded from liability to third parties for negligence from possession, and [] the time required to eject a borrower is shortened under a receivership versus a foreclosure action.³²

Generally, the grounds for appointment of a receiver are designated by statute,³³ and one of those grounds is typically the dissolution or liquidation of a distressed business.³⁴ As mentioned above, a receiver may also be appointed in equity.³⁵ In addition, similar to a bankruptcy petition, a receivership proceeding may be initiated voluntarily (by the debtor) or involuntarily (by the

29. John M. Tanner, *Equitable Receivership as an Alternative to Bankruptcy*, 40 COLO. LAW 41, 46 (2011). “An equitable receivership may provide better relief for investors in or creditors of a troubled company than a bankruptcy reorganization. Receiverships immediately replace management, are more flexible, and can be more closely tailored to the situation.” *Id.* at 41. “Generally speaking, receivership proceedings are less formalistic and less structured than federal bankruptcy proceedings.” Allan M. Shine, *Receiverships Survive Pre- Emption Attack*, 47 R.I. B.J., Mar. 1999, at 11.

30. Tanner, *supra* note 29, at 41.

31. *See id.*

32. Shine, *supra* note 29, at 11 (citation omitted).

33. *See* FLETCHER, *supra* note 28, § 7709, at 171; *see also* DEL. CODE ANN. tit. 8, § 291 (2016); NEV. REV. STAT. ANN. § 32.010 (West, Westlaw through 2015 Reg. Sess.); N.Y. C.P.L.R. § 6401 (McKinney, Westlaw through 2016 Reg. Sess.); R.I. GEN. LAWS § 7-1.2-1316 (2016).

34. *See Receivers*, *supra* note 28, § 36.

35. Tanner, *supra* note 29, at 41.

creditors).³⁶ If a petition for receivership is approved, the court then appoints a receiver, who takes control of the debtor's assets.³⁷ By definition, a receiver is "an officer of the court to receive, collect, care for, administer, and dispose of the property or the fruits of the property of another or others brought under the orders of court by the institution of a proper action or actions."³⁸ More simply, a receiver is an indifferent, disinterested officer of the court, who is subject to the court's direction and orders, and who possesses and controls property for the court while ensuring redress and repayment of creditors' claims against the debtor.³⁹

As a receivership proceeding sounds in equity, a court has broad powers to prevent interference in administering the estate by issuing a stay order, similar to the automatic stay in bankruptcy proceedings.⁴⁰ A stay is typically issued in the order appointing a receiver and freezes the assets of the debtor, preventing the sale, attachment, garnishment, or levy of any lien against any property in the receivership estate.⁴¹ The purpose of a receivership stay is similar to the bankruptcy stay: "a receiver must be given a chance to do the important job of marshaling and untangling a company's assets without being forced into court by every investor or claimant."⁴² However, a court, in its discretion, may grant a creditor relief from the stay in order for the creditor to exercise its rights over property in the receivership estate.⁴³

2. *Receivership Goals*

Originally, receivership served as an equitable remedy for

36. *See Receivers, supra* note 28, §§ 11, 12.

37. *See* FLETCHER, *supra* note 28, § 7665, at 15–16.

38. RALPH E. CLARK, *A TREATISE ON THE LAW AND PRACTICE OF RECEIVERS* § 11, at 13 (3d ed. 1992) (citation omitted). While there are many types of receivers, this Article will focus on the court-appointed receiver. *See id.* § 11, at 13–15.

39. *See id.* § 35(a), at 37.

40. *See Receivers, supra* note 28, §§ 120, 400.

41. *See* CLARK, *supra* note 38, § 47, at 50; *Receivers, supra* note 28, § 124. A violation of the stay will void the conveyance and is grounds for contempt of court. *Id.* §§ 125, 129.

42. *United States v. Acorn Tech. Fund, L.P.*, 429 F.3d 438, 443 (3d Cir. 2005).

43. *See id.* ("Nevertheless, an appropriate escape valve, which allows potential litigants to petition the court for permission to sue, is necessary so that litigants are not denied a day in court during a lengthy stay."); *see also Receivers, supra* note 28, § 125.

creditors.⁴⁴ The fundamental purpose of any receivership action is to bring property under the control of the court so that it may be held pending litigation and possibly disposed of in order to satisfy judgments.⁴⁵ Concerning a liquidating receivership, however, there is generally one goal: “the maximizing of the value of the assets for the benefit of the creditors,”⁴⁶ which can be done either through the sale of the entity as a going concern, or a liquidation of the company’s assets.

C. *State Regulation of Healthcare Entities*

1. *State Power to Regulate*

All states bear the ability to exert “police powers” over their citizens, which have broadly been defined as the “power of governing, possessed by the States but not by the Federal Government”⁴⁷ The United States Supreme Court has explained that “[b]ecause the police power is controlled by 50 different States instead of one national sovereign, the facets of governing that touch on citizens’ daily lives are normally administered by smaller governments closer to the governed.”⁴⁸ Such traditional police power is properly exerted by a state when it regulates its citizens’ health, safety, and general welfare.⁴⁹

Additionally, “[a] state’s police power with regard to protection of the health, morals, and welfare of the public includes, by implication, the right to regulate by requiring a license as a prerequisite to the carrying on of certain activities, commonly designated as businesses, occupations, professions, vocations, trades, or callings.”⁵⁰ Most relevant and specific to the

44. Diane Finkle, *Attorney Practice Guide: Creditors’ and Debtors’ Rights*, 56 R.I. B.J. Mar.–Apr. 2008, at 9, 10 (citing CLARK, *supra* note 38, § 4, at 4); see FLETCHER, *supra* note 28, § 7812.50, at 16.

45. See CLARK, *supra* note 38, § 47, at 51; see also *Receivers*, *supra* note 28, § 181. “The court holds and administers the estate through receivership as its officer for the benefit of those whom the court will ultimately adjudge to be entitled to it.” FLETCHER, *supra* note 28, § 7810, at 448 (citation omitted).

46. *Fleet Nat’l Bank v. H & D Entm’t, Inc.*, 926 F. Supp. 226, 244 (D. Mass.), *aff’d*, 96 F.3d 532 (1st Cir. 1996).

47. *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2578 (2012) (citation omitted).

48. *Id.*

49. *Gonzales v. Oregon*, 546 U.S. 243, 300 (2006) (Thomas, J., dissenting).

50. 51 AM. JUR. 2D *Licenses and Permits* § 9 (2011) (citing Great Atl. &

topic of this Article, “[i]t is elementary that the promotion and protection of the public health is a proper subject for exercise of the police power of the State and, obviously, [healthcare institutions], whether publicly or privately owned, are operated for that purpose and subject to State regulation.”⁵¹ Generally, there are three instances in which states regulate a healthcare institution: (1) at its inception; (2) during its operation; and (3) during the transfer of its licenses, certificate of need, ownership, or the healthcare facility’s closure.⁵²

At a healthcare institution’s inception, the majority of states require that healthcare institutions satisfy the state’s certificate-of-need statute before providing any healthcare service within the state.⁵³ A certificate of need “requires a facility to obtain the

Pac. Tea Co. v. Grosjean, 301 U.S. 412 (1937)).

51. Foster v. N. Carolina Med. Care Comm’n, 195 S.E.2d 517, 528 (N.C. 1973) (alteration in original).

52. See 41 C.J.S. *Hospitals* §§ 6, 9 (Westlaw 2016).

53. Currently, almost every state requires a healthcare institution to obtain a certificate of need before operating. See ALA. CODE § 22-21-266 (West, Westlaw through 2016 Reg. Sess.); ALASKA STAT. § 18.07.031 (2016); CAL. HEALTH & SAFETY CODE § 127245 (West, Westlaw through 2016 Reg. Sess.); CONN. GEN. STAT. ANN. § 19a-638 (West, Westlaw through 2016 Reg. Sess.); DEL. CODE ANN. tit. 16, § 9304 (West, Westlaw through 80 Laws 2016) (effective Dec. 31, 2020); D.C. Code § 44-406 (2016); FLA. STAT. ANN. § 408.041 (West, Westlaw through 2016 Reg. Sess.); GA. CODE ANN. § 31-6-40 (2016); HAW. REV. STAT. ANN. § 323D-49 (West, Westlaw through 2016 Sec. Spec. Sess.); IOWA CODE ANN. § 135.63 (West, Westlaw through 2016 Reg. Sess.); KY. REV. STAT. ANN. § 216B.061 (West, Westlaw through 2016 Reg. Sess.); LA. STAT. ANN. § 40:2116 (West, Westlaw through 2016 Extr. Sess.); ME. REV. STAT. tit. 22, § 329 (West, Westlaw through 2015 Reg. Sess.); MO. ANN. STAT. § 197.315 (West, Westlaw through 2016 Reg. Sess.); MONT. CODE ANN. § 50-5-301 (West, Westlaw through 2015 Reg. Sess.); NEB. REV. STAT. ANN. § 71-5829.03 (West, Westlaw through 2016 Reg. Sess.); NEV. REV. STAT. ANN. § 439A.100 (West, Westlaw through 2015 Reg. Sess.); N.H. REV. STAT. ANN. § 151:5-a (2016); N.J. STAT. ANN. § 26:2H-7 (West, Westlaw through 2016 Reg. Sess.); N.Y. PUB. HEALTH LAW § 2802 (McKinney, Westlaw through 2016 Reg. Sess.); N.C. GEN. STAT. § 131E-178 (2016); OHIO REV. CODE ANN. § 3702.52 (West, Westlaw through 2016 Reg. Sess.); OKLA. STAT. ANN. tit. 63, § 1-851.3 (West, Westlaw through 2016 Reg. Sess.); OR. REV. STAT. ANN. § 442.315 (West, Westlaw through 2016 Reg. Sess.); 35 PA. STAT. AND CONS. STAT. ANN. § 448.603 (West, Westlaw through 2016 Reg. Sess.); 23 R.I. GEN. LAWS § 23-15-4 (2016); S.C. CODE ANN. § 44-7-160 (2016); TENN. CODE ANN. § 68-11-1607 (2016); VT. STAT. ANN. tit. 18, § 9434 (2016); VA. CODE ANN. § 32.1-102.3 (2016); WASH. REV. CODE ANN. § 70.38.115 (West, Westlaw through 2016 Reg. Sess.); W. VA. CODE ANN. § 16-2D-8 (West, Westlaw through 2016 Reg. Sess.).

state's approval prior to purchasing major medical equipment, changing institutional health services, or making a capital expenditure."⁵⁴ By its inherent nature, an application for a certificate of need will only be granted if there is a genuine need for the proposed healthcare facility.⁵⁵ While they vary from state to state, typically, the determination of a certificate of need is decided by statutory factors.⁵⁶ If statutory factors are not applicable, the regulating agency will review "the number of persons in each region who will need [the] services, and the resources needed to provide those services, which are then compared to existing resources to determine whether additional services are needed."⁵⁷

During a healthcare institution's operation, it is subject to state regulation over its day-to-day operations.⁵⁸ For instance, there are sanitary, labor, and insurance regulations imposed by states to assure that healthcare institutions are operating in accordance with business practices deemed a necessity by the state and to guarantee adequate healthcare treatment.⁵⁹

Healthcare institutions, specifically hospitals, are subject to licensing requirements in addition to certificate of need requirements.⁶⁰ Once a healthcare's certificate of need is approved, it must also make application for a license to operate a

54. Palmer & Meises, *supra* note 1, at 5.

55. 41 C.J.S. *Hospitals* § 10 (Westlaw 2016).

56. *Id.*

57. *Id.*

58. *See* Desai v. St. Barnabas Med. Ctr., 510 A.2d 662, 667–68 (N.J. 1986).

59. *See id.* This Article will not address this instance of regulation during an insolvency proceeding by states, as it has already been addressed by the Code. *See* 11 U.S.C.A. § 333 (Westlaw through Pub. L. No. 114-244). If a healthcare institution enters bankruptcy, a 2005 amendment to the Code permits a bankruptcy court to order the appointment of a patient care ombudsman "to monitor the quality of patient care and to represent the interests of the patients of the health care business." *Id.* Based on this amendment, it is likely that receivership proceedings would also appoint such an ombudsman to assure adequate patient treatment. Accordingly, the law in this instance of state regulation seems to be well settled, and this Article will only focus on state regulation during the subsequent sale of healthcare institutions that have entered insolvency proceedings.

60. 40A AM. JUR. 2D *Hospitals and Asylums* § 5 (2008) ("The operation of an institution for the shelter, feeding, and care of sick, aged, or infirm persons bears a reasonable relation to the health, safety, and welfare of the community, and is thus subject to licensing and regulation by the state as a valid exercise of the police power.").

healthcare institution.⁶¹ If a license is approved, it may be

61. *Id.* All states, except Ohio and the District of Columbia have licensing requirements for hospitals. See ALA. CODE § 22-21-22 (West, Westlaw through 2016 Reg. Sess.); ALASKA STAT. § 47.32.020 (West, Westlaw through 2016 Reg. Sess.); ARIZ. REV. STAT. ANN. § 36-430 (West, Westlaw through 2016 Reg. Sess.); ARK. CODE ANN. § 20-9-213 (West, Westlaw through 2016 Sec. Extr. Sess.); CAL. CODE REGS. tit. 22, § 70103 (West, Westlaw through 2016 Register); COLO. REV. STAT. ANN. § 25-3-101 (West, Westlaw through 2016 Reg. Sess.); CONN. GEN. STAT. ANN. § 19A-491 (West, Westlaw through 2016 Spec. Sess.) (effective Oct. 1, 2015 to Sept. 30, 2016); DEL. CODE ANN. tit. 16, § 1003 (West, Westlaw through 80 Laws 2016); D.C. CODE ANN. § 44-502 (West, Westlaw through 2016 Reg. Sess.); FLA. STAT. § 395.003 (West, Westlaw through 2016 Reg. Sess.); GA. CODE ANN. § 31-7-3 (West, Westlaw through 2016 Reg. Sess.); HAW. REV. STAT. § 321-14.5 (West, Westlaw through 2016 Sec. Spec. Sess.); IDAHO CODE § 39-1303 (West, Westlaw through 2016 Reg. Sess.); 210 ILL. COMP. STAT. 85/4 (West, Westlaw through 2016 Reg. Sess.); IND. CODE § 16-21-2-10 (West, Westlaw through 2016 Reg. Sess.); IOWA CODE ANN. § 135B.3 (West, Westlaw through 2016 Reg. Sess.); KAN. STAT. ANN. § 65-427 (West, Westlaw through 2016 Reg. Sess.); KY. REV. STAT. ANN. § 216B.105 (West, Westlaw through 2016 Reg. Sess.); LA. STAT. ANN. § 40:2103 (West, Westlaw through 2016 Reg. Sess.); ME. STAT. tit. 22, § 1811 (West, Westlaw through 2015 Reg. Sess.); MD. CODE ANN., HEALTH-GEN. § 19-318 (West, Westlaw through 2016 Reg. Sess.); MASS. GEN. LAWS ch. 111, § 51 (West, Westlaw through 2016 Reg. Sess.); MICH. COMP. LAWS § 333.21511 (West, Westlaw through 2016 Reg. Sess.); MINN. STAT. § 144.50 (West, Westlaw through 2016 Reg. Sess.); MISS. CODE ANN. § 41-9-7 (West, Westlaw through 2016 Reg. Sess.); MO. REV. STAT. § 197.040 (West, Westlaw through 2016 Reg. Sess.); MONT. CODE ANN. § 50-5-201 (West, Westlaw through 2015 Reg. Sess.); NEB. REV. STAT. § 71-432 (West, Westlaw through 2016 Reg. Sess.); NEV. REV. STAT. § 449.030 (West, Westlaw through 2015 Reg. Sess.); N.H. REV. STAT. § 151:2 (West, Westlaw through 2016 Reg. Sess.) (effective June 30, 2016); N.J. ADMIN. CODE § 8:43G-2.2 (West, Westlaw through 2016 amendments); N.M. STAT. ANN. § 24-1-5 (West, Westlaw through 2016 Reg. Sess.); N.Y. PUB. HEALTH LAW § 2805 (McKinney, Westlaw through 2016 Reg. Sess.); N.C. GEN. STAT. § 131E-77 (West, Westlaw through 2016 Reg. Sess.); N.D. CENT. CODE § 23-16-01 (West, Westlaw through 2015 Reg. Sess.); OKLA. STAT. tit. 63, § 1-702 (West, Westlaw through 2016 Reg. Sess.) (effective through Sept. 1, 2016); OR. REV. STAT. § 441.015 (West, Westlaw through 2016 Reg. Sess.); 35 PA. CONS. STAT. § 448.806 (West, Westlaw through 2016 Reg. Sess.); 23 R.I. GEN. LAWS § 23-17-4 (2016); S.C. CODE ANN. § 44-7-260 (West, Westlaw through 2016 Reg. Sess.); S.D. CODIFIED LAWS § 34-12-2 (West, Westlaw through 2016 Sess. Laws); TENN. CODE ANN. § 68-11-204 (West, Westlaw through 2016 Reg. Sess.); TEX. HEALTH & SAFETY CODE ANN. § 241.021 (West, Westlaw through 2015 Reg. Sess.); UTAH CODE ANN. § 26-21-8 (West, Westlaw through 2016 Third Spec. Sess.); VT. STAT. ANN. tit. 18, § 1903 (West, Westlaw through 2016 Spec. Sess.); VA. CODE ANN. § 32.1-125 (West, Westlaw through 2016 Reg. Sess.); WASH. REV. CODE § 70.41.090 (West, Westlaw through 2016 Reg. Sess.) (effective June 28, 2016); W. VA. CODE § 16-5B-2 (West, Westlaw through 2016 Reg. Sess.); WIS. STAT. § 50.35 (West, Westlaw through 2015 Act 392); WYO. STAT. ANN. § 35-2-902 (West, Westlaw through 2016 Budget Sess.).

revoked for certain causes enumerated by statute, typically having to do with gross negligence or abusive or reckless conduct.⁶²

In the event that a healthcare institution changes ownership, generally, neither a certificate of need nor a license can be transferred or assigned.⁶³ Therefore, a healthcare institution's most valuable asset—its licenses to operate—cannot be “acquired” as part of a transfer in ownership.⁶⁴ Instead, a change in ownership will require the application for a new set of licenses and certificate of need.⁶⁵ Thus, a purchasing organization must obtain a license and certificate of need through a purchaser's application for licensure.⁶⁶ Further, in addition to application for approval of a certificate of need and other licenses, many states require that the purchaser also seek approval from the state under “conversion laws,” which regulate the conversion of hospitals.⁶⁷

2. Goals of State Regulation

While state regulation of a healthcare facility has numerous purposes and goals, there are several goals specific to certificates of need and other licensing demands. The primary purpose of certificate of need statutes “is to ensure that the citizens of the state will receive necessary and adequate institutional health services in an economical manner.”⁶⁸ “Included among the

62. *Hospitals and Asylums*, *supra* note 60, §5.

