

# **Rx FOR AILING RURAL PUBLIC HOSPITALS: CHAPTER 9 BANKRUPTCY AND PRO BONO LAWYERING**

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## I. THE PROBLEM OF RURAL PUBLIC HOSPITAL INSOLVENCIES AND CLOSURES

The second decade of the 21st century has been a difficult time for all healthcare providers. Problems have ranged from frequently changing, hard-to-forecast, and often unreliable sources of payment and reimbursement, to the technological and financial challenges of implementing the mandates for electronic medical record systems. In the shifting financial and regulatory landscape of this period, many rural<sup>2</sup> hospitals have encountered serious financial distress; more and more of them are falling into insolvency and then closing. A National Rural Health Association (the “NRHA”) press release issued in February 2017 warns, “Since 2010, 80 rural hospitals have closed. Right now, 673 additional facilities are vulnerable and could close—this represents *over 1/3 of rural hospitals* in the U.S.”<sup>3</sup>

Similarly, at the end of 2016, the University of North Carolina’s Cecil G. Sheps Center for Health Services Research (the “Sheps Center”) reported:

From January 2005 to July 2016, 118 rural hospitals have closed permanently, not including seven others that closed and subsequently reopened. The number of closures has increased each year since 2010,

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<sup>2</sup> Government agencies and academic analysts have posited multiple definitions of the term “rural.” This essay adopts the definition of “rural” utilized by the Office of Rural Health Policy, a division of the federal Health Resources & Services Administration (HRSA); in short, “rural” means “Non-Metro” where “Metro” is defined as “contain[ing] a core urban area of 50,000 or more population.” HEALTH RESOURCES & SERVS. ADMIN., *Defining Rural Populations*, HRSA.GOV, <https://www.hrsa.gov/ruralhealth/aboutus/definition.html> (last visited Oct. 1, 2017). “After the 2010 Census, the Non-Metro counties contained 46.2 million people, about 15% of the total population and covered 72% of the land area of the country.” *Id.* The HRSA identifies the subject county, Hardeman County, Texas, as “rural” in its online analyzer. See HEALTH RESOURCES & SERVS. ADMIN., *Rural Health Grants Eligibility Analyzer*, <https://datawarehouse.hrsa.gov/tools/analyzers/geo/Rural.aspx> (last visited Oct. 17, 2017).

<sup>3</sup> NAT’L RURAL HEALTH ASS’N, *Rural Health Crisis Brings Advocates to Washington*, RURALHEALTHWEB.ORG, [https://www.ruralhealthweb.org/NRHA/media/Emerge\\_NRHA/Press%20releases/NRHA-release-2017-Rural-Health-Policy-Institute.pdf](https://www.ruralhealthweb.org/NRHA/media/Emerge_NRHA/Press%20releases/NRHA-release-2017-Rural-Health-Policy-Institute.pdf) (Feb. 3, 2017) (emphasis added). This release is based on analysis of the latest information. See also *Rural Relevance - Vulnerability to Value: A Hospital Strength INDEX® Study*, iVATAGE HEALTH ANALYTICS, CHARTIS, [http://www.chartis.com/resources/files/INDEX\\_2016\\_Rural\\_Relevance\\_Study\\_FINAL\\_Formatted\\_02\\_08\\_16.pdf](http://www.chartis.com/resources/files/INDEX_2016_Rural_Relevance_Study_FINAL_Formatted_02_08_16.pdf). (last visited Sept. 14, 2017).

and in the first half of 2016, the closure rate surpassed two closures per month.<sup>4</sup>

A searchable map of rural hospital closures since 2010 provided by the Sheps Center demonstrates the widespread, nearly nationwide scope of the problem,<sup>5</sup> and a Government Accountability Office report confirms the accelerating nature of the problem.<sup>6</sup>

The NRHA describes the consequences of rural hospital closures in foreboding terms:

Due to the closure crisis, medical deserts are forming across rural America, where populations are per capita, older, poorer and sicker. . . . [T]he mortality gap between rural and urban America is widening with many rural populations life expectancy rates on a tragic decline.<sup>7</sup>

Specifically, healthcare analysts in academia have observed:

On average, rural populations have relatively more elderly people and children, higher unemployment and underemployment rates, and lower population density with higher percentages of poor, uninsured, and underinsured residents. Rural populations are more vulnerable than their urban counterparts to economic downturns because of their concentrated economic specialization. Other unique circumstances include longer travel distances to—and higher costs associated with—needed health care services; diseconomies of scale; high rates of fixed overhead per-patient revenue; fewer health care providers and a greater emphasis on generalists; health care facilities with limited scopes of service; economically fragile hospitals with high closure rates; greater dependency on Medicare and Medicaid reimbursement; higher rates of chronic diseases; and different clinical practice behaviors, practice arrangements, and reimbursement levels. . . .<sup>8</sup>

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<sup>4</sup> Brystana G. Kaufman et al., *Trends in Risk of Financial Distress Among Rural Hospitals*, CECIL G. SHEPS CTR. FOR HEALTH SERVS. RES., <http://www.shepscenter.unc.edu/product/trends-risk-financial-distress-among-rural-hospitals/> (last visited Mar. 23, 2018).

<sup>5</sup> See *81 Rural Hospital Closures: January 2010–Present*, CECIL G. SHEPS CTR. FOR HEALTH SERVS. RES., <http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/> (last visited Sept. 14, 2017).

<sup>6</sup> See U.S. GOV'T ACCOUNTABILITY OFF., *RURAL HOSPITALS: FACTORS THAT AFFECT RISK OF CLOSURE*, 3 (1990), GAO/HRD-90-134. .

<sup>7</sup> See NAT'L RURAL HEALTH ASS'N., *supra* note 3.

<sup>8</sup> L. Gary Hart et al., *Rural Definitions for Health Policy and Research*, 95 AM. J. PUB. HEALTH 1150 (2005).

Such distress is palpable and is increasing, according to these authorities.<sup>9</sup>

Moreover, the healthcare policy analysts have lately found that the profitability of rural hospitals generally is decreasing while, in contrast, that of urban hospitals is increasing.<sup>10</sup> A recent analysis published in the *Journal of Rural Health* has identified both *internal* and *external* causes of financial strains and rural closures. The analysts there identified internal, or “hospital-specific,” factors of “poor financial health, aging facilities, low occupancy rates, difficulty in recruiting and retaining health care professionals, reduction of medical services, and inadequacy of outpatient revenue,” as well as external, or “market-based,” causes that are primarily socioeconomic and competitive in nature.<sup>11</sup> Also pertinent to the subject of this article, about one-third of those failing rural hospitals are *public* hospitals.<sup>12</sup>

Healthcare and policy analysts have not canvassed and assessed the means and methods presently available to such hospitals to *deal with* insolvency and hopefully to *avoid* closure. Two methods are necessarily improvisational and piecemeal in nature: either to negotiate a “workout,” a voluntary restructuring agreement of a debtor with one or more of its creditors that scales back, and provides easier repayment terms for, the existing debts; or just to defend, as best can be done, the lawsuits as and when they are filed by creditors holding defaulted debts.<sup>13</sup> Those two methods are necessarily *ad hoc* in

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<sup>9</sup> Contemporary newspaper accounts reinforce these findings. See, e.g., Amy Goldstein, *Rural America's Dying Hospitals*, WASH. POST, (Apr. 12, 2017); see also Brianna Bailey, *Oklahoma's Bankrupt and Closed Rural Hospitals*, OKLAHOMAN (Mar. 20, 2017, 9:44 AM), <http://newsok.com/article/5542311>.

<sup>10</sup> See Sharita R. Thomas et al., *2012-14 Profitability of Urban and Rural Hospitals by Medicare Payment Classification*, RURAL HEALTH RES. GATEWAY (Mar. 9, 2016), <https://www.ruralhealthresearch.org/alerts/113>.

<sup>11</sup> B.G. Kaufman et al., *The Rising Rate of Rural Hospital Closures*, 32 J. RURAL HEALTH 35, 36 (2016).

<sup>12</sup> Email from Ann Howard, Applications Specialist, CECIL G. SHEP'S CTR. FOR HEALTH SERVICES RES., to Josiah M. Daniel, III, Of Counsel, Vinson & Elkins LLP, (Oct. 2, 2016 11:37 CST) (on file with author).

<sup>13</sup> The former is actually a prerequisite to seeking Chapter 9 relief, as later noted, but the latter is idiosyncratic and unpredictable, often requiring a long time and entailing significant

nature. A third means is a comprehensive solution for the problems of debt and financial failure of those *rural hospitals* that are *governmental units*: Chapter 9 of the federal Bankruptcy Code.<sup>14</sup>

Chapter 9 is entitled “Adjustment of Debts of a Municipality.” The recent case here presented demonstrates how Chapter 9 worked to save one insolvent rural public hospital and how the debt relief and restructuring opportunities uniquely offered through the municipal bankruptcy process in a federal bankruptcy court were made more available—and more availing—for this hospital because my law firm provided services to the hospital on a *pro bono publico* basis. From this experience, I argue that the combination of the Chapter 9 process and *pro bono* legal services is a model by which insolvent rural public hospitals may achieve rehabilitation and survive into the future to continue their mission of providing healthcare for their residents and patients.

## II. HARDEMAN COUNTY MEMORIAL HOSPITAL

From 2013 to 2016, my law firm served as legal counsel to an insolvent rural public hospital, Hardeman County Memorial Hospital (the “Hospital”), which is owned and operated by the Hardeman County Hospital District (“HCHD”), in its successful reorganization under Chapter 9 of the Bankruptcy Code. Covering most of rural Hardeman County, HCHD is a political subdivision of the State of Texas, and it holds the statutory power to tax, borrow, and spend for its mission of “(1) operating hospital facilities; and (2) providing medical and hospital care for the district’s needy inhabitants.”<sup>15</sup> The Hospital is located in a small town, Quanah, Texas (pop. 2,650), that lies eighty miles west-northwest of the nearest city, Wichita Falls.

The residents of Quanah and Hardeman County depend in many ways on the Hospital, a critical-access facility licensed for twenty-four beds and providing acute care, outpatient services, rehabilitation, clinic services, and mental health services for seniors. The 24/7

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defense costs.

<sup>14</sup> See 11 U.S.C. §§ 901–946 (2012) (discussing Chapter 9 of the Bankruptcy Code as the applicable law).

<sup>15</sup> TEX. SPEC. DIST. CODE § 1078.101 (2005) (explaining the statutory requirements).

emergency room is crucial for employers, including the wallboard manufacturing plant that employs 130 people, and the school district that is the largest employer in the town, as well as for all residents, young and old. The Hospital is itself the second largest employer in this economically challenged town. The social, cultural, and community-building effects of the Hospital cannot be calculated in mere dollars and cents.

Money is, of course, important.<sup>16</sup> The Hospital was exhibiting symptoms identified in the recent healthcare literature as indicative of high-risk of closure.<sup>17</sup> The building is a half-century old, and the facility and some of its equipment were exhibiting obsolescence.<sup>18</sup> The inpatient occupancy rate had been falling, and the Hospital was offering services—such as surgery—that did not make financial sense. Costly missteps including the establishment of several additional clinics in nearby communities, undertaking the operation of a nursing home facility, and leasing and attempting to operate a medical imaging center located more than 300 miles away from the Hospital which resulted in a significant lawsuit by that facility’s landlord.<sup>19</sup>

By early 2013, HCHD found itself in serious financial distress; its ability to continue to make biweekly payroll became highly doubtful. It was “insolvent” within the special definition pertinent to municipal

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<sup>16</sup> Sharita R. Thomas et al., *Geographic Variation in the Profitability of Urban and Rural Hospitals*, RURAL HEALTH RES. GATEWAY (Mar. 2016), <https://www.ruralhealthresearch.org/publications/1007> (“The notion that if a hospital doesn’t make enough money to keep its doors open, its higher purpose is moot may be a simplistic view, but historic and recent evidence suggest that unprofitability can reduce hospital services and quality, or worse, lead to closure.”).

<sup>17</sup> See generally Thomas et al., *2012-14 Profitability of Urban and Rural Hospitals by Medicare Payment Classification*, *supra* note 10; see also Kaufman et al., *supra* note 11 (noting that there are relevant factors attributed to hospitals similar to the author’s).

<sup>18</sup> *Second Amended Disclosure Statement for the Amended Plan of Adjustment*, at 37–38, ECF No. 288, Sept. 15, 2015, at 37 [hereinafter *Disclosure Statement*] (“The Hospital’s building is nearly 50 years of age [and] is showing its age. . . . Many items of equipment are past their prime and in need of replacement or upgrading.”); see also *In re Hardeman County Hospital District*, 540 B.R. 229 (Bankr. N.D. Tex. 2015).