63. Palmer & Meises, *supra* note 1, at 5; *see, e.g.*, 210 ILL. COMP. STAT. 85/4 (West, Westlaw through 2016 Reg. Sess.); IND. CODE ANN. § 16-29-2-7 (West, Westlaw through 2016 Reg. Sess.); LA. STAT. ANN. § 40:2115.11 (West, Westlaw through 2016 Reg. Sess.); N.Y. PUB. HEALTH LAW § 2801-A (McKinney, Westlaw through 2016 Reg. Sess.); OHIO REV. CODE ANN. § 3702.523 (West, Westlaw through through File 124 of the 131st General Assembly 2015–2016); 3 R.I. GEN. LAWS § 3-5-19 (2016); TENN. CODE ANN. § 68-11-1620 (West, Westlaw through 2016 Reg. Sess.); WYO. STAT. ANN. § 35-2-902 (West, Westlaw through 2016 Budget Sess.).

64. Palmer & Meises, *supra* note 1, at 5.

65. *Id.*

66. *Id.*

67. Samuel R. Maizel & Mary D. Lane, *The Sale of Nonprofit Hospitals Through Bankruptcy: What BAPCPA Wrought*, 30 AM. BANKR. INST. J. 12, 74 (2011); *see e.g.*, 23 R.I. GEN. LAWS § 23-17.14-5 (2016); CONN. GEN. STAT. § 19a-486c (West, Westlaw through 2016 Spec. Sess.) (effective Oct. 1, 2015 to Sept. 30, 2016); NEB. REV. STAT. ANN. § 71-20,104 (West, Westlaw through 2016 Reg. Sess.).

68. *Hospitals and Asylums*, *supra* note 60, § 6; 41 C.J.S. *Hospitals* § 9 (Westlaw 2016).

The essence of American certificate-of-need legislation, in general . . .

legitimate purposes for a certificate of need statute is ensuring geographically convenient access to healthcare for state residents”⁶⁹ Certificates of need accomplish this purposes by: (1) regulating capital expenditures of the healthcare institution; (2) preventing unnecessary expansion and encouraging “appropriate allocation of resources for healthcare purposes”; and (3) reducing healthcare cost through the prevention of “unnecessary duplication of health resources.”⁷⁰

State licensing requirements also serve several state regulatory goals. The inherent requirement in a state’s ability to require licenses is that such licensing requirements must relate to the health, moral, or general welfare of the state’s citizens.⁷¹ Accordingly, any purpose of a license requirement must advance those goals. For instance, a state may establish certain standards that must be satisfied as a prerequisite to engaging in the regulated activity, thereby being able to ensure the competency and fitness of the licensee.⁷² By vetting a licensee’s training, knowledge, and experience, and holding them to certain standards, the state protects the public from being subject to unreasonable risk from unqualified individuals engaging in the licensed activity.⁷³ Such license protections allow for uniformity within the regulated field and ensure that the licensed services are being provided in an adequate manner.

II. THE INHERENT CONFLICT BETWEEN THE GOALS OF STATE

[is] to provide the statutory ability to refuse permission to build beds or provide services, without providing any counter-balancing authority to initiate action to either build more beds when they are needed or develop alternative patterns of care that would make more beds unnecessary.

Gerard R. Goulet, *Certificate of Need Over Hospitals in Rhode Island*, 15 ROGER WILLIAMS U. L. REV. 127, 130 (2010).

69. *Hospitals*, *supra* note 68, § 9.

70. *Hospitals and Asylums*, *supra* note 60, § 6; 41 C.J.S. *Hospitals* § 9 (Westlaw 2016).

71. *Williamson v. Lee Optical of Okla., Inc.*, 348 U.S. 483, 487–88 (1955). If the license requirement is rationally related to the health, safety, morals, or general welfare of society, it is a proper exercise of the state’s police function. *Id.* at 489. As the Supreme Court has explained, “[t]he day is gone when [a] Court uses the Due Process Clause of the Fourteenth Amendment to strike down state laws, regulatory of business and industrial conditions, because they may be unwise, improvident, or out of harmony with a particular school of thought.” *Id.* at 488.

72. 51 AM. JUR. 2D *Licenses and Permits* §§ 51, 52 (2011).

73. *See id.* § 82.

REGULATION AND INSOLVENCY PROCEEDINGS

In examining the purposes and goals of bankruptcy, receivership, and state regulation, an inherent conflict between the purposes of insolvency proceedings and state regulatory goals is evident when a healthcare institution is a debtor.⁷⁴ In fact, this conflict was the primary focus of *In re United Healthcare Systems, Inc.*⁷⁵ when a federal district court recognized that the case “present[ed] the very complex and difficult interrelation between public healthcare and bankruptcy.”⁷⁶

United Healthcare Systems, Inc. (United) was a New Jersey hospital that offered healthcare services to children and adults.⁷⁷ In the beginning of 1997, United, who was experiencing serious financial trouble, notified the Commissioner of Health and Senior Services of New Jersey of its economic plight, which was attributable to the fact that its primary lender refused to advance it any further funds.⁷⁸ Recognizing the importance of United’s services to the citizens of New Jersey, the Commissioner provided United with \$3 million to keep pediatric care operating.⁷⁹ Further, because United’s doctors and nurses were being solicited by other hospitals, the Commissioner issued a moratorium against the hiring of United’s medical staff.⁸⁰

Over the next month, United worked with the Commissioner to draft a request for proposal (RFP) for the sale of United’s

74. *In re United Healthcare Sys., Inc.*, No. 97-1159, 1997 WL 176574, at *5 (D.N.J. Mar. 26, 1997).

75. *Id.*; see also Maizel & Lane, *supra* note 67, at 12.

76. *In re United Healthcare*, 1997 WL 176574, at *1. The *United Healthcare* Court was the first to address the interrelation between public healthcare and insolvency; in fact, it noted that it was a matter of first impression at the time. *Id.* at *5.

77. *Id.* at *1.

78. *Id.*

79. *Id.* The Commissioner stated:

[T]he services currently provided at United are extremely critical and cannot be discontinued without disrupting a crucial source of care for the community. United, for example, currently has over 150 patients, including numerous neonatal and pediatric patients in neonatal intensive care, pediatric intensive care, neonatal intermediate care, and patients in a general care pediatric floor. I therefore conclude that an emergency situation exists necessitating the use of the expedited review process.

Id. at *2.

80. *Id.* at *1. The moratorium was in effect until February 14, 1997. *Id.*

assets.⁸¹ Four bidders responded to the RFP: Saint Barnabas Corporation (Saint Barnabas), University of Medicine and Dentistry of New Jersey/Cathedral Healthcare Systems, Inc. (University of Medicine and Dentistry), Primary Health Care (Primary Health), and Medical Management of America (Medical Management).⁸² After reviewing the submissions, United's Board of Trustees "awarded the sale of United to Saint Barnabas."⁸³ The next day, Saint Barnabas and United negotiated and finalized a definite agreement that memorized the sale.⁸⁴ Pursuant to the agreement, United was to file Chapter 11 bankruptcy so that Saint Barnabas would not have to assume United's liabilities.⁸⁵ Additionally, the agreement required United and Saint Barnabas to apply for and obtain requisite certificates of needs and licenses.⁸⁶ Due to the emergent nature of United's financial crisis, the Commissioner granted the certificate of needs and authorized United to close its hospital and Saint Barnabas to operate a pediatric acute care facility.⁸⁷

Pursuant to the agreement, United filed bankruptcy under Chapter 11 of the Code the next day.⁸⁸ At the same time, United filed an "Application for an Order Authorizing the Sale of Certain of Debtor's Assets" (Sale Application) under § 363 of the Code.⁸⁹ However, University of Medicine and Dentistry filed an objection to the Sale Application and tendered an offer for United's assets.⁹⁰ The bankruptcy court held that "it was the clear intention of the parties that . . . in the § 363 bankruptcy process the Court would have the opportunity to take higher and better offers, subject to the Commissioner's approval required in the certificate of need process."⁹¹ Further, the bankruptcy court determined that "the Board's decision to award the sale to Saint Barnabas was not a sound business judgment" as it "defeated the ability of the

81. *Id.*

82. *Id.*

83. *Id.* at *2.

84. *Id.*

85. *Id.*

86. *Id.*

87. *Id.* at *2-3.

88. *Id.* at *3.

89. *Id.*

90. *Id.*

91. *Id.* (quoting *In re United Healthcare Sys., Inc.*, No. 97-21785, at *9 (Bankr. D.N.J. Mar. 5, 1997)).

Bankruptcy Court to carry out its function to obtain a fair price for the debtor's assets for the benefit of the creditors of th[e] estate."⁹² Consequently, because the sale to Saint Barnabas was not as beneficial to creditors as the sale to University of Medicine and Dentistry, the bankruptcy court voided the sale.⁹³ United appealed to the district court, arguing that the bankruptcy court abused its discretion in voiding the sale to Saint Barnabas.⁹⁴

The district court, in its review of the bankruptcy court's decision, recognized that "[t]he issue of the interrelation of [a] [s]tate's healthcare concerns and the bankruptcy court's monetary goals" are hard to reconcile.⁹⁵ Noting that healthcare institutions pose unique and complex policy considerations, the district court held that they are "[u]nlike the sale of corporations in the private sector," because a healthcare institution's petition for insolvency "involves the rights and obligations of the State to govern public health."⁹⁶ For instance, "[t]he most valuable asset of the [healthcare institution], *i.e.*, its goodwill, is inextricably intertwined with the requisite [certificate of needs] and licenses which can only be granted by the [state]."⁹⁷ Accordingly, the district court held that a court must "look to the overriding consideration of public health represented by the virtual orchestration of the . . . sale process" of a healthcare institution.⁹⁸ With that policy consideration in mind, the district court held that a court "cannot mechanically apply [insolvency] principles of 'highest and best' offer" in the sale of a healthcare institution.⁹⁹ The district court explained that instead, a court "must not only weigh the financial aspects of the transaction but also look to the countervailing consideration of a public health emergency."¹⁰⁰ The district court further explained that courts should engage in a

92. *Id.* (quoting *In re United Healthcare Sys., Inc.*, No. 97-21785, at *17 (Bankr. D.N.J. Mar. 5, 1997)).

93. *Id.* The bankruptcy court found that University of Medicine and Dentistry's offer "saved more jobs; gave better protection to physician contracts and was for more money when the waiver of [University of Medicine and Dentistry] over \$1 million claim is factored in the equation." *Id.* at *6.

94. *Id.* at *3.

95. *Id.* at *5.

96. *Id.*

97. *Id.*

98. *Id.*

99. *Id.*

100. *Id.* at *5.

“totality of the circumstances” approach and not “overwhelmingly focus[] on the monetary aspects of [] competing bids.”¹⁰¹ Because the bankruptcy court simply made a monetary analysis, without consideration to the state’s need to regulate healthcare institutions, the district court reversed the decision of the bankruptcy court and remanded the matter for further consideration.¹⁰²

In re United Healthcare illustrates the inherent conflict that exists when state regulation of healthcare institutions collides with the goals and purposes of insolvency proceedings.¹⁰³ This dichotomy is seen in the differing approaches employed by the bankruptcy court and district court: while the bankruptcy court conducted a pure monetary analysis, finding “highest and best” offer to be appropriate because it resulted the maximum recovery for creditors, the district court recognized that the case presented a unique situation in which the “highest and best” offer may not yield the best result without taking public health concerns into account.¹⁰⁴ In *In re United Healthcare*, it is apparent that the district court gave effect to the Commissioner’s actions and the state’s need for pediatric services in Newark, New Jersey, which served to trump University of Medicine and Dentistry’s “highest and best” offer.¹⁰⁵

The conflict between achieving a maximum recovery for creditors and ensuring compliance with healthcare regulation can be illustrated in more specific instances. For example, a state regulatory agency may believe that the hospital should be closed completely because either the need for such services has decreased or the hospital cannot afford to stay open.¹⁰⁶ However, creditors

101. *Id.* at *5, 6.

102. *Id.* at *5, 10.

103. *See id.* at *1–10.

104. *Id.* at *5.

105. *See id.* at *7. The district court found that “the [bankruptcy] [c]ourt is without the technical and expert knowledge to second guess the Commissioner on public health and safety issues.” *Id.* at *8. Further, it pronounced that “[c]ourts are not experts in public health and safety issues and this Court bows to the knowledge of the Commissioner in those areas. If the Commissioner felt that there was a public need for the Children’s Hospital to be operated as a unit . . . , federal courts should accept it as such.” *Id.*; *see also* Palmer & Meises, *supra* note 1, at 13–14.

106. *See In re Saint Vincents Catholic Med. Ctrs.*, 429 B.R. 139, 143 (Bankr. S.D.N.Y. 2010), discussed *infra*. The hospital in *In re Saint Vincents* arguably closed because “the State Department of Health said there [was] no

may believe that a return on the hospitals assets can be maximized if it is sold as a going concern entity.¹⁰⁷ Additionally, an acquirer of a hospital may make assumptions that it will be able to renegotiate Medicaid or commercial insurance contracts in order to receive higher reimbursement rates; yet, a state regulator charged with Medicaid regulation may reject such proposed modifications because a reimbursement rate may be statutorily capped.¹⁰⁸ Or, a sale of a not-for-profit hospital to a for-profit entity, which may yield a higher return to the creditors, may be objected to by the state because such sale would result in a decrease in charitable healthcare. Further, the selling hospital may need an expedited review of the acquiring entity's transfer licenses so that a sale may be finalized; however, state regulators may need to conduct their due diligence to ensure the purchaser is qualified to provide healthcare to the state's citizens, regardless of how long that process may take.¹⁰⁹

III. THE IMPORTANCE OF STATE REGULATORS

A regulator can be a debtor's most "valuable ally" or "worst nightmare" because of the substantial impact they can have on an insolvency proceeding.¹¹⁰ Regulators derive their powers from (1) explicit powers in the Code and federal law and (2) their inherent powers outside the Code, such as their ability to grant or deny certificates of need or licenses, make capital infusions, or waive administrative fees.¹¹¹

need for an acute care hospital in Greenwich Village." Kevin Clarke, *The Last Days of St. Vincent's*, AMERICA, July 5, 2010, at 18.

107. See *In re Saint Vincents Catholic Med. Ctrs.*, 429 B.R. at 143, discussed *infra*.

108. *Gaube v. Landmark Med. Ctr.*, No. 08-4371, at 3-5 (R.I. Super. Ct. Jan. 7, 2015) (order denying plaintiff's Motion to Enforce); see also Richard Salit, *Landmark denied pass on Medicaid minimums*, PROVIDENCE J., Jan. 12, 2015, at A1, A6.