<sup>19</sup> *Disclosure Statement*, *supra* 18.

bankruptcy.<sup>20</sup> A Texas statute authorizes its financially troubled political subdivisions to access Chapter 9 relief,<sup>21</sup> and under that authority HCHD filed its Chapter 9 bankruptcy petition in the U.S. Bankruptcy Court for the Northern District of Texas on March 21, 2013.<sup>22</sup> The Hospital successfully reorganized; the bankruptcy court confirmed the Plan of Adjustment on November 2, 2015,<sup>23</sup> and entered the final decree on March 30, 2016.<sup>24</sup>

### III. THE CHAPTER 9 BANKRUPTCY PROCESS

Bankruptcy lawyers know Chapter 9 as a seldom-invoked<sup>25</sup> but powerful chapter of the Bankruptcy Code, yet most managers of small public hospitals are dimly aware of it at best.<sup>26</sup> Chapter 9 was added to the national bankruptcy law during the 1930s to ameliorate the widespread financial distress of municipal agencies of all types that had issued, but could not pay, municipal bonds during the Great Depression.<sup>27</sup> Originally called “Chapter IX” and renumbered with the Arabic numeral “9” when reenacted as part of the Bankruptcy Code in 1978, this chapter of the national bankruptcy law initially provided

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<sup>20</sup> See also *id.*; 11 U.S.C. § 101(32)(c) (2012); see *infra* note 37 (explaining that “insolvent” in the context of municipal bankruptcy means that the entity is not paying or is unable pay its debts as they become due). See text accompanying n. 37 *infra*.

<sup>21</sup> TEX. LOCAL GOV'T CODE § 140.001(a) (2016).

<sup>22</sup> *Voluntary Petition*, ECF No. 1, Mar. 21, 2013, *In re HCHD*.

<sup>23</sup> *Order Confirming Plan*, ECF No. 328, Nov. 2, 2015, *In re HCHD*; *Findings of Fact and Conclusions of Law in Support of Order Confirming Plan of Adjustment*, ECF No. 329, Nov. 2, 2015 [hereinafter *Confirmation Opinion*].

<sup>24</sup> *Final Decree and Order Closing Case*, ECF No. 347, Mar. 30, 2016, *In re HCHD*.

<sup>25</sup> See JAMES E. SPIOTTO ET AL., *MUNICIPALITIES IN DISTRESS?: HOW STATES AND INVESTORS DEAL WITH LOCAL GOVERNMENT FINANCIAL EMERGENCIES* 103 (2d ed. 2016) (“Chapter 9 cases have been rare and until recently limited, for the most part, to small utilities, special tax districts and other local governments (cities, towns, villages, hospitals, etc.)”) [hereinafter *MUNICIPALITIES IN DISTRESS*]; see also ADMIN. OFF. OF U.S. CTS, *Chapter 9 - Bankruptcy Basics*, U.S.CTS.GOV, <http://www.uscourts.gov/services-forms/bankruptcy/bankruptcy-basics/chapter-9-bankruptcy-basics> (last visited Mar. 23, 2018) (“[C]hapter 9 cases are rare . . .”).

<sup>26</sup> The author’s review of both the public health and the legal literatures finds no discussions of Chapter 9 bankruptcy specifically utilized for rural public hospitals.

<sup>27</sup> 6 COLLIER ON BANKRUPTCY ¶ 900.LH[1] (16th ed. 2017).

governmental units a new means of dealing with the “holdout problem”<sup>28</sup> in municipal bond restructurings while preserving municipal services.<sup>29</sup> Moreover, over time Congress incorporated into Chapter 9 the much better known business reorganization sections of the Bankruptcy Code, generally known as Chapter 11. This chapter included provisions for the formulation of a plan of adjustment that is subject to voting by creditors and becomes binding on them after approval by the bankruptcy judge based on statutory criteria, as well as an array of other debt restructuring tools for the municipal debtors that invoke it.<sup>30</sup>

Chapter 9 provides these tools while at the same time respects the political and governmental decision-making of the debtor’s elective governing board and, concomitantly, limits the authority of the bankruptcy court over the debtor.<sup>31</sup> The reason is federalism. Due to

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<sup>28</sup> See *id.* (explaining that the “holdout problem” results from the ability of a minority of bondholders to prevent the voluntary restructuring of the debts to which the majority desire to consent. Chapter 9, like Chapter 11 business reorganization law, solves that problem by enabling the debtor to impose a restructuring on the holders of the debt provided that a requisite majority do consent). COLLIER ON BANKRUPTCY ¶ 900.LH (16th ed. 2017) (prior to Chapter IX, “the existence of a few recalcitrant creditors made implementation of [a workout] agreement difficult”); Michael McConnell & Randal Picker, *When Cities Go Broke: A Conceptual Introduction to Municipal Bankruptcy*, 60 U. CHI. L. REV. 425, 428, 449 (1993) (stating that “individual creditors may find it in their interest to resist a solution even when it is in the interest of the creditors as a whole” and that before Chapter 9, there were no “legal means to prevent holdouts from refusing to cooperate with the compromise solution.”).

<sup>29</sup> *In re Addison Cmty. Hosp. Auth.*, 175 B.R. 646, 648-49 (Bankr. E.D. Mich. 1994) (citing H.R. Rep. No. 1011, 100th Cong., 2d Sess. 2 (1988), reprinted in 1988 U.S.C.C.A.N. 4415, 4416.) (“Chapter 9 of the Bankruptcy Code was drafted solely for municipalities. The provision allows debt adjustment that fosters the continuance of municipalities rather than their dissolution. Because the purpose of municipalities (i.e. police protection, fire protection, sewage, garbage removal, schools, hospitals) is to provide essential services to residents . . . .”); *In re Mount Carbon Metro. Dist.*, 242 B.R. 18, 34 (Bankr. D. Colo. 1999) (stating that there would be “no purpose in confirming a Chapter 9 plan if the municipality [is] unable to provide future government services.”).

<sup>30</sup> MUNICIPALITIES IN DISTRESS, *supra* note 25, at 157–163 (discussing other debt restructuring tools); Omer Kimhi, *Chapter 9 of the Bankruptcy Code: A Solution in Search of a Problem*, 27 YALE J. ON REG. 351, 362–69 (2010).

<sup>31</sup> See 6 COLLIER ON BANKRUPTCY ¶ 904.01 (16th ed. 2017) (“Section 904(1) protects the municipality from the court exerting control over the political or governmental affairs of the debtor.”).

concerns about the Tenth Amendment to the Constitution<sup>32</sup> as addressed in a pair of Depression-era U.S. Supreme Court decisions,<sup>33</sup> this law may only be invoked by a municipality, which is defined as a “political subdivision or public agency or instrumentality of a State”<sup>34</sup>; moreover, the applicable state’s law must authorize the entity to file a municipal bankruptcy case.<sup>35</sup> About half of the states’ legislatures have authorized their governmental units to file Chapter 9 cases for insolvency relief, and some of the others have authorized it on specific occasions.<sup>36</sup> In order to file a Chapter 9 case, the governmental unit must also establish that it is proceeding in good faith, has attempted to work things out with its creditors without success, and meets the Bankruptcy Code’s definition of “insolvent”: “financial condition such that the municipality is . . . generally not paying its debts as they become due unless such debts are the subject of a bona fide dispute; or [is] unable to pay its debts as they become due.”<sup>37</sup>

The headline-generating Chapter 9 cases of the past half-dozen years—several cities in California<sup>38</sup>; Jefferson County, Alabama<sup>39</sup>; and

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<sup>32</sup> U.S. CONST. amend. X provides: “The powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the states respectively, or to the people.”

<sup>33</sup> See generally *U.S. v. Bekins*, 304 U.S. 27 (1938) (validating municipal bankruptcy); *Ashton v. Cameron Cty. Water Improvement Dist. No. 1*, 298 U.S. 513 (1936) (explaining the Court’s concern over municipal bankruptcy under the 10th Amendment).

<sup>34</sup> 11 U.S.C. § 101(40).

<sup>35</sup> *Id.* at § 109(c).

<sup>36</sup> H. SLAYTON DABNEY, JR. ET AL., *MUNICIPALITIES IN PERIL: THE ABI GUIDE TO CHAPTER 9*, Appendix: Chapter 9 State Statutes (2d ed. 2013) 78–88 [hereinafter *GUIDE TO CH. 9*]; JAMES E. SPIOTTO, *FINANCIAL EMERGENCIES: DEFAULT AND BANKRUPTCY*, Robert D. Ebel & John E. Peterson, eds., *OXFORD HANDBOOK OF STATE & LOCAL GOVERNMENT FINANCE* (2012) at 779–780 n.23. For a map of the 50 states keyed to designate the extent of their respective authorizations for Chapter 9 filings, see *Municipal Bankruptcy State Laws, Governing the States and Localities*, GOVERNING <http://www.governing.com/gov-data/state-municipal-bankruptcy-laws-policies-map.html>.

<sup>37</sup> Bankr. Code §§ 101(32)(c), 109(c).

<sup>38</sup> See, e.g., *Deocampo v. Potts*, 2016 WL 788429 (9th Cir. 2014) (the city of Vallejo); *Newberry v. San Bernardino* (*In re City of San Bernardino*), 558 B.R. 321 (C.D. Cal. 2016) (the city of San Bernardino); *In re City of Stockton*, 526 B.R. 35 (Bankr. E.D. Cal. 2015) (the city of Stockton).

<sup>39</sup> See *Bennett v. Jefferson County*, 518 B.R. 613 (N.D. Ala. 2014) (the sewer system of Jefferson County, Ala.).

the largest ever, the City of Detroit<sup>40</sup>—have centered on, and successfully resolved, otherwise intractable problems of public-worker union contracts and municipal-pension funding.<sup>41</sup> As applied to *rural* public hospitals that are financially troubled, however, Chapter 9 is simpler because such hospitals typically have no union contracts, unfunded pensions, or even outstanding municipal bonds. This was the situation with HCHD, and it utilized the tools of Chapter 9 to resolve all of the factors identified as causes of its insolvency.

In HCHD municipal bankruptcy case, we, the bankruptcy lawyers, invoked the processes and procedures of Chapter 9 to address substantially all of those internal, or hospital-level, factors as well as the external, or market-based competitive, factors that the analysts have identified recently as causes of rural hospital insolvency and closure.<sup>42</sup> An examination of HCHD case demonstrates that when the debilitations of insolvency and financial distress infects a rural public hospital and imperil its very survival—and thus threaten the existence of the community it serves—a dose of Chapter 9 can provide, as a last resort, a curative for the ailment of unpayable debt and a tonic for financial rejuvenation—at least when the hospital is a political subdivision of one of the states that authorize their governmental units to access Chapter 9 for relief.

The treatment does come with significant costs, however, principally the incurrence of fees to the provider, that is, the compensation owed to its bankruptcy counsel.<sup>43</sup> HCHD's case

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<sup>40</sup> See *In re City of Detroit*, 841 F.3d 684 (6th Cir. 2016).

<sup>41</sup> The high-profile Chapter 9 cases of the past ten years have generated a substantial amount of academic commentary, ranging from the laudatory to the critical. Compare Elizabeth M. Watkins, *In Defense of the Chapter 9 Option: Exploring the Promise of a Municipal Bankruptcy as a Mechanism for Structural Political Reform*, 39 J. LEGIS. 89 (2012–2013), with David A. Skeel, Jr., *What Is a Lien? Lessons from Municipal Bankruptcy*, 2015 U. ILL. L. REV. 675 (2015). For a balanced assessment of the high-profile Chapter 9 cases, see Zack A. Clement & R. Andrew Black, *How City Finances Can Be Restructured: Learning from Both Bankruptcy and Contract Impairment Cases*, 88 AM. BANKR. L.J. 41 (2014).

<sup>42</sup> See Kaufman et al., *The Rising Rate of Rural Hospital Closures*, *supra* note 11, at 35–36.

<sup>43</sup> Bankr. Code § 330(a) (authorizing professionals employed by or at the expense of the debtor in bankruptcy to periodically apply for and to receive reasonable compensation for services rendered).

demonstrates that this cost impediment for a rural public hospital bankruptcy can be overcome by the *pro bono publico* donation of legal services by bankruptcy counsel.