109. See Application for Expedited Consideration of First Day Matters at 1, *In re Saint Michaels Med. Ctr., Inc.*, 15-24999 (Bankr. D.N.J. Aug. 10, 2010), discussed *infra*.

110. Stuart Phillips & Hal F. Morris, *The Care and Feeding of State Regulators in Chapter 11 Cases*, 22 AM. BANKR. INST. J. 8, 8 (2003).

111. See U.S. CONST. amend. XI; 28 U.S.C.A. § 959(b) (Westlaw through Pub. L. No. 114-244); 11 U.S.C.A. §§ 362(b)(4), 503(b) (Westlaw through Pub. L. No. 114-244).

A. *The Code and Other Federal Laws*

Under the Code, a regulator's importance and power stems from their ability to ensure that the debtor, bankruptcy trustee, or receiver is operating its business in a lawful manner during the insolvency proceedings.¹¹² Such ability is less restrictive than other creditors or parties in the insolvency proceeding because federal law requires that the debtor comply with all state laws during the time of the insolvency.¹¹³ On a federal level, this grant of power and authority to state regulatory agencies is found in the Code, the U.S. Code, and the U.S. Constitution.¹¹⁴

The U.S. Code requires that all trustees, receivers, and debtors in possession comply with state regulations and laws during the insolvency proceeding. Specifically,

a trustee, receiver or manager appointed in any cause pending in any court of the United States, including a debtor in possession, shall manage and operate the property in his possession as such trustee, receiver or manager according to the requirements of the valid laws of the State in which such property is situated, in the same manner that the owner or possessor thereof would be bound to do if in possession thereof.¹¹⁵

Courts have interpreted this section of the U.S. Code to mean that the trustee, receiver, or debtor in possession must comply with state laws and regulation as if no insolvency proceeding were in place.¹¹⁶

112. Phillips & Morris, *supra* note 110, at 8.

113. *See id.*; 28 U.S.C.A. § 959(b) (Westlaw). Any state action, proceeding or judgment against a debtor in order to enforce the state's regulatory power is exempt from the automatic stay. *See* 11 U.S.C.A. § 362(b)(4) (Westlaw). "The legislative history for this police power exception is sparse, but it indicates that the police power exception was not intended to be given an expanded interpretation. Rather, Congress intended only to safeguard the states' ability to protect the health and safety of their citizens." Sward, *supra* note 6, at 421–22.

114. *See* U.S. CONST. amend. XI; 28 U.S.C.A. § 959(b) (Westlaw); 11 U.S.C.A. §§ 362(b)(4), 503(b) (Westlaw); *see also* Phillips & Morris, *supra* note 110, at 8.

115. 28 U.S.C.A. § 959(b) (Westlaw).

116. Phillips & Morris, *supra* note 110, at 8; *see also* SEC v. Wealth Mgmt., LLC, 628 F.3d 323, 334 (7th Cir. 2010) ("Just as an owner or possessor of property is required to comply with state law, so too must a receiver comply with state law in the 'management and operation' of the receivership property in his possession.").

Specific to bankruptcy, certain exceptions have been carved out of the Code for regulators. First, in certain instances, regulators may claim an exception to the automatic stay.¹¹⁷ While the automatic stay affords a debtor relief inasmuch as it halts or prevents any claims against the debtor, an exception exists to the automatic stay for a state to exercise its “police powers.”¹¹⁸ “This so-called ‘police power exception’ specifically empowers regulators to continue to exercise their police and regulatory power against the debtor (including, incidentally, fixing the amount of fines or penalties owed to the government).”¹¹⁹ Second, in a bankruptcy proceeding, the Code provides that regulatory fees and fines imposed post-petition for bankruptcy are to be treated as administrative expenses, and thus entitled to priority in distributing the estate.¹²⁰ Further empowering a state regulator in a bankruptcy proceeding is the fact that the Eleventh Amendment to the Constitution protects any state (or its regulatory agencies) from being a part of a federal law suit; therefore, a debtor in bankruptcy may only have limited circumstances in which it is seek remedies against the regulator.¹²¹

As seen above, the Code, the U.S. Code, and the U.S. Constitution provide a state regulator with the ability and power to drastically change and affect the outcome of an insolvency proceeding by assuring the debtor’s lawful compliance with state laws, or increasing fees, costs, and administrative expenses charged to the estate.

B. *Inherent Powers Outside the Code*

Regulators further derive their power from their inherent

117. See 11 U.S.C.A. § 362(b)(4) (Westlaw).

118. See *id.*

119. Phillips & Morris, *supra* note 110, at 8; see also *In re Saint Vincents Catholic Med. Ctrs.*, 429 B.R. 139, 148 (Bankr. S.D.N.Y. 2010) (“Courts have narrowly construed 362(b)(4) to allow actions by governmental units to continue if they are enforcing laws affecting health, welfare and public safety and not to merely protect its pecuniary interest.”).

120. See 11 U.S.C.A. § 503(b) (Westlaw).

121. See U.S. CONST. amend. XI (“The Judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by Citizens of another State, or by Citizens or Subjects of any Foreign State.”); Phillips & Morris, *supra* note 110, at 8.

ability to approve, deny, or otherwise modify any license or certificate of need necessary to operate a healthcare institution or to affect a healthcare institution's finances by making capital infusions, waiving licensing fees, or issuing loans secured by bonds.

1. *Licenses and Certificates of Need*

Perhaps the most obvious and inherent power of a regulator is its ability to approve licenses and certificates of need because such approval is a requisite to operation of a healthcare institution.¹²² If an entity wishes to operate a hospital, it must first receive approval from the state's department of health.¹²³ Therefore, the department of health's decision as to whether to grant a license or certificate of need is a gateway to operating a hospital; the existence or non-existence of a hospital is dependent upon the department of health's decision and finding that such hospital is needed. Such ultimate determination gives the department of health the power over the operation or closure of healthcare institutions. For example, Peninsula Hospital was a New-York-based not-for-profit teaching hospital with resident-training programs in "orthopedics, general surgery and family practice."¹²⁴ Peninsula Hospital faced serious financial trouble and submitted a plan of closure to the New York Department of Health (NY DOH).¹²⁵ However, that plan of closure was subsequently withdrawn¹²⁶ and, on August 16, 2011, an involuntary Chapter 11 petition was filed against Peninsula Hospital.¹²⁷ Thereafter, NY DOH informed Peninsula Hospital that it was "extremely concerned about the current ability of Peninsula to admit new patients in a manner that maintain[ed] patient safety and me[t] minimum standards required by the State Hospital Code."¹²⁸ As a

122. See *Hospitals and Asylums*, *supra* note 60, § 5.

123. See *id.*

124. Urban & Berkowitz, *supra* note 1, at 1.

125. *Id.*

126. *Id.*

127. See Involuntary Chapter 11 Petition, *In re* Peninsula Hospital Ctr., 11-47056 (Bankr. E.D.N.Y. Aug. 16, 2011), ECF No. 1. Peninsula Hospital ultimately consented to an order for relief. See Consent To The Entry Of An Order For Relief, *In re* Peninsula Hospital Ctr., 11-47056 (Bankr. E.D.N.Y. Sept. 19, 2011), ECF No. 20.

128. Urban & Berkowitz, *supra* note 1, at 1 (quoting Letter from Richard M. Cook, Deputy Commissioner, Office of Health Systems Management, to

result, NY DOH prohibited Peninsula Hospital from admitting any new patients.¹²⁹

Five months later, Wadsworth Center, a public health laboratory that was run by NY DOH, conducted an inspection at Peninsula Hospital that resulted in the issuance of two summary orders: (1) an order summarily suspending Peninsula Hospital's clinical laboratory permit for thirty days; and (2) an order determining that the continued operation of Peninsula Hospital without the services of its clinical laboratory poses a danger to the health of current and future patients and required that Peninsula Hospital divert ambulances, cease admitting new patients, immediately develop a plan to relocate current patients, cancel all surgeries and procedures, and suspend all general activity dependent on laboratory services.¹³⁰

One day after the issuance of the NY DOH's orders, the U.S. Trustee filed a motion seeking the appointment of a Chapter 11 Trustee, arguing that there was gross mismanagement of Peninsula Hospital and that the appointment of a trustee was in the best interests of Peninsula Hospital's creditors.¹³¹ Upon consent of the parties, a Chapter 11 Trustee was appointed.¹³² Following operational and financial due diligence, the Chapter 11 Trustee submitted a plan of closure for Peninsula Hospital, which was approved by NY DOH—the hospital promptly closed and thereafter on April 9, 2012, its emergency department and services no dependent on a clinical laboratory ceased.¹³³ It has been observed that NY DOH's decision to close Peninsula Hospital's clinical laboratory “sealed the hospital's fate,” and lead

Robert Levine, President and CEO, Peninsula Hospital Center (Aug. 19, 2011) (on file with N.Y. Department of Health)).

129. *Id.*

130. See Motion to Appoint Trustee Pursuant to 11 U.S.C § 1104(a)(1) and (2) at Exs. C and D, *In re Peninsula Hospital Ctr.*, 11-47056 (Bankr. E.D.N.Y. Feb. 24, 2012), ECF Nos. 438-4, 438-5.

131. See Motion to Appoint Trustee Pursuant to 11 U.S.C § 1104(a)(1) and (2) at 19-20, *In re Peninsula Hospital Ctr.*, 11-47056 (Bankr. E.D.N.Y. Feb. 24, 2012), ECF No. 438.

132. Consent Order Directing the United States Trustee to Appoint a Chapter 11 Trustee, *In re Peninsula Hospital Ctr.*, 11-47056 (Bankr. E.D.N.Y. Mar. 6, 2012), ECF No. 463.

133. See Status Report of Chapter 11 Trustee at 1–2, *In re Peninsula Hospital Ctr.*, 11-47056 (Bankr. E.D.N.Y. Mar. 26, 2012), ECF No. 510; see also Second Status Report of Chapter 11 Trustee at 2, *In re Peninsula Hospital Ctr.*, 11-47056 (Bankr. E.D.N.Y. Mar. 26, 2012), ECF No. 542.

to its ultimate closure.¹³⁴

2. *Capital Infusions*

After the grant of the requisite licenses, or during the insolvency proceeding, state regulators can also affect a healthcare institution's financial status by making capital infusions, waiving fees, and issuing loans. As seen in *In re United Healthcare supra* and discussed *infra* in Part IV, state regulatory agencies have assisted distressed hospitals by giving them operating capital to prevent bankruptcy and allow time for a transfer of ownership.¹³⁵ The capital allows the hospital to continue operation and ensures the state regulator that the public need is being met while also allowing time for the hospital to seek sponsors, partners, or potential purchasers to help satisfy its obligations to its creditors.¹³⁶ Such capital contribution literally can "buy time" for an insolvent hospital to assess its financial options and determine a plan of action, making regulators a valuable ally in tough economic times. Capital infusions by state regulators typically take the form of "debtor in possession" (DIP) financing from the state.¹³⁷ For instance, Interfaith Medical Centers, a not-for-profit hospital in New York, successfully navigated through a Chapter 11 bankruptcy because the NY DOH

134. Rich Brockman, *Peninsula Trustee Alleges Fraud Lead to Closure*, TIMES LEDGER (Sept. 20, 2013), http://www.timesledger.com/stories/2013/38/peninsulalawsuit_tl_2013_09_20_q.html; see also N.Y. STATE DEPT OF HEALTH, REPORT ON THE CLOSING OF PENINSULA HOSPITAL (2012), https://www.health.ny.gov/events/public_hearing_reports/peninsula_hospital/docs/2012-07-10_public_hearing_closure_rpt.pdf.

135. See *In re Interfaith Med. Ctr., Inc.*, 1-12-48226 (Bankr. E.D.N.Y. Dec. 2, 2012); *In re Saint Vincents Catholic Med. Ctrs. of N.Y.*, 10-11963 (Bankr. S.D.N.Y. Apr. 14, 2010); *In re United Healthcare Sys., Inc.*, 1997 WL 176574 (L. Civ. R. Mar. 26, 1997).

136. See, e.g., Debtor's Motion for Interim and Final Orders: (I) Authorizing the Debtor to Utilize Cash Collateral of Prepetition Secured Party; (II) Granting a Superpriority Claim; (III) Granting Adequate Protection; (IV) Providing Related Relief; and (V) Scheduling a Final Hearing at 3, *In re Interfaith Med. Ctr., Inc.*, 1-12-48226 (Bankr. E.D.N.Y. Dec. 2, 2012), ECF No. 7 [hereinafter Debtor's Motion for Interim and Final Orders].

137. See *id.* at 1–9 (noting that many DIP loans treat the state as a bank); Pei Shan Hoe, *Hospital troubles leave taxpayers on hook to pay back state loans*, THE NEW YORK WORLD (May 22, 2012), <http://www.thenewyorkworld.com/2012/05/22/hospital-troubles-leave-taxpayers-on-hook-to-pay-back-state-loans>. DIP loans by the state are typically backed by bonds, and the bonds are guaranteed by the state. *Id.* Therefore, if the hospitals fail to pay the bonds, the state must pay the investors. *Id.*

and Dormitory Authority of New York (DANY) gave it a capital infusion to filibuster its closure.¹³⁸ After Interfaith Hospital (Interfaith) entered Chapter 11 bankruptcy, NY DOH was dissatisfied with the management of Interfaith and in a letter to Interfaith's Board of Directors explained that it would only fund Interfaith if Interfaith submitted a business restructuring plan that would enable Interfaith to operate outside of Chapter 11 without future funding by NY DOH.¹³⁹ Interfaith submitted its restructuring plan, but NY DOH rejected the plan as not "fiscally viable"; therefore, NY DOH ordered Interfaith to submit a plan of closure.¹⁴⁰ NY DOH indicated that if the plan of closure were submitted, DIP financing would be available but such availability was conditioned on closure of Interfaith.¹⁴¹ Because no other funding was available, and a transfer of ownership looked unfeasible, Interfaith submitted a motion to the bankruptcy court for approval to close.¹⁴² With Interfaith's only option besides closing being receiving funding from the state, the bankruptcy court continued Interfaith's motion to close, and referred the closure to mediation with the hope that an agreement could be made between NY DOH and Interfaith.¹⁴³ Despite hesitation by NY DOH, the matter emerged from mediation with an agreement between Interfaith, NY DOH, and DANY, in which DANY's DIP

138. See Debtor's Motion for Interim and Final Orders, *supra* note 136, at 2–5.

139. Declaration of John D. Leech in Support of Debtor's Motion for Entry of an Order Pursuant to Sections 105, 363, and 1108 of the Bankruptcy Code, Authorizing the Debtor to Implement, in Accordance with New York State Law, a Plan of Closure for the Debtor's Hospital and Certain Affiliated Outpatient Clinics and Practices at Exhibit A, *In re Interfaith Med. Ctr., Inc.*, 12-48226 (Bankr. E.D.N.Y. Aug. 23, 2013), ECF No. 673 [hereinafter Declaration of John D. Leech].

140. *Id.* at Exs. B, C.

141. *Id.* at Ex. C.

142. Notice Of Hearing On Debtor's Motion For Entry Of An Order Pursuant To Sections 105, 363 And 1108 of The Bankruptcy Code, Authorizing the Debtor to Implement, In Accordance With New York State Law, a Plan of Closure For the Debtor's Hospital and Certain Affiliated Outpatient Clinics and Practices at Ex. A, *In re Interfaith Med. Ctr., Inc.*, 12-48226 (July 30, 2013), ECF No. 602 [hereinafter Interfaith's Motion to Close]; Nina Bernstein, *Interfaith Med. Ctr. Plans to Close*, N.Y. TIMES (July 31, 2013), http://www.nytimes.com/2013/08/01/nyregion/interfaith-medical-center-plans-to-close.html?_r=0.

143. See Order Assigning Matter to Mediation, *In re Interfaith Med. Ctr., Inc.*, 12-48226 (Bankr. E.D.N.Y. Nov. 13, 2013), EFC No. 797.

loan would be modified so that Interfaith may receive a capital infusion in the amount of \$7.5 million for it to continue operations, \$3.5 million of which was to be from NY DOH.¹⁴⁴ Because of this capital infusion, Interfaith was able to avoid closure, continue operations, and successfully adopt a plan of reorganization.¹⁴⁵

3. Administrative Fees

State regulators can financially assist a distressed hospital by waiving or deferring payment of administrative fees, such as licensing fees. As reimbursement models have changed, licensing fees have steadily increased from year to year.¹⁴⁶ As the costs of licensing fees enter the millions¹⁴⁷, a state regulator's ability to enforce, defer, or otherwise waive the fee gives that regulator the ability to drastically affect a hospital's financial status. For example, in *Kinney v. Westerly Hospital Healthcare, Inc.*, addressed *infra*, prior to its insolvency, Westerly Hospital was paying \$3.5 million in licensing fees.¹⁴⁸ During its receivership proceeding, the Rhode Island Division of Taxation (who is charged

144. See Stipulation and Order Modifying Final DIP Order, *In re Interfaith Med. Ctr., Inc.*, 12-48226 (Bankr. E.D.N.Y. Jan. 27, 2014), ECF No. 864; Paul DeBenedetto, *Interfaith to Stay Open Until March as Judge Approves \$25 Million*, BEDFORD-STUYVESANT (Jan. 28, 2014), <https://www.dnainfo.com/new-york/20140128/bed-stuy/interfaith-stay-open-until-march-as-judge-approves-25-million>.

145. Findings of Fact, Conclusions of Law, and Order Confirming Second Amended Plan of Reorganization for Interfaith Medical Center, Inc., *In re Interfaith Med. Ctr., Inc.*, 12-48226 (Bankr. E.D.N.Y. June 11, 2014), ECF No. 1158. The Reorganization plan calls for NY DOH to assume control of Interfaith Hospital and replace senior management in return for additional state funding. *Id.*

146. See S. FISCAL OFFICE, ISSUE BRIEF: MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENTS at 3 (Aug. 3, 2010), [http://www.rilin.state.ri.us/sfiscal/Other%20Documents/Medicaid%20Disproportionate%20Share%20Hospital%20\(DSH\)%20Program.pdf](http://www.rilin.state.ri.us/sfiscal/Other%20Documents/Medicaid%20Disproportionate%20Share%20Hospital%20(DSH)%20Program.pdf); see also R.I. DEP'T OF REVENUE DIV. OF TAX'N, NOTICE: HOSPITAL LICENSING FEE INCREASE FOR FISCAL YEAR ENDING ON OR AFTER JANUARY 1, 2013 (July 2015), <http://www.tax.ri.gov/Tax%20Website/TAX/notice/Notice%202015-07%20-%20Hospital%20licensing%20fee%20change.pdf>; CAL. DEP'T. OF PUB. HEALTH, HEALTH FACILITY LICENSE FEES ANNUAL REPORT FY 2012–2013 at 6 (2012), available at <https://www.cdph.ca.gov/pubsforms/fiscalrep/Documents/LicCertAnnualReport2012.pdf>.

147. See ISSUE BRIEF: MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENTS, *supra* note 146; NOTICE: HOSPITAL LICENSING FEE INCREASE FOR FISCAL YEAR ENDING ON OR AFTER JANUARY 1, 2013, *supra* note 146.

148. S. FISCAL OFFICE, ISSUE BRIEF: HOSPITALS IN R.I. FISCAL OVERVIEW at 13 (Mar. 24, 2011), <http://www.rilin.state.ri.us/sfiscal/Other%20Documents/Hospitals%20Financial%20Overview.pdf>.

with the enforcement of hospital licensing fees) brought a claim for payment of Westerly Hospital's licensing fee in the amount of \$4,420,600.¹⁴⁹ Pursuant to the Rhode Island Department of Health's authority to issue and revoke operating licenses, it threatened to revoke Westerly Hospital's operating license if the fee was not paid.¹⁵⁰

A review of the above reveals that a regulator's power is founded in many areas, is extensive, and can have a drastic impact on an insolvency proceeding. Accordingly, it is evident that state regulators deserve "special attention" in healthcare insolvency proceedings.¹⁵¹

IV. CASE STUDIES

The dichotomy between bankruptcy, receivership, and state regulatory goals, as addressed in *In re United Healthcare*, exploits the inherent conflict between a state's regulatory police power and the goals of insolvency proceedings. While such conflict is far-reaching in application,¹⁵² this section of this Article will focus on the conflict between the goals of insolvency proceedings and state regulation in the purview of healthcare institutions. Specifically, this Article and the following section will analyze cases in which a healthcare institution has entered an insolvency proceeding—either bankruptcy or receivership—and how the conflict between the goals of state regulation and insolvency are achieved by the early and active participation of state regulators. This section will address two cases: *In re Saint Vincent's Catholic Medical Centers of New York* and *In re Saint Michael's Medical Centers, Inc.* The matter of *In re Saint Vincent's* illustrates that the active participation of state regulatory agencies can result in the successful wind down of a hospital, while obtaining a satisfactory recovery for creditors.¹⁵³ *In re Saint Michael's* demonstrates that when regulators are not involved in insolvency, such lack of

149. *Id.*

150. Order, *Kinney v. Westerly Hosp. Healthcare, Inc.*, 2011-0781 (May 9, 2013).

151. Phillips & Morris, *supra* note 110, at 8.

152. This conflict has been subject to scholarly review in several other areas. The area that has received the most attention has been the intersection of a state's environmental regulatory power over an entity while that entity is in bankruptcy or receivership. See Sward, *supra* note 6, at 404.

153. See *In re Saint Vincents Catholic Med. Ctrs. of N.Y.*, 10-11963 (Bankr. S.D.N.Y. Apr. 14, 2010).

involvement may have detrimental affects on the overall transfer of assets or recovery for the hospital's creditors.¹⁵⁴ This section will also review *Kinney* and give a judicial perspective on how regulator involvement can affect receivership proceedings.

A. *In re Saint Vincent's*

Saint Vincent's Catholic Medical Centers of New York (St. Vincent's Network), and certain of its affiliates, was an acute-care hospital network in New York City that provided healthcare services to "all who [came] to [them] in need, especially the poor."¹⁵⁵ St. Vincent's Network operated numerous businesses, including a behavioral health facility, nursing homes, continuing care facilities, a hospice, and a home health agency; however, its core business centered around the operation of its hospital, St. Vincent's Hospital Manhattan (St. Vincent's Hospital), which was located in the Greenwich Village section of Manhattan.¹⁵⁶ St. Vincent's Hospital was a 727-bed facility that offered medical services for acute-care, including behavioral health, cancer, cardiology, HIV treatment, orthopedic surgery, obstetric and maternity services, pediatrics, intensive care units, rehabilitation, and child psychiatry.¹⁵⁷

In 2000, St. Vincent's Network merged with several other hospitals and healthcare facilities; however, after the merger, St. Vincent's Network faced financial difficulties and filed a Chapter 11 bankruptcy petition in 2005.¹⁵⁸ After a two-year long Chapter 11 proceeding, in 2007, St. Vincent's Network emerged from bankruptcy with a consummated plan of reorganization that

154. *In re Saint Michaels Med. Ctr., Inc., et al.*, 15-24999 (Bankr. D.N.J. Aug. 10, 2015).

155. Motion of the Debtors for Entry of Interim and Final Orders Pursuant to Sections 105(a), 363, and 1108 of the Bankruptcy Code (A) Authorizing the Debtors to Continue the Implementation, in Accordance with New York State Law, of a Plan of Closure for the Debtors' Manhattan Hospitals and Certain Affiliated Outpatient Clinics and Practices; and (B) Scheduling a Final Hearing at 3, ¶ 9, *In re Saint Vincents Catholic Med. Ctrs. of N.Y.*, 10-11963 (Bankr. S.D.N.Y. Apr. 14, 2010) [hereinafter Motion to Close].

156. Declaration of Mark E. Toney Pursuant to Local Bankruptcy Rule 1008-2 and in Support of First Day Motions and Applications at ¶ 5, *In re Saint Vincents Catholic Med. Ctrs. of N.Y.*, 10-11963 (Bankr. S.D.N.Y. Apr. 14, 2010) [hereinafter Toney Affidavit].

157. *Id.* at 5, ¶¶ 13, 15.

158. *Id.* at 15–16, ¶ 34.

restructured its debts, which totaled over \$1 billion.¹⁵⁹ Subsequent to the bankruptcy, St. Vincent's Network continued to face financial difficulty; while revenues remained consistent, in 2008 and 2009, it suffered operating losses of \$43 million and \$64 million, respectively.¹⁶⁰ In 2008 and 2009, St. Vincent's Hospital alone had an operating loss of \$81 million and \$107 million, respectively.¹⁶¹ As a result, in 2009, St. Vincent's Network's Board of Directors appointed a "Restructuring Committee" that was tasked with the oversight of the network's financial restructuring and to determine and evaluate all of its strategic alternatives.¹⁶² However, at the end of 2009, St. Vincent's Network's liquidity crisis remained.¹⁶³ From December 2009 to February 2010 the network's senior management began discussions with its major creditors and informed them of St. Vincent's Network's distressed financial condition.¹⁶⁴ St. Vincent's Network also discussed with its creditors its options to preserve St. Vincent's Hospital's long-term viability, including selling the network's non-hospital assets to another healthcare provider.¹⁶⁵ However, in early February 2010, St. Vincent's Network's economic state had deteriorated to the point where it was unable to make its upcoming payroll.¹⁶⁶ To ensure that St. Vincent's Network could make its payroll and to prevent a bankruptcy filing, the NY DOH and two of the network's current creditors, General Electric Corporation and T.D. Bank, N.A., provided it with a \$6 million emergency loan.¹⁶⁷

After St. Vincent's Network's financial crisis drew the attention of state agencies, on February 3, 2010, the then-governor of New York, David Paterson, held a meeting with St. Vincent's Network's management, NY DOH officials, elected officials, "senior secured lenders, union leaders, and other key constituents."¹⁶⁸ At this meeting Governor Paterson requested

159. *Id.* at 15, ¶ 35.

160. *Id.* at 25, ¶ 62.

161. *Id.*

162. Toney Affidavit, *supra* note 156, at 14, ¶ 32.

163. Motion to Close, *supra* note 155, at 6, ¶ 16.

164. Toney Affidavit, *supra* note 156, at 27, ¶ 69.

165. *Id.*

166. *Id.* at 27, ¶ 70.

167. *Id.*; see Motion to Close, *supra* note 155, at 7, ¶ 18.

168. Toney Affidavit, *supra* note 156, at 27, ¶ 71; Motion to Close, *supra* note 155, at 7, ¶ 19.

that the parties in attendance form a “task force” that would take the lead on securing emergency financing to allow St. Vincent’s time to research and assess its options—“outside of bankruptcy—for an alliance, affiliation, partnership, or new sponsorship with a financially stronger healthcare group or chain.”¹⁶⁹ This task force, which included representatives from NY DOH, “was closely engaged in the restructuring process,” and met by telephone and in person almost on a daily basis.¹⁷⁰ Simultaneously, St. Vincent’s Network, with the assistance of its investment bankers and brokers—Cain Brothers & Company, LLP, Shattuck Hammond Partners, and Loeb & Troper, LLP—worked to market and sell the network’s non-hospital assets to other healthcare facilities.¹⁷¹

As St. Vincent’s Hospital continued to face deficits, and in an attempt to prevent the costs of an all-out shut down of the hospital, St. Vincent’s Network began searching for a partner, sponsor, or any other affiliation for the hospital that would preserve its operations.¹⁷² St. Vincent’s Network discussed potential business deals with more than ten major hospitals or healthcare institutions, including Mount Sinai Medical Center, New York Presbyterian, and New York University-Langone Medical Center, just to name a few.¹⁷³ These institutions, after signing confidentiality agreements, were permitted to view all information related to St. Vincent’s Network and St. Vincent’s Hospital.¹⁷⁴ During this process, Mount Sinai emerged as the most interested and qualified candidate, conducting over sixty hours of document review, making sixty facility visits to St. Vincent’s Hospital, and attending several meetings with St. Vincent’s Network’s management.¹⁷⁵ Despite all of its due diligence, Mount Sinai withdrew as a potential purchaser on March 31, 2010.¹⁷⁶

After Mount Sinai withdrew as a potential purchaser of St. Vincent’s Hospital, it was evident that no other viable entities were interested or qualified to purchase, partner, or sponsor the

169. Toney Affidavit, *supra* note 156, at 28, ¶ 72.

170. *Id.*

171. *Id.* at 15, ¶ 33.

172. *Id.* at 29, ¶ 76.

173. *Id.* at 30, ¶ 77.

174. *Id.*

175. *Id.* at 30, ¶ 78.

176. *Id.* at 30, ¶ 79.

hospital as a “going-concern[]” entity.¹⁷⁷ As a result, on April 6, 2010, St. Vincent’s Network’s board voted to approve the closure of St. Vincent’s Hospital for the health and safety of its patients.¹⁷⁸ Two days later, the network submitted a closure plan to the NY DOH for its approval, and began the wind-down of its operations.¹⁷⁹ At this juncture, while NY DOH did not formally approve the closure plan, NY DOH was actively involved in “numerous discussions [with the network] . . . regarding the possibility of a closure.”¹⁸⁰ The closure plan required the following:

- (a) the orderly discharge or relocation of all patients to neighboring hospitals as quickly and safely as manageable; (ii) the redirection of emergency room admissions while keeping the Hospital’s emergency room open as a ‘treat and release or transfer’ urgent care center through April 15, 2010; (iii) the continued operation of certain outpatient clinics for a limited period of time to allow for the possibility of their transfer to new sponsors; (iv) the transfer and storage of medical records in compliance with all regulations; (v) the orderly and safe disposition of the Hospital’s equipment, pharmaceuticals, and inventory through appropriate channels in full compliance with regulatory requirements and (vi) the implementation of a communication program for patients, families, employees, providers and the community at large.¹⁸¹

The closure plan further required that all inpatient operations at St. Vincent’s Hospital cease by April 30, 2010.¹⁸² During the month of April, in carrying out the wind-down of the hospital and the closure plan, St. Vincent’s Network lacked liquid funds to continue its closure, and filed for Chapter 11 bankruptcy on April 14, 2010. On the same day, St. Vincent’s Network filed a motion to continue to operate pursuant to §§ 1107 and 1108 of the Code

177. *Id.* at 31, ¶ 80.

178. *Id.*

179. Motion to Close, *supra* note 155, at 10, ¶ 27–28. (“New York State regulations require that a hospital obtain written approval of the DOH to close.”) (citing N.Y. COMP. CODES R. & REGS. tit. 10, § 401.3(g)).

180. *Id.* at 10, ¶ 28.

181. Toney Affidavit, *supra* note 156, at 31, ¶ 82.

182. Motion to Close, *supra* note 155, at 3, ¶ 3.

and the motion to close.¹⁸³ A hearing was held on the motion to close on April 15, 2010, and the motion to close was granted on an interim basis.¹⁸⁴

During the bankruptcy and implementation of the closure plan, NY DOH was actively involved with St. Vincent's Network.¹⁸⁵ NY DOH, along with other government regulatory agencies, assisted St. Vincent's Network in preventing a "disruption of patient care and [to] ensure a smooth transition of [St. Vincent's Hospital's] patients to new care providers."¹⁸⁶ NY DOH accomplished this successful and smooth closure by submitting input on the closure timeline,¹⁸⁷ assisting in the transfer and discharge of hospital patients,¹⁸⁸ soliciting sponsorships for St. Vincent's Hospital's HIV Extension Clinics,¹⁸⁹ assisting with the transfer of behavioral health patients,¹⁹⁰ and drafting and disseminating communications regarding St. Vincent's Hospital's closure to other agencies and the public.¹⁹¹ During the bankruptcy, it was noted that NY DOH "[has] been immersed in this case for several months now from the very beginning and [it has] worked very closely with [St.] Vincent's Hospital on [its] closure."¹⁹² Such collaborative effort included "daily phone calls from top management to staff . . . [and] on-site monitors who [were] at the hospital to verify the closure that's being done."¹⁹³

On May 14, 2010, the bankruptcy court granted the final order of closure, charging NY DOH and St. Vincent's Network with the completion of the closure plan.¹⁹⁴ After the final order of

183. *Id.* at 4, ¶ 8.

184. *In re Saint Vincents Catholic Med. Ctrs. of N.Y.*, 429 B.R. 139, 143 (Bankr. S.D.N.Y. 2010).

185. *Id.* (Saint Vincent's Network "worked under the supervision and with the active participation of the New York State Department of Health to implement the closure plan.").

186. *Id.*

187. Motion to Close, *supra* note 155, at 11–12, ¶ 33.

188. *Id.* at 12, ¶ 35.

189. *Id.* at 12–13, ¶ 36.

190. *Id.* at 11–12, ¶ 33.

191. *Id.* at 14–15, ¶ 40.

192. *In re Saint Vincents Catholic Med. Ctrs. of N.Y.*, 429 B.R. 139, 145 (Bankr. S.D.N.Y. 2010).