#### IV. THE PROBLEM OF THE CHAPTER 9 DEBTOR'S PROFESSIONAL FEES

A key problem today in bankruptcy court reorganizations of private business organizations under the Bankruptcy Code's Chapter 11, to which Chapter 9 is in many ways related, is professional-fee expenses. As commentators have noted recently, the fees for bankruptcy reorganization representation "continu[e] to skyrocket"<sup>44</sup>; and ability to pay the lawyers' fees is a factor that must be taken into account in the planning for a Chapter 11 case<sup>45</sup> because those amounts constitute "administrative expenses" of the proceeding and the Bankruptcy Code requires that they be fully paid in cash as a condition to confirming a plan,<sup>46</sup> which is the ultimate goal sought. The upshot for Chapter 9 debtors is the same; even though Chapter 9, unlike Chapter 11 of the Bankruptcy Code, does not incorporate the Code's provisions for court approval of employment and of compensation charged by professional persons,<sup>47</sup> a municipality *must* be represented by bankruptcy counsel in commencing and conducting a Chapter 9 case.<sup>48</sup> The costs of bankruptcy counsel, which are unavoidable, can be

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<sup>44</sup> Harvey R. Miller, *Chapter 11 in Transition - From Boom to Bust and into the Future*, 81 AM. BANKR. L.J. 375, 395 (2007).

<sup>45</sup> See Nancy B. Rapoport, *Rethinking Professional Fees in Chapter 11 Cases*, 5 J. BUS. & TECH. L. 263, 263-64, 274-75 (2010); Stephen J. Lubben, *Corporate Reorganization & Professional Fees*, 82 AM. BANKR. L.J. 77, 82-84, 130 (2008).

<sup>46</sup> See Bankr. Code §§ 330(a), 503(b)(2), 507(a)(2), 1129(a)(9)(A).

<sup>47</sup> See Bankr. Code § 901(a) (failing to list Code §§ 327-31, which cover professional fees). It is, however, a requirement for confirming a Chapter 9 plan that the court find that the fees for services during the case or incident to the plan have been disclosed and are reasonable. Bankr. Code § 943(b)(3).

<sup>48</sup> DABNEY, JR. ET AL., *supra* note 36, at 37 ("The decision to file . . . must be taken with the advice of legal and financial professionals). See also 28 U.S.C. 1654; Bankr. N.D. Tex. L.B.R. 1002-2 Commencement of Case Without Counsel (except for individuals, "[a]ll other entities, including partnerships, corporations and trusts may not, without counsel, appear in court or sign pleadings"); *Turner v. ABA*, 407 F. Supp. 451, 476 (N.D. Tex. 1975) ("Corporations and partnerships, by their very nature, are unable to represent themselves and the consistent

daunting.<sup>49</sup> The legal fees for the City of Detroit's Chapter 9 case, for instance, aggregated \$170.2 million.<sup>50</sup>

Of course, the legal work to confirm the Motor City's plan of adjustment was orders of magnitude greater than required for a rural hospital. As draining as professional fees can be on available cash for anybody, proportionately, such fees can pose an even larger problem for a rural public hospital. From planning to execution, the Chapter 9 process for HCHD presented a panoply of issues, tasks, and opportunities that demanded sustained, creative lawyering.<sup>51</sup> Representing a debtor in a Chapter 9 case requires at least as much effort by the lawyers as in a comparably sized Chapter 11 business reorganization case. And fees for professionals in Chapter 9 include also the necessary accountants (and possibly a lawyer for a creditors committee, if one is formed).<sup>52</sup> Such fees can quickly deplete cash resources and impair the post-petition net revenues of a rural hospital.

Throughout its Chapter 9 proceeding, HCHD worked prudently to reduce expenses while increasing its revenues; but within a few months after the filing, our law firm recognized that even discounted fees were too much for the debtor to pay, so the firm simply donated all further fees, *pro bono publico*,<sup>53</sup> over this three-year case, charging only for expense reimbursements.

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interpretation of § 1654 is that the only proper representative of a corporation or a partnership is a licensed attorney.”).

<sup>49</sup> *Id.* at 34 (“Fees for lawyers, financial advisors, expert witnesses and so forth almost immediately will run to six figures in even a small case, and much more in larger cases.”).

<sup>50</sup> Christine Ferretti & Robert Snell, *Detroit Bankruptcy Fees Top \$170M*, DETROIT NEWS (Dec. 31, 2014), <http://www.detroitnews.com/story/news/local/wayne-county/2014/12/30/detroit-bankruptcy-fees-top/21074011/>.

<sup>51</sup> See Josiah M. Daniel, III, *A Proposed Definition of the Term “Lawyering,”* 101 L. LIB’Y J. 207, 214–15 (1999) (“‘Lawyering’ is the work of a lawyer to achieve an objective desired by the client within the boundaries of legal ethics.”). See also *Lawyering*, BLACK’S LAW DICTIONARY (10th ed. 2014) (incorporating this definition).

<sup>52</sup> A creditors’ committee may be formed pursuant to Bankr. Code § 901 (incorporating § 1103 providing an option for formation of a creditors committee).

<sup>53</sup> *Confirmation Opinion*, *supra* note 23, at 17, ECF No. 329 (“Debtor’s counsel has provided the bulk of its work in this Case on a pro bono basis.”).

## V. THE RESUSCITATION OF THIS HOSPITAL

Throughout the case, on behalf of HCHD, we employed the processes and procedures provided by Chapter 9 and addressed and remedied substantially all of those hospital-level and competitive factors that the analysts have identified recently as causes of rural hospital insolvency and closure.<sup>54</sup>

### A. "Poor financial health"

Chapter 9 provided several means by which the financial health of the Hospital was improved:

#### 1. *Insolvency Determination and Case Filing*

The most significant expression of "poor financial health" is insolvency, which, as noted, is the inability to pay debts as they fall due. Chapter 9 addresses such financial conditions in multiple ways. To begin, section 109(c) of the Bankruptcy Code requires that, as predicates to filing a case, a political subdivision be insolvent, be acting in good faith, and have either attempted unsuccessfully to work things out with its creditors, or else have an urgent need for protection.<sup>55</sup> With those predicate issues satisfied, HCHD filed its Voluntary Petition<sup>56</sup> to commence the case and enable its access to the restructuring tools and procedures of Chapter 9.

#### 2. *Notice to Creditors*

Chapter 9 offers comprehensive relief for poor financial health, and as with all chapters of the Bankruptcy Code, one key to achieving the broadest possible relief is the giving of adequate notice to all known creditor parties as well as all persons who might have a claim against the debtor or its properties.<sup>57</sup> In HCHD case, the debtor's counsel prepared and gave notice of the case and of the deadline to file

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<sup>54</sup> KAUFMAN ET AL., *supra* note 11, at 36.