193. *Id.*

194. Final Order Pursuant to Sections 105(A), 363, And 1108 of the Bankruptcy Code Authorizing the Debtors to Continue the Implementation, in Accordance with New York State Law, of a Plan of Closure for the Debtors'

closure was approved, St. Vincent's Network, with the assistance of NY DOH, began selling its assets.¹⁹⁵ As a result of its financial condition and the closure of St. Vincent's Hospital, St. Vincent's Network was no longer able to provide hospice care for patients and began marketing Pax Christi Hospice, Inc. (Pax Christi), one of its other assets.¹⁹⁶ Ultimately, Visiting Nurse Service of New York Hospice Care (VNS) purchased Pax Christi for \$9 million.¹⁹⁷ Notably, NY DOH indicated that it would issue VNS an emergency certificate of need to operate Pax Christi.¹⁹⁸ Under normal circumstances, the review and the grant of a certificate of need may take many months.¹⁹⁹ "However, in recognition of the critical need for continued operations at [Pax Christi] . . . [St. Vincent's Network] received indications from the [NY DOH] that it would consent to approving VNS as hospice operator on an expedited basis."²⁰⁰ Such emergency approval by NY DOH "would allow VNS to step in and operate the hospice even though the formal Certificate of Need approval process has not been completed, contingent upon VNS completing the process after the closing of the transaction."²⁰¹ NY DOH's expedited approval of VNS was based upon the "DOH's belief that VNS [was] an appropriate operator" of hospice services.²⁰² Because of the liquidation value of \$9 million, and NY DOH's assurances that VNS was an adequate provider of hospice services, the bankruptcy court confirmed the expedited sale of Pax Christi's assets to

Manhattan Hospital and Certain Affiliated Outpatient Clinics and Practices at 18, *In re Saint Vincents Catholic Med. Ctrs. of N.Y., et al.*, No. 10-11963 (Bankr. S.D.N.Y. May 14, 2010) [hereinafter Final Order to Close].

195. Emergency Motion of the Debtors for an Order (A) Approving the Sale of Assets of Pax Christi Hospice, Inc. on an Expedited Basis to Visiting Nurse Service of New York Hospice Care, Free and Clear of Liens, Claims, Encumbrances and Other Interests; (B) Approving the Retention of an Appraiser in Connection with the Sale; (C) Authorizing the Debtors to Enter Into a Management Consulting Agreement; and (D) Authorizing Payment of the Investment Bankers' Transaction Fee, *In re Saint Vincents Catholic Med. Ctrs. of N.Y.*, No. 10-11963 (Bankr. S.D.N.Y. May 5, 2010) [hereinafter Motion to Sell Pax Christi].

196. *Id.* at 8, ¶¶ 14–15, 19.

197. *Id.* ¶ 29.

198. *Id.* at 3–4, ¶ 8.

199. *Id.* at 9, ¶ 22.

200. *Id.*

201. *Id.* at 9, ¶ 22.

202. *Id.* at 16, ¶ 36.

VNS.²⁰³

St. Vincent's Network also began marketing its behavioral health assets,²⁰⁴ and entered into an agreement with St. Joseph's Medical Center (St. Joseph's), who agreed to purchase the behavioral health assets for \$18 million.²⁰⁵ Again, NY DOH assisted with the transaction to make the transfer as seamless as possible.²⁰⁶ NY DOH, along with other governmental organizations, "repeatedly indicated their strenuous objection to any closure of [St. Vincent's Network's] various inpatient and outpatient behavioral health programs."²⁰⁷ Accordingly, it agreed to expedite and facilitate the transfer of the network's behavioral health programs and services to St. Joseph's, which NY DOH prequalified as a competent purchaser.²⁰⁸ Alternatively, if NY DOH could not get approval from the appropriate counsels, NY DOH indicated that it would issue St. Joseph's emergency approval of its certificate of need and other licenses to ensure adequate patient care.²⁰⁹

Various other sales of assets constituted the remainder of St. Vincent's Network's Chapter 11 proceeding, but the majority did not involve regulator involvement. For example, several real

203. Order (A) Approving the Sale of Assets of Pax Christi Hospice, Inc. on an Expedited Basis to Visiting Nurse Service of New York Hospice Care, Free and Clear of Liens, Claims, Encumbrances and Other Interests; (B) Approving the Retention of an Appraiser in Connection with the Sale; (C) Authorizing the Debtors to Enter into a Management Consulting Agreement; and (D) Authorizing Payment of the Investment Bankers' Transaction Fee at 8, ¶ 4, *In re Saint Vincents Catholic Med. Ctrs. of N.Y.*, No. 10-11963 (Bankr. S.D.N.Y. May 18, 2010) [hereinafter Final Order to Sell Pax Christi].

204. Debtors' Motion for (I) An Order (A) Approving the Sale of Substantially All the Debtors' Behavioral Health Assets Including the Operations of St. Vincent's Hospital Westchester to Saint Joseph's Medical Center, and (B) Approving the Assumption and Assignment of Certain Executory Contracts and Unexpired Leases; (II) an Order (A) Approving Bidding Procedures for the Auction of a Real Estate Option, and (B) Scheduling an Auction and Real Estate Option Sale Hearing; and (III) an Order Approving the Sale of the Real Estate Option at 11, ¶ 25, *In re Saint Vincents Catholic Med. Ctrs. of N.Y.*, No. 10-11963 (Bankr. S.D.N.Y. Aug. 25, 2010) [hereinafter Motion to Sell Behavioral Health Assets] ("The marketing process for the Behavioral Health Assets commenced before the filing of these Chapter 11 Cases had been ongoing.").

205. *Id.* at 14, ¶ 33.

206. *Id.* at 19, ¶ 44.

207. *Id.* at 20, ¶ 46.

208. *Id.*

209. *Id.* at 21, ¶¶ 47, 67.

estate sales occurred in an attempt to satisfy the network's outstanding obligations;²¹⁰ however, such transactions are not subject to certificate of need requirements or other forms of healthcare regulation, and thus are outside the scope of this Article. After a full liquidation of assets, unsecured creditors received five to ten cents on the dollar of the \$875 million they were owed.²¹¹

In re Saint Vincent's reveals the importance of involving state regulators in a healthcare insolvency so that during the healthcare organization's liquidation they may assist with the transfer of assets and coordinate the appropriate licenses or certificate of needs. While NY DOH was widely criticized by the public and the media for facilitating the "closure" of a hospital through its nonfeasance²¹², quite the opposite is true. NY DOH was actively involved in St. Vincent's Network's financial crisis even before the bankruptcy, working together with St. Vincent's Network to achieve a successful business model.²¹³ Further, NY

210. Samuel Howard, *St. Vincent's Inks \$260M Sale to Real Estate Kingpin*, LAW360 (Apr. 8, 2011, 3:29 PM), <http://www.law360.com/articles/237690/st-vincent-s-inks-260m-sale-to-real-estate-kingpin>. St. Vincent's sold the real estate that hosted its hospital to Rudin Management Co. for \$260 million. Rudin proceeded to build a 200-unit condominium complex on the former site of St. Vincent's, and have sold the condominiums, on average, for \$3,500 per square foot. Daniel Geiger, *Condos at Old St. Vincent's Site Fetch \$3,500 PSF*, CRAIN'S N.Y. BUS. (Feb. 18, 2015, 1:20 PM), http://www.crainsnewyork.com/article/20150218/REAL_ESTATE/150219857/sales-at-complex-on-old-st-vincent-hospital-site-defy-high-end-condo-glut (describing how Rudin had just sold one of five townhouses being built for nearly \$25 million).

211. Gale Scott, *St. Vincent's Emerges from Bankruptcy*, CRAIN'S N.Y. BUS. (July 6, 2012, 4:00 PM), http://www.crainsnewyork.com/article/20120706/health_care/120709941/.

212. See *In re Saint Vincents Catholic Med. Ctrs. of N.Y.*, 429 B.R. 139, 152 (Bankr. S.D.N.Y. 2010) (noting that certain plaintiff initiated an action against DOH in an attempt to prevent St. Vincent's closure); see also Kevin Clarke, *The Last Days of St. Vincent's*, AMERICA (July 29, 2016), <http://americamagazine.org/issue/742/article/last-days-st-vincent>. Many have said that DOH "nailed the coffin closed" during the closure of St. Vincent's, while others attributed it to the "politics in the city of New York." *Id.* In fact, a board member remarked that "I think the easiest way to explain why . . . St. Vincent's is closing its doors tomorrow . . . is that the [DOH] said there is no need for an acute care hospital in Greenwich Village. *Id.* And while St. Vincent's had many problems, they were on their way to being fixed. *Id.* But with the Department of Health saying that there's no need for an acute care hospital here, the board had no choice but accept a vote to close." *Id.*

213. *State DOH Response on St. Vincent's*, VILLAGER (July 29, 2016), http://thevillager.com/villager_388/statedoh.html (reporting that "since the

DOH, along with other creditors, supplied St. Vincent's Network with a \$6 million capital infusion to ensure continued operations.²¹⁴ NY DOH did not want St. Vincent's Hospital to close, but simply could not continue making capital contributions to keep it financially afloat.²¹⁵ NY DOH was also a part of the Governor's appointed "task force" to help St. Vincent's Hospital assess its options for a transfer of ownership, partnership, or sponsorship with another healthcare entity, and met almost daily with other members of the task force to assess the hospital's restructuring plan.²¹⁶ When it was evident that such transfer of ownership, partnership, or sponsorship was not practical, NY DOH was actively involved in implementing the closure plan throughout the bankruptcy.²¹⁷ During the bankruptcy, NY DOH was proactive in working with potential purchasers or St. Vincent's Network's assets in either issuing emergency licenses and certificates of need, or reviewing applications for same on an expedited basis, so that the public need for such services would not be sacrificed.²¹⁸

NY DOH's active involvement advanced the goals of insolvency and state regulation. On one hand, NY DOH, in granting emergency certificates of need or other licenses, made a sale of St. Vincent's Network's assets more practical for the purchasers by expediting the licensing process. By incentivizing the deal in this way, NY DOH assisted in liquidating St. Vincent's Network's assets and generating capital to return to its creditors. On the other hand, NY DOH was assuring that the public at large

fall of 2008 the State Health Department had been meeting with the hospital leadership to help them restructure to become a viable business model").

214. Toney Affidavit, *supra* note 157, at 27, ¶ 70; *see also* Motion to Close, *supra* note 155, at 7, ¶ 18.

215. *State DOH Response on St. Vincent's*, *supra* note 213. Diane Mathis, Deputy Director of the Public Affairs Group of NY DOH, stated that the hospital needed \$300 million to continue operations as a stand-alone facility, which was an amount "beyond the capability of the State as well as private investors." *Id.* At the time, the state of New York was facing a \$9.2 billion deficit. *Id.* Mathis also commented that "[t]he State Health Department did not advocate for, nor in any way support or encourage, the closure of St. Vincent's." *Id.*

216. Toney Affidavit, *supra* note 156, at ¶ 72.

217. *See id.* ¶ 10.

218. *See In re Saint Vincents Catholic Med. Ctr.*, 429 B.R. 139, 143 (Bankr. S.D.N.Y. (2010); *see also* Motion to Sell Pax Christi, *supra* note 195, at 9, ¶ 22; Motion to Sell Behavioral Health Assets, *supra* note 204, at 20–21, ¶¶ 46–47, at 32, ¶ 67.

was protected and ensured that services such as nursing homes and behavioral health programs remained in place and were available to the public at large.

There is nothing easy about closing a non-profit hospital with a charitable mission. However, while the closure of St. Vincent's Hospital was a difficult and emotional decision, it was an easy financial one. NY DOH's involvement in St. Vincent's Hospital's closure yielded a result that served the public policy while also maximizing a return for creditors; an aspirational result for every insolvency proceeding.

B. *In re Saint Michael's*²¹⁹

Founded in 1897 by the Franciscan Sisters of the Poor, Saint Michael's Medical Center, Inc. (St. Michael's) was a 357-bed hospital that provided tertiary-care to the Newark region of New Jersey.²²⁰ During 2012, St. Michael's finances became hampered by disproportionately low Medicaid reimbursement rates, unsustainable debt levels, long-term and above-market lease obligations, and a reduction in inpatient daily revenue.²²¹ Accordingly, St. Michael's "set out to find a solution to sustain the medical center's mission and help it flourish both financially and clinically."²²² While St. Michael's solicited a number of entities that expressed interest in purchasing St. Michael's, Prime Healthcare Services-Saint Michael's, LLC (Prime) appeared to be

219. *In re Saint Michaels Med. Ctr., Inc.*, 15-24999 (Bankr. D.N.J. Aug. 10, 2015) <https://cases.primeclerk.com/smmc/Home-Index>. This case is still pending in Bankruptcy court as of this writing.

220. Verified Application in Support of the Debtors' Motion for an Order Pursuant to 11 U.S.C. §§ 363 and 365 and Fed. R. Bankr. P. 2002, 6004 and 6006: (1) Approving "Stalking Horse" Asset Purchase Agreement for the Sale of Substantially all the Debtors' Assets; (2) Approving Bidding Procedures, Including Certain Bid Protections, and Form, Manner and Sufficiency of Notice; (3) Scheduling (a) an Auction Sale and (b) a Hearing to Consider Approving the Highest and Best Offer; (4) Authorizing the Debtors to Sell Substantially all their Assets Free and Clear of Liens, Claims, Encumbrances, and Interests; (5) Authorizing the Debtors to Assume and Assign Certain Executory Contracts and Unexpired Leases; and (6) Granting Other Related Relief at 3, ¶ 6, *In re Saint Michaels Med. Ctr., Inc.*, 15-24999 (Bankr. D.N.J. Aug. 10, 2015), ECF No. 17-1 [hereinafter Motion to Approve Stalking Horse Bid].

221. Declaration of David A. Ricci in Support of Debtors' First Day Pleading at 10-11, ¶ 25, *In re Saint Michaels Med. Ctr., Inc.*, 15-24999 (Bankr. D.N.J. Aug. 10, 2015), ECF No. 14 [hereinafter Ricci Affidavit].

222. Motion to Approve Stalking Horse Bid, *supra* note 220, at 4, ¶ 9.

the most “viable option to financially stabilize and secure a vibrant future” for St. Michael’s.²²³ On February 8, 2013, St. Michael’s and Prime entered into an asset purchase agreement and submitted the appropriate applications to the New Jersey Attorney General (NJ AG) and New Jersey Department of Health (NJ DOH) for the transfer of ownership for St. Michael’s.²²⁴

Roughly a month later, Navigant Consulting Inc. (Navigant)—on behalf of New Jersey Healthcare Facilities Financing Authority—issued a report (the Navigant Report), recommending that the healthcare services in Newark be consolidated, and opining that Prime could not solve St. Michael’s economic plights.²²⁵ In response, St. Michael’s retained Honigman, Miller, Schwartz, and Cohn LLP to draft another report—the Honigman Report.²²⁶ The Honigman Report concluded that adoption of the Navigant Report recommendations would create an unregulated monopoly of healthcare services in Newark, which would result in higher costs to patients due to a decrease of competitiveness in the market.²²⁷ After submitting the appropriate applications, and the publication of the Navigant and Honigman Reports, St. Michael’s did not receive a decision from NJ DOH regarding the sale of St. Michael’s to Prime for over two years.²²⁸

During the two-year wait, St. Michael’s financial status

223. *Id.* at 5, ¶ 10.

224. *Id.*

225. *Id.* at 5, ¶ 11.

226. *See id.* at 5, ¶ 12.

227. *Id.* (The Honigman Report estimated that if the Navigant Report recommendations were adopted, the community’s healthcare costs would increase by \$180 million annually.)

228. *Id.* at 5, ¶ 10. David Ricci, CEO of St. Michael’s stated that “[w]e’ve done everything the state has asked us to do . . . after two and a half years, it would appear we’re no further along than when we started.” Kathleen O’Brien, *St. Michael’s Medical Center Files for Bankruptcy Protection*, NJ.COM (Aug. 10, 2015), http://www.nj.com/healthfit/index.ssf/2015/08/st_michaels_medical_center_files_for_bankruptcy_pr.html. Ricci explained that “the hospital answered the state’s sixth round of questions regarding the sale in June and at this point have answered more than 400 questions, but have received no indications from the state as to when its application under the [certificate of need] process would be considered complete.” Andrew Kitchenman, *With Bankruptcy Filing, Saint Michael’s Opens up New Front in Battle Over Sale*, NJ SPOTLIGHT (Aug. 11, 2015), <http://www.njspotlight.com/stories/15/08/10/with-bankruptcy-filing-saint-michael-s-opens-up-new-front-in-battle-over-sale/>.

continued to deteriorate.²²⁹ For a six month period that ended on June 30, 2015, St. Michael's produced \$101.5 million in revenue and incurred \$113 million in operating expenses, yielding a net operating loss of \$11.5 million in six months.²³⁰ Before resorting to bankruptcy, St. Michael's and Prime engaged in discussions with NJ DOH regarding a solution to Prime's application; however, those discussions were unsuccessful.²³¹ Due to the state's inaction, the Navigant Report's recommended consolidation, and St. Michael's dismal financial performance, St. Michael's "management and Board of Directors, along with their advisors, evaluated various restructuring options and determined that the best way to maximize [St. Michael's] going concern value for the benefit of all stakeholders was to commence" a bankruptcy proceeding to force a sale under § 363 of the Code.²³²

On August 10, 2015, St. Michael's filed a voluntary petition for bankruptcy relief under Chapter 11 of the Code.²³³ Contemporaneous with its petition for bankruptcy, St. Michael's filed a motion to approve a "stalking horse" bid from Prime for a purchase of St. Michael's assets, schedule an auction, and approving the highest and best offer, among other things.²³⁴ NJ DOH objected to St. Michael's motion, stating that the motion presupposes NJ DOH's approval of a hospital operating license and certificate of need for Prime.²³⁵ Specifically, "before the

229. See Ricci Affidavit, *supra* note, 221, at 9, ¶¶ 19–21. NJ DOH justified its lengthy review with the following statement: "The department has taken a reasonable and deliberative approach as it always does with certificate of need applications. Having completed multiple rounds of questions, it remains under review." O'Brien, *supra* note, 228.

230. Ricci Affidavit, *supra* note 221, at 9, ¶ 21.

231. See *id.* at 12, ¶ 28.

232. *Id.* at 11, ¶ 27. The bankruptcy was also filed to relieve St. Michael's from making a \$1.8 million payment that was due to the New Jersey Healthcare Facilities Financing Authority. Susan K. Livio, *N.J. Bankruptcy Judge Approves \$62M St. Michael's Hospital Sale*, NJ.COM (Nov. 12, 2015), http://www.nj.com/healthfit/index.ssf/2015/11/nj_bankruptcy_judge_approves_622m_st_michaels_purc.html.

233. Ricci Affidavit, *supra* note 221, at 3, ¶ 5.

234. See Motion to Approve Stalking Horse Bid, *supra* note 220, at 3–4, ¶ 15.

235. Limited Objection of the New Jersey Department of Health to Debtors' Motion for an Order (1) Approving "Staking Horse" Asset Purchase Agreement and (2) Approving Form, Manner and Sufficiency of Notice Bidding Procedures at 2, *In re Saint Michaels Med. Ctr., Inc.*, 15-24999 (Bankr. D.N.J. Aug. 10, 2015), ECF No. 81 [hereinafter NJ DOH Objection].

ownership of a general acute care hospital can be transferred, the owner of the hospital must apply for and receive a [certificate of need] from the [NJ DOH] authorizing the transfer.”²³⁶

Despite NJ DOH’s objection, the bankruptcy court approved the “stalking horse” bid, auction, and bidding procedures.²³⁷ On November 5, 2015, St. Michael’s conducted a sale auction at which sixteen bids were submitted by Prime and Prospect Saint Michael’s, Inc. (Prospect).²³⁸ Both Prime and Prospect presented their vision of the hospital and their credentials to St. Michael’s Board of Directors, which determined that Prime was the successful bidder.²³⁹ Prime and St. Michael’s executed a purchase agreement, in which Prime agreed to pay \$62,247,750 (Purchase Price) for the purchase of St. Michael’s assets.²⁴⁰ Based upon the successful bidding of Prime, St. Michael’s filed a proposed sale order with the bankruptcy court, which was subsequently granted on November 13, 2015.²⁴¹ However, at the time of the order granting the sale, NJ DOH had still not made a determination on Prime’s application for a certificate of need.²⁴² Months after the

236. *Id.* at 4.

237. *See* Motion to Approve Stalking Horse Bid, *supra* note 220, at 2–3, ¶ 5.

238. Declaration of Thomas Buck in Support of Debtors’ Motion for Entry of an Order Authorizing the Debtor to (A) Sell Substantially All of their Assets Free and Clear of Liens, Claims, Encumbrances, and Interest and (B) Assume and Assign Certain Executory Contracts and Unexpired Leases ¶ 8, *In re Saint Michaels Med. Ctr., Inc.*, 15-24999 (Bankr. D.N.J. Aug. 10, 2015), ECF No. 369 [hereinafter Buck Affidavit].

239. *Id.* at 3, ¶ 9.

240. *Id.* at 4, ¶ 11. The purchase price was subject to certain increases or decreases based upon Saint Michael’s working capital and cash equivalents at the time of the sale. *Id.* The Purchase Price was \$500,000 more than Prospect’s bid and \$13 million more than the stalking horse bid. Transcript for approval of the auction sale before Honorable Vincent J. Papalia United States Bankruptcy Court Judge at 10, *In re Saint Michaels Med. Ctr., Inc.*, 15-24999 (Bankr. D.N.J. Aug. 10, 2015), ECF No. 398 [hereinafter Transcript Before Papalia].

241. *See* Order Pursuant to 11 U.S.C. §§ 105(A), 363 and 365 (1) Authorizing the Debtors to Sell Substantially All of their Assets Free and Clear of All Liens, Claims, Encumbrances and Interests; (2) Authorizing the Debtors to Assume and Assign Certain Executory Contracts and Unexpired Leases; and (3) Granting Other Related Relief ¶ 4, *In re Saint Michaels Med. Ctr., Inc.* 15-24999 (Bankr. D.N.J. Aug. 10, 2015), ECF No. 383.

242. *See* N.J. DEP’T OF HEALTH, CN# 1304-07-01, CERTIFICATE OF NEED DEPARTMENT STAFF PROJECT SUMMARY, ANALYSIS & RECOMMENDATIONS, TRANSFER OF OWNERSHIP (2015) at 9–11, [http://web.doh.state.nj.us/apps2/documents/bc/Staff%20Recommendations%20-%20Saint%20Mike’s%20\(Final](http://web.doh.state.nj.us/apps2/documents/bc/Staff%20Recommendations%20-%20Saint%20Mike’s%20(Final)

sale, in early February, 2016, the State Health Planning Board approved a recommendation²⁴³ by NJ DOH staff to approve a certificate of need for the transfer of ownership from St. Michael's to Prime.²⁴⁴ The NJ DOH staff commented that it "believe[d] that the decision to transfer the ownership of St. Michael's is in the best interest of the hospital's patient base. This transfer, the only option presented to [NJ DOH], would be the least disruptive to the area's health care delivery system of all the possible options, at this time."²⁴⁵ A month after the NJ DOH Staff Recommendation, the commissioner of NJ DOH and the NJ AG finally approved the transfer of the certificate of need.²⁴⁶ The acting commissioner of NJ DOH commented that she "agree[d] that the proposed transfer of ownership, as opposed to closure of St. Michael's, will preserve appropriate access to healthcare services for the community, including the medically indigent and medically underserved population."²⁴⁷

In re Saint Michael's illustrates the simple proposition that if state regulatory agencies are not involved with a distressed hospital pre- and post-petition for insolvency, an ultimate disposition of the hospital's assets may be delayed by the state's bureaucratic processes.²⁴⁸ Without understanding the urgency and exigency of the need to transfer ownership to Prime, NJ DOH did not act with the urgency, flexibility, or assistance as seen in *In re Saint Vincent's*. While it is NJ DOH's prerogative to undertake a comprehensive and diligent review of a certificate of need application, if they had been involved on the "front end" of St.

.pdf [hereinafter NJ DOH STAFF REPORT].

243. See *id.* at 17–18. The NJ DOH decided that although St. Michael's had complied with state protocol and guidelines, and despite some misgivings, the transfer would be best for St. Michael's and the community. *Id.*

244. *Sale of Saint Michael's Medical Center to Prime Healthcare Services Clears Major Hurdle*, SAINT MICHAEL'S MEDICAL CENTER (Feb. 4, 2016), <http://www.smmcnj.com/News/2016/February/Sale-of-Saint-Michaels-Medical-Center-to-Prime-H.aspx>.

245. NJ DOH STAFF REPORT, *supra* note 242, at 16.

246. See Susan K. Livio, *N.J. Approves Sale of Bankrupt Newark Hospital*, NJ.COM (Mar. 9, 2016, 11:14 PM), http://www.nj.com/politics/index.ssf/2016/03/state_approves_sale_of_bankrupt_newark_hospital.html.

247. *Id.*

248. See generally *In re Saint Michaels Med. Ctr., Inc.*, 15-24999 (Bankr. D.N.J. Aug. 10, 2015). But see *In re Saint Vincents Catholic Med. Ctrs. of N.Y.*, 10-11963 (Bankr. S.D.N.Y. Apr. 14, 2010).

Michael's financial problems, the transparency of the sale to Prime would have assisted in expediting NJ DOH's decision process.

C. *A View from the Bench: A Judicial Perspective of the Westerly Hospital Special Master Proceeding*²⁴⁹

Westerly Hospital was a 125-bed healthcare facility, located in Westerly, Rhode Island, that had served Westerly and its surrounding communities for approximately ninety years.²⁵⁰ Westerly Hospital and its related entities²⁵¹ employed more than 750 union and non-union individuals; had affiliations with more than 135 primary and specialty physicians; and provided primary and tertiary care, including interventional cardiology, obstetrics and gynecology, wound care, and general surgery.²⁵² However, in 2011, with patient revenue of \$87.8 million and uncompensated care totaling \$8.3 million, Westerly Hospital operated at a loss, for the fifth consecutive year, of more than \$5.7 million and could not pay its bills as they became due.²⁵³ After failed attempts to find an economically beneficial transfer, partnership or sponsorship, Westerly Hospital's Board of Directors authorized the Chief Executive Officer (CEO) to enter insolvency proceedings.²⁵⁴ On December 7, 2011, the CEO filed a Petition for the Appointment of a Special Master²⁵⁵ (Petition), with the statutory powers of a receiver, for Westerly Hospital and its related entities²⁵⁶ on the Business Calendar of the Rhode Island Superior Court.²⁵⁷

249. See *Kinney v. Westerly Hosp. Healthcare, Inc.*, No. 2011-0781, 2011 WL 6296898 (R.I. Super. Ct. Dec. 9, 2011). Many of the following facts are garnered from public record, but others are from the observations and experiences of Judge Brian P. Stern, who presided over the matter.

250. *Id.* at *1.

251. The related entities at the time of the Petition, were comprised of both not-for and for-profit entities, including Westerly Hospital Health Care, Inc., Atlantic Medical Group, Inc., Ocean Myst MSO, LLC, Women's Health of Westerly, LLC, and North Stonington Health Center, Inc. *Id.* at *1.

252. *Id.* at *2.

253. *Id.* at *1.

254. *Id.*

255. The appointment of a Special Master is permitted by Rule 53 of the Rhode Island Superior Court Rules of Civil Procedure. See R.I. Super. Ct. R. Civ. P. 53. Pursuant to subsection (c) of Rule 53, a court may limit or expand a Special Master's powers as it deems appropriate. See *id.*

256. *Id.*

257. Administrative Order No. 2011-10 (R.I. Super. Ct. 2011), <https://www.courts.ri.gov/Courts/SuperiorCourt/DecisionsOrders/AdministrativeOrd>

In order to avoid closure, and in an effort to continue to provide low-cost, high-quality healthcare to its patients, the CEO requested that the court appoint a fiduciary Special Master, with the powers of a Receiver, to manage the day-to-day operations and take charge of Westerly Hospital's assets.²⁵⁸ In addition, the Petition requested that the Special Master be authorized to review and make recommendations to the court, including but not limited to a sale of Westerly Hospital, a reorganization of Westerly Hospital's debts, or a closure.²⁵⁹ After notice and hearing, the court appointed attorney W. Mark Russo as a Temporary Special Master and authorized the firms of Ferrucci Russo, P.C. and Adler, Pollack and Sheehan, P.C. to act as legal counsel to the Special Master.²⁶⁰

It was clear to the court that from the time of the filing of the Petition that Westerly Hospital's insolvency proceeding involved an array of complicated issues and a wide variety of stakeholders, including medical providers, patients, insurers, secured and unsecured creditors, employees, unions, and retirement plans.²⁶¹ It was also evident to the court that a major and critical participant in the proceeding would be state departments and agencies as the continued operation and disposition of the estate was inextricably tied to state licensing statutes, regulatory requirements, and the statutes governing the transfer or disposal of the assets of hospitals.²⁶²

The court found that in order for the Special Master to have the greatest likelihood of success, the Special Master needed to have formal and informal means of communication with the state's agencies and regulators from the earliest point possible in the insolvency proceeding.²⁶³ The court, mindful of the inherent conflicts between the goals of the insolvency process and the state statutory and regulatory process, as well as the significant amendments made by the BAPCPA with respect to healthcare

ers/2011-10.pdf.

258. *Kinney*, 2011 WL 6296898, at *1.

259. *See* Petition for the Appointment of a Special Master at ¶ 9(a), *Kinney v. Westerly Hosp. Healthcare, Inc.*, No. 2011-0781, 2011 WL 6296898 (R.I. Super. Ct. Dec. 9, 2011).

260. *Kinney*, 2011 WL 6296898, at *2–3.

261. *See id.* at *2, *4–5.

262. *See id.* at *2, *4.

263. *See id.* at *4.

entities, determined that these issues needed to be addressed from the inception of the proceeding to reduce the possibility that these conflicts would become an impediment to a successful resolution of the insolvency proceeding.²⁶⁴ Specifically, a disagreement or a “turf battle” between the Special Master and regulators over matters that could be resolved or avoided through early communication would benefit neither the insolvency estate nor would it be in the best interest of the state regulators. Only through open and timely communication between the Special Master and the state regulators could material issues be identified so that the hospital could have the ability to find a pathway that would satisfy the goals of both the estate and the regulators.

The court determined that Westerly Hospital’s distressed state and its special master proceeding “raise[d] significant public health, regulatory and public protection issues.”²⁶⁵ The court found that a formal and informal mechanism for the Special Master²⁶⁶ to share information and receive feedback from these regulatory, public health, and public protection agencies was critical to address these issues and provide for an efficient and successful outcome.²⁶⁷ Accordingly, the court appointed a voluntary²⁶⁸ Standing Regulatory and Public Protection Committee (Committee).²⁶⁹ The Committee was comprised of key

264. *See id.*

265. *Id.*

266. Depending upon the type of insolvency proceeding, the sharing of information may be between the state regulators and agencies and the debtor in possession, trustee, receiver, assignee, or special master.

267. While any regulated entity within or outside of an insolvency proceeding will have responsibilities to act in accordance with state statutes and regulations, as well as compliance and reporting requirements, this procedure allows the insolvent entity, under court supervision, to share information and discuss potential options with state regulators within a fluid insolvency proceeding.

268. The Committee was voluntary. The court stated in an order that participation in the Committee was in no way intended to affect the rights and duties of each member, and that participation is advisory only, and specifically intended not to have any effect on any independent statutory, licensing, regulatory or public protection authority of these agencies or officials under federal or state law. This portion of the Order was based upon input from these agencies and/or officials because it was important that their voluntary participation not be viewed as consenting to the jurisdiction of the Court, or being estopped from exercising its authority under statutes or regulations, based upon their participation.

269. While the Bankruptcy Code does not provide for the Committee for this purpose, an ad hoc or related group may be formed for this purpose.

regulators involved in the process, including the Rhode Island Secretary of Health and Human Services; the Director of the Rhode Island Department of Health; the Director of the Department of Administration; the Rhode Island Attorney General; the Rhode Island Health Insurance Commissioner; and the Lieutenant Governor of the State of Rhode Island, in her capacity as the Chairperson of the Healthcare Reform Commission.²⁷⁰ The court required that the Special Master work diligently with the Committee when taking actions during the course of the proceeding that impacted public health, regulatory, and public protection matters.²⁷¹

The initial meeting of the Committee was scheduled by the court shortly after the Petitions initial filing and was intended to bring these stakeholders up to date on the status of the special master proceeding.²⁷² Topics discussed by the Special Master at the initial meeting included operational and financial issues such as: (1) the status of Westerly Hospital's licenses and permits; (2) changes to the Board of Directors and Management; (3) employment and union issues; (4) communications with the public regarding the proceeding; (5) the ongoing provision of services by Westerly Hospital; (6) the maintenance of medical records, patient confidentiality, and the appointment of a Patient Care Ombudsman; (7) the hospital's financial situation; and (8) the sharing of timely information with the Committee.²⁷³

During the course of the proceeding, there were a number of specific issues that were addressed by the Committee, including establishing a Patient Care Ombudsman, developing RFPs, payments of hospital fees, operation of the hospital prior to closing, and support in navigating and meeting the requirements of the Hospital Conversion Act.

270. *Kinney v. Westerly Hosp. Healthcare, Inc.*, No. 2011-0781, 2011 WL 6296898, at *4 (R.I. Super. Ct. Dec. 9, 2011).

271. *Id.*

272. While some regulators were consulted in advance of the Petition, others were not. It became apparent that these stakeholders should have been notified and briefed, in detail, prior to the filing.

273. Issues, such as investigations into licenses, including physicians and Medicaid issues, were addressed with the individual Committee members in their official regulatory capacity.