<sup>55</sup> 11 U.S.C. § 109(c) (2016).

<sup>56</sup> *Voluntary Petition*, ECF No. 1 & *Declaration of Dave Clark in Support of Petition and First-Day Motions*, ECF No. 9, Mar. 21, 2013, *In re* HCHD.

<sup>57</sup> 11 U.S.C. §§ 501, 502 (2016); F. R. Bankr. P. 3002-3.

proofs of claims to all persons who might possibly have a claim. To maintain public confidence and to respect the rights of individuals who were patients or who had sought treatment in the Hospital, the lawyers for HCHD developed and implemented steps to protect current and former patients' privacy.<sup>58</sup>

### *3. The Automatic Stay*

One of the principal and immediate debt-relief benefits available to a debtor is the halting of all claim-collection actions. The filing of the Chapter 9 petition by HCHD invoked the Bankruptcy Code's automatic stay under Bankruptcy Code section 362(a), which is an injunction that prevented all creditors from undertaking any claim-recovery activities other than through filing and presenting motions and contested matters in the Bankruptcy Court.<sup>59</sup> Through section 922 of the Code, Chapter 9 expands the already broad reach of the automatic stay to also protect the debtor's officers, as well as its inhabitants, from any efforts of creditors to collect on their claims against the debtor.<sup>60</sup> Freed of concern about collection attempts, the leadership of HCHD was able to focus on restructuring and renewal as discussed further below.

### **B. "Aging facilities"**

HCHD's Chapter 9 case assisted in solving the problem of aged facilities and outworn equipment and burdensome contracts and leases:

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<sup>58</sup> *Debtor's Emergency Motion to Establish Notice Procedures, Limit Publication, and Set Hearing Dates*, ECF No. 2, Mar. 21, 2013; *Order Establishing Notice Procedures, Limiting Publication, and Setting Hearing Dates*, ECF No. 22, Mar. 27, 2013, *In re HCHD*.

<sup>59</sup> 11 U.S.C.A. § 362(a) (2016).

<sup>60</sup> In Chapter 9, the automatic stay also prohibits "a judicial, administrative, or other action or proceeding against *an officer or inhabitant of the debtor* that seeks to enforce a claim against the debtor." 11 U.S.C.A. § 922(a) (2016) (emphasis added).

### 1. No “Property of the Estate”

The Tenth Amendment to the U.S. Constitution has been held by the courts to mean that a state’s political subdivision that chooses to commence a bankruptcy case must retain complete control of its assets.<sup>61</sup> Accordingly, HCHD retained control of its Hospital, its other physical assets, and its cash resources during the case. It determined when and how to dispose of unneeded properties, operated under its own budget, and acquired a new cat-scan machine and other equipment, all without court involvement.<sup>62</sup> All properties and Hospital activities remained subject to the political governance of the district, whose directors continued to stand for election and to conduct regular public meetings<sup>63</sup> with attendant reportage in the local press.<sup>64</sup>

### 2. Executory Contracts and Leases

Chapter 9 incorporates section 365 of the Bankruptcy Code which enables the debtor to assume (and retain), to reject (be freed from), or to assign its open contracts and its leases of real or personal property pursuant to Bankruptcy Code § 365(a).<sup>65</sup> HCHD carefully evaluated

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<sup>61</sup> U.S. CONST. amend. X (stating that the powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people); *In re City of Detroit*, 524 B.R. 147, 250 (Bankr. ED. Mich. 2014) (holding that 11 U.S.C.A. § 903 (2016) is “[c]onsistent with (or perhaps required by) that amendment”).

<sup>62</sup> *Disclosure Statement*, *supra* note 18, at 27.

<sup>63</sup> *Confirmation Opinion*, *supra* note 23, 540 B.R. at 237 (“The Debtor’s Board of Directors has continued to hold public meetings each month during the Case.”).

<sup>64</sup> *Hospital Seeks Financial Restructure: Officials Make Assurances that it Will Be “Business as Usual” at the Hospital*, QUANA TRIBUNE-CHIEF, Mar. 22, 2013, at 1, col. 1-4; *Hospital Sails Through Chapter 9 Bankruptcy Hearing*, QUANA TRIBUNE-CHIEF, Apr. 5, 2013, at 1, col. 1-6; *Hospital Continues Recovery*, QUANA TRIBUNE-CHIEF, Sept. 20, 2013, at 1, col. 3; *Settlement Near on Marble Falls Suit*, QUANA TRIBUNE-CHIEF, Nov. 1, 2013, at 1, col. 1-5; *Hospital Putting Out Last of Bankruptcy “Fires,”* QUANA TRIBUNE-CHIEF, Jan. 17, 2014, at 1, col. 1-5; *Physicians, Community to Help Administration Chart Course for Hospital, Clinic*, QUANA TRIBUNE-CHIEF, July 4, 2014, at 1, col. 3-4; *Hospital May Be Out of Bankruptcy in January*, QUANA TRIBUNE-CHIEF, Sept. 19, 2014, at col. 1-3; *Hospital Audit Confirms Fast Turn-Around*, QUANA TRIBUNE-CHIEF, Oct. 3, 2014, at 1, Col. 2014 *Bankruptcy Resolution Delayed*, QUANA TRIBUNE-CHIEF, Nov. 21, 2014, at 1, col.3-4; *Hospital Board Oks Equipment Purchases*, QUANA TRIBUNE-CHIEF, Feb. 20, 2015, at 1, col. 1-5; *Hospital Bankruptcy End in Sight*, QUANA TRIBUNE-CHIEF, July 31, 2015, at 1, col. 1-2; *Hospital Exits Chapter 9 Bankruptcy*, QUANA TRIBUNE-CHIEF, Oct. 30, 2015, at 1, col. 1-6.