1. *The Patient Care Ombudsman*

In order to assure that that quality patient care was provided and medical issues were addressed during the proceeding, the court ordered that a Patient Care Ombudsman be appointed and funded by the estate.²⁷⁴ The Special Master provided information to the Committee about the type of individual and experience it sought as it went through the search for the appropriate candidate and provided the Committee, in advance of seeking approval from the court, with the experience and scope of work regarding the candidate selected. After receiving no further input from the Committee, a petition was filed and approved by the court for the retention of the Patient Care Ombudsman.²⁷⁵ The Ombudsman was highly qualified and well respected by the regulators and the medical community and ultimately provided necessary services at a reasonable cost to assure that the appropriate level of quality of care was being maintained during the special master proceeding. The use of a Patient Care Ombudsman, while not required under state law, provided an important safeguard during the insolvency proceeding. By appointing an Ombudsman that was supported by the Special Master, as well as the regulators, it allowed all parties to more fully concentrate on important decisions about the future of the hospital.

2. *The Development of the Request for Proposals*

After the Special Master conducted an extensive review, he suggested that a RFP should be issued to help to determine the disposition of the hospital and its assets.²⁷⁶ While a Special

274. *Kinney v. Westerly Hosp. Healthcare, Inc.*, No. 2011-0781, 2011 WL 629689, at *4 (R.I. Super. Ct. Dec. 9, 2011). “The concept of a Patient Care Ombudsman is taken from the Federal Bankruptcy Code. Section 333(a)(1) of the Bankruptcy Code requires that ‘[i]f the debtor in a case under Chapter 7, 9 or 11 is a health care business, the court shall order . . . the appointment of an ombudsman to monitor the quality of patient care and to represent the interests of the patients of a health care business.’” *Kinney*, 2011 WL 6296898 at *4 n.2 (citing 11 U.S.C. § 333(a)(1)). “[T]he appointment of an ombudsman [is] to monitor the quality of patient care and to represent the interests of the patients of the health-care business.” *Id.* (citing AM. JUR. *Bankruptcy* § 696).

275. Order Petition for Instruction, *Kinney v. Westerly Hosp. Healthcare, Inc.*, No. 2011-0781 (R.I. Super. Ct. Feb. 7, 2012).

276. Order Entered, *Kinney v. Westerly Hosp. Healthcare, Inc.*, No. 2011-0781 (R.I. Super. Ct. Apr. 2, 2012).

Master may, through a court-approved process, solicit proposals, any successful bidder of a hospital is required to proceed independently through the state's regulatory and licensing process. To ensure that any bidder successfully navigated through the regulatory and licensing process, the Special Master requested input from the Committee about the information that should be requested in the RFP that would assist in the review of the proposals. Through this process, the RFP documents were extensively modified to include information about the bidder's ability to meet certain requirements under the regulatory statutes, which dramatically assisted the Special Master in making a recommendation to the court regarding the best value to the estate and its creditors.²⁷⁷ The responses to the RFP also provided the regulators with specific information about the bidders, which may not have been available otherwise prior to the formal application process.

In addition to formulating the questions in the RFP, another significant challenge was the inclusion of a stalking horse bidder as part of the RFP process.²⁷⁸ The Special Master concluded that in order to achieve the highest and best offer a stalking horse bidder should be allowed, as a part of the solicitation process.²⁷⁹ The purpose of the stalking horse was to set the floor for bidding and to indicate to prospective bidders that there was at least one other qualified bidder ready, willing and able to acquire the hospital.²⁸⁰ The agreement with the stalking horse bidder included a requirement of a breakup fee, upon approval by the court, should another bidder be successful.²⁸¹ The use of a stalking horse bid was a foreign concept to the Committee, which had a number of concerns, including: (1) allowing a bidder to be designated a stalking horse without filing an application or receiving formal approval from the regulators; (2) that a stalking

277. See Order at 2–4, *Kinney v. Westerly Hosp. Healthcare, Inc.*, No. 2011-0781 (R.I. Super. Ct. Mar. 12, 2012).

278. Special Master's Petition for Instructions Regarding the Presentation and Acceptance of a Stalking Horse Offer at 5–6, *Kinney v. Westerly Hosp. Healthcare, Inc.*, No. 2011-0781 (R.I. Super. Ct. May 30, 2012).

279. *Id.* at 6.

280. *Id.*

281. *Id.* at 5; see also Special Master's Emergency Petition For Instructions Authorizing the Special Master to Bring a Stalking Horse Bid Before the Court for Consideration at 2, *Kinney v. Westerly Hosp. Healthcare, Inc.*, No. 2011-0781 (R.I. Super. Ct. May 23, 2012).

horse bid may give an unfair advantage to one bidder over others, as that bidder would have the ability to negotiate a purchase agreement and material terms of the transaction; and (3) that a breakup fee may have to be paid to the stalking horse bidder, even if they did not ultimately acquire the hospital. However, the Special Master eased the Committee's concerns by providing it with information about the advantages and disadvantages of the stalking horse process and how these transactions have been effectuated in other jurisdictions, and because of the working relationship that had been built between the Special Master and the Committee, this process was brought before the court by Petition and approved without objections by the regulators. As a result of the sharing of information and communication between the Special Master and the Committee, a more efficient and effective RFP process took place.

3. Payment of Hospital Licensing Fees

A significant financial issue that arose during the insolvency proceeding was the unpaid licensing fees owed to the State, both pre- and post-filing. Due to Westerly Hospital's cash flow issues, the Special Master maintained that the hospital could not satisfy its outstanding licensing fee payments when they became due, which totaled almost \$4 million each year. The State argued that if the licensing fees were not paid in full that it had the power and authority to revoke or suspend the hospital's operating license. Despite the number of legal arguments that both the Special Master and the State could have raised, through robust communication, the State and the Special Master were able to come to an agreement allowing the hospital to pay the licensing fees over a period of time, including payment of a portion of those fees by the acquirer after closing. The State, by its involvement in the Committee, recognized the Special Master's cash flow issues and the Special Master recognized the licensing fees and the relationship to the charitable care payments made to the hospital during the same periods. A very expensive and uncertain conflict was avoided through communication between the Committee and the Special Master, allowing the estate to concentrate on the operation of the hospital and disposition of its assets.

4. Operating Agreement Prior to Closing

Prior to closing the sale of the hospital with the successful

bidder and prior to the obtaining final approvals and licenses under the hospital conversion act and other statutes, the Special Master determined that it would be in the estate's best interest to enter into an operating agreement, which would allow the successful bidder to assume the day-to-day management of the hospital under the authority of the Special Master. This required an understanding and consent by the regulators that this arrangement would be permissible. Although the licensing process had yet to be finalized, the regulators agreed, after conversations and communications with the Special Master and the successful bidder that it was in the best interest of all parties to permit the operating agreement to go forward. When the petition to authorize the operating agreement was filed with the court, it was approved by the court without objection. It is unclear whether such an operating agreement would have been permitted or possible without ongoing communication among the Special Master, the successful bidder, and the regulators throughout the process.

5. Support During the Hospital Conversion Act Proceedings

During the Hospital Conversion Act proceedings before the Department of Health and the Attorney General, there was information and answers to questions that the estate was in the best position to provide. With the lines of communication fully opened, often brief communication about issues that could have slowed down the process allowed it to proceed forward in a timely and efficient manner.

The outcome of Westerly Hospital's Special Master proceeding was extremely successful. A critical hospital serving Rhode Island and a portion of Connecticut was sold and the sale received expedited approval by the Department of Health and the Attorney General.²⁸² This outcome was the opposite of the distinct possibility when the petition was filed that the hospital would close. Under the terms of the purchase, Lawrence and Memorial Hospital agreed to a total of \$69 million in cash and other commitments, including the assumption of \$22 million in debt, committing \$6.5 million in working capital during the first two years, and investing \$30 million in new technology, equipment

282. The certificate of need process was expedited in accordance with R.I. GEN. LAWS § 23-15-5(a) (2014).

and expansion of services over the next five years.

Overall the Committee process worked very well. Members of the Committee had real-time information about the status of the insolvency proceeding that related to their areas of regulatory and statutory responsibility. The Committee process fostered a degree of trust between the regulators and the Special Master, and when issues arose, rather than the regulators or the Special Master jumping to conclusions that there was a lack of candor or an issue could not be resolved, a discussion would take place. Based on open and honest communication, numerous issues were resolved before they became major issues. The creditors and prospective bidders also had a degree of comfort that the debtor and the regulators were not working at cross-purposes or that the insolvent estate would close and be liquidated because of the failure of communication or coordination. If one change could be made to the Committee concept it would be to have a structure in place prior to filing the Petition, when the hospital was in distress, in an attempt to “hit the ground running” upon the hospital filing for insolvency. Arguably the formation and use of a Committee, in this case, resulted in secured creditors that were more comfortable allowing their collateral to be used during the insolvency process and provided additional comfort to potential purchasers, ultimately obtaining a higher value for the assets of the Westerly Hospital and related entities.

V. RECOMMENDATIONS ON REGULATOR INVOLVEMENT

As seen above, when a hospital faces insolvency, the conflict between maximizing recovery for creditors and complying with state regulation can be reconciled;²⁸³ however, such reconciliation can only be accomplished when regulators are “brought to the table” and are actively involved prior to and during the insolvency proceeding. If regulators are not considered, consulted, or involved, the disposition of the hospital’s assets, or its transfer of ownership, may become a difficult and lengthy process, resulting in higher costs and less return to the insolvent estate.²⁸⁴ There are several ways regulators can be involved in the affairs of a distressed hospital: (1) states can establish an emergency hospital

283. See *In re United Healthcare Sys., Inc.*, No. 97-1159, 1997 WL 176574, at *10 (Bankr. D.N.J. Mar. 26, 1997).

284. See *id.*

and healthcare working groups made up of relevant state regulatory agencies that identify and consult distressed hospitals within or entering insolvency; (2) state regulatory agencies can create ad hoc regulatory and public protection committees during the insolvency proceeding; and (3) state regulatory agencies can participate in mediation during bankruptcy proceedings.

A. *Establish an Emergency Hospital and Healthcare Working Group*

Each state should establish a Working Group to address healthcare institutions that are in distress or that have or may file for insolvency.²⁸⁵ The Working Group should consist of representation from each licensing and public protection organization that regulates the healthcare institutions in the state. The purpose of formation of a regulatory Working Group is to facilitate communication and coordinate the sharing of all material information concerning the distressed hospital between regulatory agencies.

To be effective, at its inception, the Working Group should establish operating guidelines and procedures. Such operating guidelines may be memorialized in a memorandum of understanding or similar interagency agreement. Several governing policies and procedures that should be considered include: (1) the authority and limits of the Working Group, including maintaining the independence and statutory authority of each individual regulatory member; (2) the appointment of one department or agency that will be responsible for the administrative operations of the Working Group, including identifying the committee membership and maintaining up to date contact information for each members representative; (3) the process for activating the committee; (4) the protocol for the Working Group Chair to act as a liaison to assure that all members have the latest, most accurate information; (5) if the committee is a public body under law, assure that all public records and public meeting requirements are complied with; (6)

285. Depending on the type of governmental entity, the Working Group can be formed through methods, including, statute, ordinance, regulation or Executive Order. Some states have already authorized such working groups. See Governor Jon S. Corzine, Executive Order No. 39 (Oct. 12, 2006), <http://nj.gov/infobank/circular/eojsc39.htm>.

coordinate reporting, where appropriate, to senior government policy makers that have an interest in the healthcare institution; and (7) recognize that many healthcare institutions conduct business in other states, counties or jurisdictions, and that there needs to be a procedure for the Working Group to coordinate and communicate, where possible, with the Working Groups established in other jurisdictions. Working Group members should be trained in these operating procedures, in advance, so if and when a qualifying event arises the Working Group can be activated and begin its tasks immediately.

As aforementioned, during the normal operation of a healthcare institution and during an insolvency proceeding the healthcare institution is required to maintain compliance with state statutes, regulations, and policies implemented and enforced by a variety of agencies and departments.²⁸⁶ These different functions are generally distributed among a number of agencies and departments that have expertise in various areas.²⁸⁷ A healthcare institution is required to deal with a variety of departments, agencies, or commissions on an individual basis during its normal operations. However, during a period where a healthcare institution faces insolvency, it is important that regulatory and statutory compliance are administered in a more coordinated and holistic manner. This is because, during a period of distress, there is an increased risk of material change within the hospital, such as a change of control, increase or decrease in the lines of services offered, requests for purchase or sale of

286. See 28 U.S.C.A. § 959(b) (Westlaw through Pub. L. No. 114–244).

287. For instance, the State's Department of Health generally handles licensing and certificate of needs; the Office of the Health Insurance Commissioner generally handles private insurance contracts; the Department of Human Services generally handles Medicaid reimbursement; the Department of Labor generally handles employment and safety issues; and the Department of the Attorney General generally handles public protection issues, not-for-profit issues, and transfer of health care license under hospital conversion acts. See *What we License*, R.I. DEP'T OF HEALTH, <http://health.ri.gov/licenses/index.php> (last visited Sept. 5, 2016); *Laws, Regulations, and Orders*, R.I. OFF. OF THE HEALTH INS. COMMISSIONER, <http://www.ohic.ri.gov/ohic-regulation.php> (last visited Sept. 5, 2016); *Workforce Regulation and Safety*, R.I. DEP'T OF LAB. & TRAINING, <http://www.dlt.ri.gov/wrs/> (last visited Sept. 5, 2016); *Medicaid Programs*, R.I. DEP'T OF HUM. SERVS., <http://www.dhs.ri.gov/Programs/index.php> (last visited Sept. 5, 2016); *Office of the Health Care Advocate*, R.I. DEP'T OF THE ATTORNEY GENERAL, <http://www.riag.ri.gov/CivilDivision/OfficeoftheHealthCareAdvocate.php> (last visited Sept. 5, 2016).

capital assets, or the sale or closure of the healthcare facility, all of which involve different regulatory agencies. Accordingly, in such scenarios it is appropriate for the Working Group be activated to share information, have real time structured interagency communication, address issues, and coordinate among regulatory departments to the extent possible. A proactive approach is a better course of action than the licensing and public protection authorities being faced with an emergency that has festered, without communication and coordination. Without such involvement, a State and a hospital may be left with a “Hobson’s choice”: either the healthcare institution closes immediately or it will require an immediate capital contribution from the state to remain open or have an orderly wind down of operations.²⁸⁸ When dealing with healthcare entities that impact the public health, safety, and welfare of citizens, it is critical that all government entities that have an interest in the healthcare institution have an avenue to timely receive and process all material information so that deliberate and informed decisions can be made.

The concept of an emergency committee or operations center already exists in most jurisdictions to address certain public health and safety emergencies. The Emergency Operations Center, generally under the auspices of the Emergency Management Agency, have the statutory and/or executive authority to bring together departments and agencies in a central location to provide interagency coordination in support of a regional incident and local response.²⁸⁹ These emergencies generally include such events as snowstorms, hurricanes, flooding, power failures, mass casualty incidents, and other public safety emergencies.²⁹⁰ The Emergency Operations Center brings together the parties for a particular incident necessary to address the emergency.²⁹¹ The parties may include government

288. “Hobson’s Choice” is “the necessity of accepting one of two or more equally objectionable alternatives.” *Hobson’s Choice*, MERRIAM WEBSTER DICTIONARY ONLINE, [http://www.merriam-webster.com/dictionary/Hobson’s%20choice](http://www.merriam-webster.com/dictionary/Hobson's%20choice) (last visited Aug. 5, 2016) (second full definition).

289. *See, e.g.*, KY. REV. STAT. ANN. § 39A.050(1), (2)(d) (West, Westlaw through 2016 Reg. Sess.).

290. *See, e.g.*, KY. REV. STAT. ANN. § 39A.010 (West, Westlaw through 2016 Reg. Sess.).

291. *See, e.g.*, KY. REV. STAT. ANN. § 39A.050(2)(d) (West, Westlaw through 2016 Reg. Sess.).

departments, agencies, law enforcement, utilities and provide a structured vehicle to receive information, make recommendations, and for policy makers to coordinate a response.²⁹²

This type of communication and coordination that exists in the Emergency Operation Center may work well in a potential healthcare insolvency matter. There are a variety of regulatory and public protection departments, agencies, commissions, and subgroups therein that have an interest in the regulation, licensing, and oversight of healthcare institutions. All of these governmental institutions should be identified for inclusion in the Working Group. Other governmental departments and agencies may also be considered for inclusion in the Working Group, such as a representative from the budget/finance department, taxation department, and governmental bonding authority.²⁹³

B. *Establish an Ad Hoc Regulatory and Public Protection Committee*

In a Chapter 11 bankruptcy proceeding, parties can be a part of official committees, which are “designed to foster the development of consensual Chapter [11] plans of reorganization.”²⁹⁴ A principal task of an official committee is to “directly participate in crafting the debtor’s plan” of reorganization.²⁹⁵ Members of official committees generally owe fiduciary duties to the remainder of the committee; individual members may not use their positions to advance their own interests at the expense of other members.²⁹⁶ These official committees are granted statutory powers, including the right to consult with the debtor; the right to retain professionals, paid for by the debtor; and standing to be heard by the bankruptcy

292. See, e.g., KY. REV. STAT. ANN. § 39A.0502(a), (c), (d) (West, Westlaw through 2016 Reg. Sess.).

293. These non-regulatory, public-protection agencies may not have access to all non-public confidential information. This can be addressed in the Committee’s policies and procedures.