<sup>65</sup> 11 U.S.C. §§ 365(a), 901(a) (2016).

and worked through its 250 executory service and supply contracts and unexpired equipment leases. HCHD also rejected those that were clearly unprofitable or disadvantageous, renegotiated the terms of certain contracts and leases, and assumed the rest. Using another bankruptcy tool called “ride through,”<sup>66</sup> the plan provided for one executory service agreement to *pass through* the bankruptcy, with the rights and claims of both parties unaffected, so that matters could be resolved later in state court litigation, which HCHD desired.<sup>67</sup>

### **3. Bankruptcy Settlements**

The procedural device of motions under the settlement rule of bankruptcy practice<sup>68</sup> worked well as a vehicle to seek and obtain court approval for contract and equipment lease rejections and renegotiations achieved by the debtor’s counsel as well as bargained-for claim reductions and withdrawals.<sup>69</sup>

### **C. “Low occupancy rates” and “inadequacy of outpatient revenue”**

Furthermore, the Chapter 9 process enabled the Hospital to solve the problem of inadequate inpatient and patient revenue:

#### **1. Postpetition Financing**

HCHD had very little cash on hand on the petition date, and revenues were tenuous. Chapter 9 enables a debtor to incur new, postpetition financing, including secured credit, with court approval.<sup>70</sup> All three of the district’s secured lenders worked collaboratively with

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<sup>66</sup> See *Stumpf v. McGee (In re O’Connor)*, 258 F.3d 392, 402 (5th Cir. 2001) (citing *Century Indem. Co. v. Nat’l Gypsum Co. Settlement Tr. (In re Nat’l Gypsum Co.)*, 208 F.3d 498, 507 (5th Cir. 2000)).

<sup>67</sup> *Confirmation Opinion*, 540 B.R. at 247.

<sup>68</sup> F. R. Bankr. P. 9019(a) (2017).

<sup>69</sup> See *In re City of Stockton*, 486 B.R. at 197 (exemplifying a Chapter 9 debtor utilizing Rule 9019 to enable or facilitate agreements reached with creditors).

<sup>70</sup> 11 U.S.C. § 364(d) (2016) (incorporated into 11 U.S.C. § 901(a) (2016)).

the debtor during the case; and to reassure the public and the vendors supplying the Hospital after the petition that the Hospital would be capable of paying all post-bankruptcy bills, the flagship lender opened a postpetition line of credit for HCHD.<sup>71</sup> Remarkably, by carefully managing its cash flow, HCHD never had to draw on that post-bankruptcy loan.

## 2. *Out of Court Restructuring Work*

Only a few months prior to the petition, HCHD board hired as administrator, a hospital consultant with experience in both turnarounds and closures. The *pro bono* contribution of bankruptcy representation services enabled the Hospital's management to work closely with the lawyers, without serious time and financial constraint. The manager focused throughout the case on the business goal of cutting expenses. Innovation and creative thinking were employed. For example, the spouse of one of the managers suggested borrowing labor from a nearby prison; and the cost-free labor of convicts repainted the Hospital inside and out.<sup>72</sup> Cost-cutting measures also included staff attrition and creative reassignments of responsibilities to avoid layoffs. The management thereby created operating cash surpluses while maintaining and improving patient care and Hospital services, and at the same time dealing with the somewhat perverse cost-reimbursement formulae of Medicare and Medicaid.<sup>73</sup>

The manager also concentrated on increasing revenues from the primary market for the Hospital's services: the community. Modern medicine sees therapeutic value for a medical patient's recovery in the involvement of a supportive community of family and friends.<sup>74</sup> In the

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<sup>71</sup> *Final Order Granting Approval of Agreement for Postpetition Secured Credit and Adequate Protection*, ECF Doc. # 55, Apr. 26, 2013, *In re HCHD*.

<sup>72</sup> *Disclosure Statement*, *supra* note 18, at 27.

<sup>73</sup> Medicare reimbursements to hospitals are cost-based on prior year estimates; amounts funded one year are trued up the next. Because of applicable precedents about recoupment, the Hospital reducing its expenses each year during Chapter 9 had the counterintuitive effects of reducing its Medicare reimbursements and of triggering recoupments the next year. *See In re AHN Homecare, L.L.C.*, 222 B.R. 804, 812 (Bankr. N.D. Tex. 1998). HCHD complied with post-petition Medicare audits and resulting true-ups and found the Medicare agent cooperative in return. *Id.*

<sup>74</sup> Lisa F. Berkman et al., *Emotional Support and Survival After Myocardial Infarction: A Prospective*,

case of HCHD, similarly, a key to the revival of the Hospital was the generation of a similar sort of involvement and support by the community and taxpayers. After years of negative news and financial setbacks, the residents were apprehensive about the Hospital's future and had been increasingly seeking treatments out of the county, reducing the utilization rate. To encourage the residents to resume using the Hospital, the administrator marshalled the community's resources. The town's clergy were early recruits, and one by one they brought their congregations to the Hospital premises. The manager also worked with the leadership of the town and the county and the major institutions to build concern and to regain support. By the time of the confirmation hearing on October 21, 2015, that work paid off, as exemplified by an entire busload of ordinary citizens, Hospital employees, and county and town leaders traveling the 220 miles from Quanah to Dallas to attend the hearing in support of the plan of adjustment.<sup>75</sup>

#### **D. "Difficulty in recruiting and retaining health care professionals" and "reduction of medical services"**

This cause of the Hospital's insolvency was dealt with in three ways in the Chapter 9 case:

##### ***1. The Physicians***

A rare bright spot for the Hospital before bankruptcy had been its long-term retention of a well-respected physician, and early in the restructuring process, HCHD hired a second, young doctor. The devotion of these two physicians, whose clinics are housed within the Hospital building, was another significant factor in the revitalization through Chapter 9.

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*Population-Based Study of the Elderly*, 117 ANNALS INTERNAL MED. 1003-09 (1992); Lisa F. Berkman et al., *Social Networks, Host Resistance, and Mortality: A Nine-Year Follow-Up Study of Alameda County Residents*, 109 AM. J. EPIDEMIOLOGY 186-204 (1979).

<sup>75</sup> *Hospital Exits Chapter 9 Bankruptcy*, QUANAH TRIBUNE-CHIEF, Oct. 30, 2015, R 1, Col. 1-6; Stephanie Garland, *Quanah Hospital to Escape Bankruptcy*, TEXOMA, <http://www.texomashomepage.com/news/local-news/quanah-hospital-to-escape-bankruptcy> (last visited Nov. 19, 2017).