294. Henry C. Kevane, Jeffrey T. Kucera & Mathew J. Ochs, *No more Ad Lib: The Nuts & Bolts of Ad Hoc Bankruptcy Committees*, BUS. L. TODAY (Dec. 2014), at 1, available at http://www.americanbar.org/publications/blt/2014/12/02_kevane.html; see 11 U.S.C.A. § 1102(a)(1) (Westlaw through Pub. L. No. 114–244).

295. Kevane, et al., *supra* note 294, at 1.

296. *Id.* at 2; see also 11 U.S.C.A § 1103(b) (Westlaw through Pub. L. No. 114–244).

court.²⁹⁷ The official committee members also have a vote on any plan of reorganization and the committee may take an official position on proposed actions of the debtor in the bankruptcy proceeding.²⁹⁸ While participation on such a committee would seem to be an appropriate way to involve state regulatory agencies, the Code is clear that a governmental entity is not permitted to serve as a voting member of an Official Committee in a Chapter 11 bankruptcy.²⁹⁹ In fact, only a “person” may be on an official committee, and “government unit”³⁰⁰ is specifically excluded in the Code from the definition of the term “person.”³⁰¹ However, such exclusion from official committees should not dissuade regulatory agencies from forming an ad hoc committee. Rather, when it becomes likely that a healthcare institution may file or has filed for bankruptcy or state receivership, government regulatory agencies should consider participating in ad hoc regulatory and public protection committees within the insolvency proceeding.

An ad hoc committee refers to “any group of stakeholders who wish to collaborate in the pursuit of similar claims or interests.”³⁰² Ad hoc committees are fundamentally different from official committees as they are “free from many of the constraints governing official committees.”³⁰³ “As a result, an ad hoc committee is able to organize itself in almost any way it sees fit, and may be as fluid or as organized as their members and interests require.”³⁰⁴

297. 11 U.S.C.A. § 1103(a), (c)(1) (Westlaw).

298. *Id.* § 1103(c)(3).

299. *See id.* § 1102(b)(1) (“persons” can be a part of a committee); 11 U.S.C.A. § 101(41) (Westlaw through Pub. L. No. 114-244) (“The term ‘person’ . . . does not include governmental unit”). However, a government unit may be on an official committee if it is a creditor. *See id.*

300. A “government unit” includes the “United States; State; Commonwealth; District; Territory; municipality; foreign state; department, agency, or instrumentality of the United States (but not a United States trustee while serving as a trustee in a case under this title), a State, a Commonwealth, a District, a Territory, a municipality, or a foreign state; or other foreign or domestic government.” 11 U.S.C.A. § 101(27) (Westlaw).

301. *See* 11 U.S.C.A. §§ 101(41), 1102(b)(1) (Westlaw). There is a dearth of legislative history documenting the rationale behind this decision to exclude governmental entities under Chapter 11 of the Code.

302. Kevane, et al., *supra* note 294.

303. *Id.*

304. *Id.* “While official committees are frequently administered in a formal, corporate style—adopting bylaws, subcommittees, chairpersons, and

An ad hoc committee is formed through the collective action of stakeholders.³⁰⁵ The committee may exist prior to or after a bankruptcy proceeding has been filed, and the members of the committee, subject to the agreement of the members, may join or withdraw from the committee at any time.³⁰⁶ Generally, the members of an ad hoc committee do not owe a fiduciary duty to the other members and do not automatically have collective standing or any greater powers than any other individual party in the bankruptcy case.³⁰⁷ Although the ad hoc committee does not have automatic statutory standing to be heard by the bankruptcy court, the committee collectively may achieve standing if they are a party with a practical stake in the outcome of the proceeding under § 1109(b) of the Code, which provides that “[a] party in interest . . . may raise and may appear and be heard on any issue in a case under this chapter.”³⁰⁸ Due to the informal status of the ad hoc committee, the debtor is also not required to disclose information to ad hoc committees.³⁰⁹ The expenses of the ad hoc committee are not generally reimbursed unless the committee can demonstrate that its efforts made a “substantial contribution” to the debtor’s estate and to creditors generally.³¹⁰ Similarly, the ad hoc committee may retain professionals to assist it through the insolvency; however, the recovery of these “professional fees” may be questionably recoverable according to recent bankruptcy case law.³¹¹

While the Code prohibits government entities from participating as voting members in the statutory creditors’ committees under Chapter 11 of the Code, one or more government entities should create ad hoc committees prior to and during the insolvency proceeding to establish an avenue of

regular meetings—ad hoc committees are typically more informally managed.” *Id.*

305. *Id.*

306. *Id.* Ad hoc committees are often formed prior to an insolvency filing in an attempt to reach a resolution that results in a prepackaged bankruptcy or receivership.

307. *Id.*

308. See 11 U.S.C.A. § 1109(b) (Westlaw through Pub. L. No. 114–244); *Ad Hoc Bondholders Group v. Interco Inc.*, 141 B.R. 422, 424–25 (Bankr. E.D. Mo. 1992).

309. Kevane et al., *supra* note 294, at 2.

310. See 11 U.S.C.A. § 503(b)(3)(D), (b)(4) (Westlaw through Pub. L. No. 114–244).

311. Kevane et al., *supra* note 294, at 4.

collaboration and communication. After the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005³¹² (BAPCPA), the participation of government entities is critical to the outcome of the bankruptcy case. Whether the bankruptcy court is ultimately asked to approve a sale, plan of reorganization, a plan of adjustment or liquidation, the court can only approve these outcomes under bankruptcy law when there has been compliance with state law. That makes the government regulator arguably as important, if not more important, than any other secured or unsecured creditors. The government entity, in a very real sense, is the “elephant in the room,” and an ad hoc committee is the perfect avenue for state regulators to be heard and efficiently communicate and coordinate during an insolvency proceeding. An ad hoc committee, similar to the Emergency Healthcare Coordinating Committee, allows the regulators and government entities to communicate and coordinate during the pendency of the insolvency. The ad hoc committee has the ability to set up policies and procedures to address its own membership, confidentiality and the independence of individual regulatory and government agencies. Such informal participation in an ad hoc committee will allow for collaboration, communication, and transparency among its members, including members from outside the jurisdiction, without the risk of compromising a regulatory agency’s own statutory responsibilities, obligations, and independence. The Committee may also act as a clearinghouse for information.³¹³ The ad hoc committee, on a case-by-case basis, may also determine whether or not it is prudent to fund the committee and retain professionals to advise the committee on issues during the insolvency proceeding, rather than separate departments and agencies retaining their own professionals and consultants.

Debtors, creditors, and other interested parties have used the ad hoc committee process effectively for many years in insolvency

312. Pub. L. No. 109-8A, 119 Stat. 23-217. A number of bankruptcy courts found, prior to the BAPCPA amendments, that state regulation in the health care area could be avoided in certain circumstances under § 105 of the Code.

313. One issue that arises in state regulation that is not as prevalent in federal regulation is the differing requirements for notice under the Bankruptcy Code. Through a committee, the debtor can be provided with detailed information about the government entities that require notice.

proceedings.³¹⁴ It is appropriate and necessary for government entities to begin to use this available tool prior to and during an insolvency proceeding. This is especially important during a time when the government entity has a large effect on the outcome of the insolvency proceeding. A government regulatory ad hoc committee has proven to be efficient and effective in practice. During Westerly Hospital's receivership, the court created a voluntary ad hoc "Regulatory and Public Protection Committee" so that "the regulatory and public protection agencies have access to timely information about the Westerly Hospital and Related Entities."³¹⁵ The Regulatory and Public Protection Committee was integral to the receivership, and worked closely with the Special Master during Westerly Hospital's transfer of ownership.³¹⁶

C. Consider Participation in Mediation During the Insolvency

In many insolvency proceedings there are obstacles to reaching an effective and efficient outcome that satisfies both the government entities licensing and public protection responsibilities and achieves the highest and best return to creditors. Mediation may be a valuable resource for working through these obstacles, as it can coordinate the process, timing, and sharing of information.³¹⁷ Mediation is "a process in which a mediator facilitates communication and negotiation between parties to assist them in reaching a voluntary agreement regarding their dispute."³¹⁸ Mediation allows the parties to retain control over both the method of dispute resolution as well as the outcome, which is voluntary. It provides a forum where one party can attempt to understand another party's position and attempt to

314. Kevane et al., *supra* note 294, at 1.

315. *Kinney v. Westerly Hosp. Healthcare, Inc.*, No. 2011-0781, 2011 WL 6296898, at *3 (R.I. Super. Ct. Dec. 9, 2011).

316. See discussion regarding Westerly Hospital *supra* Part IV.C.

317. See Order Assigning Matter to Mediation, *In re Interfaith Med. Ctr., Inc.*, No. 12-48226 (Bankr. E.D.N.Y. Nov. 13, 2013), ECF No. 797.

318. Nancy A. Welsh, *You've Got Your Mother's Laugh: What Bankruptcy Mediation Can Learn from the Her/History of Divorce and Child Custody Mediation*, 17 AM. BANKR. INST. L. REV. 427, 432 (2009); see also James M. Peck & Erica J. Richards, *Bankruptcy Mediation: Case Studies, Considerations and Conclusions*, INT'L COMP. LEGAL GUIDE TO CORP. RECOVERY & INSOLVENCY 16 (8th ed. 2014), <https://media2.mofo.com/documents/140701bankruptcymediationcasestudies.pdf>.

craft a solution that is mutually beneficial. Through confidentiality and “no-use” agreements, the parties can share material information in an attempt to reach consensus without fear that disclosures will be used later in an adversary proceeding.³¹⁹ The mediator, who has expertise in the field, can facilitate a resolution as an “honest broker.” When successful, mediation in bankruptcy has certain “well-recognized advantages over traditional litigation, including reduced costs and increased predictability of outcomes, a reduction in the length of bankruptcy proceedings, the removal of sensitive or undecided issues from the court’s discretion, the elimination of the potential for appeal, and the maintenance of confidentiality.”³²⁰

Mediation was first used in bankruptcy courts in 1986, and by 1990 bankruptcy courts began using mediation on an ad hoc basis.³²¹ “One of the most significant uses of mediation in the bankruptcy context is the inclusion of the process in Chapter 11 reorganization plans, in order to resolve claims that do not come within the limited jurisdiction of bankruptcy procedures.”³²² Accordingly, mediation continues to be a tool utilized by many bankruptcy courts today.³²³

Government entities have participated, to a limited extent, in the mediation process.³²⁴ To be a viable alternative for the government entity, it is critical that their independent statutory and regulatory authority be acknowledged and respected. It is also critical that an appropriate mediator is selected who has expertise in both state healthcare regulation and public protection, as well as the insolvency field. Further, it is important that the mediator can navigate the areas where mediation would be beneficial and the areas that are not proper for inclusion in mediation. The initial response of some state regulators and public protection officials will be to reject the idea of mediation, as it will somehow limit the ability of the regulator to exercise its full

319. Peck & Richards, *supra* note 318, at 19. “One workaround that has been used in a number of cases is the entry of a protective comfort order entered in advance of, and as a condition to, plan negotiations, providing that participants will be protected from specified future claims.” *Id.*

320. *Id.*

321. Welsh, *supra* note 318, at 441.

322. *Id.* at 444.

323. See Peck & Richards, *supra* note 318, at 16–19.

324. See Order Assigning Matter to Mediation, *In re Interfaith Med. Ctr., Inc.*, No. 12-48226 (Bankr. E.D.N.Y. Nov. 13, 2013), ECF No. 797.

statutory or regulatory authority.³²⁵ For example, in *In re Interfaith*, the Interfaith Hospital strongly believed that NY DOH “ha[d] to be a participant” in the mediation, but the NY DOH believed that its participation would compromise its role as a regulator.³²⁶ NY DOH explained “DOH is a regulator and would have to make decisions under state law if there’s a transfer of the ownership certificates. And they can’t be involved” in preliminarily approving or denying bidders merely based on qualifications.³²⁷ The bankruptcy court explained that NY DOH, because it was ultimately charged with the approval of the transfer license and certificates of need, was an important and critical voice to be heard in mediation; therefore, without NY DOH’s participation in mediation, the mediation would be “pointless.”³²⁸ NY DOH rebutted that it “can certainly provide input if the debtor chooses a plan, but as to competing plans, it’s not something that [it] [could] be involved in.”³²⁹ With that clarification, and with assurances that the mediation would be confidential and nonbinding, NY DOH agreed to participate in mediation in a limited role.³³⁰

In some instances, the debtor and other creditors may also be hesitant about participating in a mediation process with the state regulators and public protection officials. One reason being that the government entity may not just be a regulatory authority, but, in some cases, it may also be a significant creditor in the insolvency proceedings. A debtor may be concerned that even though the government entity is not permitted to use the “police power” exception to the automatic stay to recover pre-petition debts, the government entity will use the issues being discussed in the mediation as leverage to have its pre-petition claims paid. Additionally, a debtor may be concerned that in dealing with a regulatory agency in a healthcare insolvency matter, there often exist political issues. For instance, does the government entity want a certain predetermined result for political reasons such as the closure of the healthcare institution or an increase or decrease

325. See Transcript of Hearing at 160–61, *In re Interfaith Med. Ctr., Inc.*, No. 12-48226 (Bankr. E.D.N.Y. Nov. 19, 2013), ECF No. 801.

326. *Id.* at 161.

327. *Id.* at 160.

328. *Id.* at 162.

329. *Id.*

330. *Id.* at 164.

in services? A political preference or opposition to a for-profit healthcare entity acquiring the healthcare entity? The debtor and other creditors may see these issues as a reason that the mediation will not result in progress, and so is not appropriate to dedicate the time, expense, and the resulting delay in the overall case that it may cause.

However, with the regulator and debtor's concerns in mind, it is important to remember that the purpose of the mediation with a government entity is the coordination and sharing of information; it is not a forum for final statutory decision-making. It is merely an impetus to open the lines of communication between state regulators and the healthcare debtor. The mediation may very well assist all parties to plan and reconcile two sometimes incongruous systems that have different goals, timelines, and public policy rationales. It is in the public interest for the government entity to discuss and coordinate, where possible, to reach a process and outcome that is in the public interest. While protecting the exercise of the regulators authority under state law is appropriate, this can still be accomplished while participating in mediation. In fact, affecting or curtailing the statutory or regulatory authority of governmental entities should never be the subject of mediation.

These perspectives from the regulators, debtors, and creditors are important considerations demonstrate that the use of mediation may lead to a more effective and efficient outcome. A well-chosen mediator, with expertise in both areas of the law, will be able to direct the mediation to areas where all parties can agree and have a common interest. The mediator may also assist in putting in place a schedule that accommodates the regulator's statutory issues, the debtor's issues continuing to operate the institution, and the creditor's concerns that its collateral will continue to decline in value while in use. The potential progress of the mediation process likely outweighs the delay and cost of the mediation proceeding. As a result, mediation should be seriously considered in the appropriate situations.

CONCLUSION

Healthcare insolvencies present a unique dilemma in which the goal of achieving the "highest and best" return for creditors may be frustrated by a state's explicit authority to control the public health. However, the cases discussed herein are

illustrative that this conflict can be ameliorated when state regulators are actively involved in the insolvency from the earliest point. While there are no formal procedures to force regulator involvement, several more informal means can accomplish the same goal. First, states can implement a distressed hospital working group that is comprised of several regulatory authorities to address hospitals in distress. Such a working group retains a regulator's independent authority while also directing its attention to hospitals facing economic troubles. Second, state regulators can form ad hoc committees as part of insolvency proceedings. Because of the informal nature of the ad hoc committee, a state regulator can control the extent of its involvement while achieving transparency and garnering material information throughout the proceeding. Further, so long as the regulatory committee is a substantial benefit to the bankrupt estate, it may be entitled to recover its costs as administrative expenses to the estate. Last, regulators can participate in mediation. Mediation is the ideal method of regulator involvement as long as it brings regulators "to the table" while at the same time protecting their independence and respecting their regulatory role. No matter what method is used one principal proposition remains: regulator involvement in a healthcare insolvency is paramount. Without involvement by state regulators, the sale, transfer, or disposition of a hospital's assets to new ownership may be substantially delayed or postponed and cost the bankrupt estate additional capital and time. Early and active regulator involvement serves to maximize recovery for creditors while ensuring public health is not sacrificed, an undeniably ideal outcome for any healthcare insolvency.