## ***2. Patient Ombudsman***

One requirement under all chapters of the Bankruptcy Code for all healthcare providers' cases is the employment of an ombudsman. With court approval, HCHD employed a retired registered nurse as its Patient Care Ombudsman, and on a monthly basis she inspected the facility, interfaced with both the healthcare professionals and the patients, and filed reports with the court with the assistance of the debtor's bankruptcy counsel.<sup>76</sup>

## ***3. Range of Services***

Early in the Chapter 9 proceeding, the Hospital ceased providing general surgery services,<sup>77</sup> which had occasioned losses. Instead, the Hospital focused on making the core services more efficient and productive.

## **E. "Market competitiveness"**

Finally, the Chapter 9 case of HCHD addressed the economic factor causing its insolvency:

### ***1. Claim Allowance and Disallowance***

One key to becoming more competitive in the marketplace was to reduce the amounts the Hospital owed to its creditors and save substantial amounts of debt-payment dollars for other purposes. A principal benefit of Chapter 9 is the opportunity it provides for the debtor to evaluate the claims of its creditors, who must file proofs of claim, and then resolve any objections it has to the claims, as to both asserted grounds of liability and the amount stated, with prompt adjudication available in the Bankruptcy Court. In HCHD's case, seventy-three proofs of claim, secured and unsecured, were filed, aggregating \$4.15 million as of the petition date; after claim objections and postpetition paydowns to the primary lender, the pre-confirmation total amount dropped to \$1.77 million and, after confirmation of the plan, to only \$1.06 million. That reduction of the

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<sup>76</sup> *Confirmation Opinion*, *supra* note 23, at 237.

<sup>77</sup> *Disclosure Statement*, *supra* note 18, at 27.

debt load was highly important to restoring the Hospital's competitiveness in the marketplace.

## ***2. Plan Formulation and Confirmation***

There is no deadline for a plan of adjustment in Chapter 9, unless the court sets one, and only the debtor may propose a plan.<sup>78</sup> HCHD used the first stage of the case to address its assets, to reduce its liabilities, and to improve the efficiency of its operations as predicates to becoming more competitive. In the latter stage of the proceeding, the management, with the assistance of the accountants, prepared a business plan for the future of the Hospital going forward; the projection, however, was limited to three years due to the difficulty in forecasting the future of healthcare.<sup>79</sup>

## ***3. Plan of Adjustment***

Financing the Hospital into the post-bankruptcy future was grounded on the projection of multiple streams of revenues including, as operating revenues, the reimbursements from Medicare and Medicaid, insurance, and commercial sources, and, as non-operating revenues, tax collections, indigent care support payments, noncapital grants and contributions, interest, and other non-patient collections. The business plan projected future property tax receipts as essentially flat. Accordingly, respecting the political and electoral sentiments of the taxpayers,<sup>80</sup> and recognizing the persistent economic conditions that existed throughout the district,<sup>81</sup> it was the political judgment of HCHD board of directors that the properties of the taxpayers would

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<sup>78</sup> Bankr. R. 941.

<sup>79</sup> *Confirmation Opinion*, *supra* note 23, at 242 ("The Debtor's three-year Business Plan, which is attached to the Disclosure Statement as Exhibit C, sets forth the Debtor's best estimates of all funds expected to be or become available to the Debtor from proceeds of its medical services and Hospital operations and revenues of its property taxation.").

<sup>80</sup> *Disclosure Statement*, *supra* note 18, at 36.

<sup>81</sup> GARY A. MATTSON, AMERICAN HOMETOWN RENEWAL: POLICY TOOLS AND TECHNIQUES FOR SMALL TOWN OFFICIALS ("Small towns . . . are spatially fixed jurisdictions . . . defined by their population levels [which] tend to limit revenue-raising capacity. . . . [T]heir tax bases are limited.").

not bear the imposition of higher taxes; in confirming the plan, the Bankruptcy Court acknowledged the board's judgment in this matter.<sup>82</sup> Making a difficult allocation of scarce cash resources,<sup>83</sup> the board of directors determined that the plan should propose to pay five cents on the dollar to the allowed general unsecured creditors, which the court approved, over the objections of two dissident creditors, by confirming the plan of adjustment.<sup>84</sup>

## VI. THE COMPOUND PRESCRIPTION OF CHAPTER 9 WITH PRO BONO LEGAL SERVICES FOR RELIEF OF RURAL PUBLIC HOSPITAL INSOLVENCY

HCHD and its counsel used the tools of bankruptcy and the Chapter 9 case proceedings to resolve all of the hospital-specific factors that have been recently identified by healthcare and policy analysts as responsible for the insolvency of rural hospitals,<sup>85</sup> and after three years, the Hospital emerged from bankruptcy substantially rejuvenated.<sup>86</sup> While HCHD is not entirely free of challenges; although significantly improved, its financial metrics remain less robust than the medians of peer hospitals in Northwest Texas, and it continues to shoulder the burdens of ongoing regulatory mandates in areas such as

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<sup>82</sup> *Confirmation Opinion*, *supra* note 23, at 242.

<sup>83</sup> Paul B. Gardent & Susan A. Reeves, *Ethics Conflicts in Rural Communities: Allocation of Scarce Resources*, in WILLIAM A. NELSON, ED., *HANDBOOK FOR RURAL HEALTH CARE ETHICS: A PRACTICAL GUIDE FOR PROFESSIONALS* (2009) at 163 (finding that resource allocation issues are "particularly challenging for rural communities where resources are not enough to meet all needs").

<sup>84</sup> Order Confirming Plan, *supra* note 22.

<sup>85</sup> Kaufman et al., *The Rising Rate of Rural Hospital Closures*, *supra* note 11.

<sup>86</sup> HCHD is not the first rural or small-town public hospital to reorganize successfully under Chapter 9, but from the reported case law, there have been relatively few. *See, e.g., In re Corcoran Hosp. Dist.*, 233 B.R. 449 (Bankr. E.D. Cal. 1999); *In re Addison Community Hospital Authority*, 175 B.R. 646, 648-49 (Bankr. E.D. Mich. 1994); *In re Barnwell County Hospital*, 459 B.R. 903, 905, 909, 911 (Bankr. D.S.C. 2011). A PACER search of the four judicial districts of Texas for the period from 1998 to 2012 shows 14 Chapter 9 cases filed, with five being rural hospital or medical provider cases. *See Debtor's Confirmation Hearing Brief* at 6, *In re HCHD*, ECF Doc. #302. A nationwide PACER search shows only 240 Chapter 9 cases filed since 1981, of which 31 are public hospital cases. Six rural public hospitals have filed for Chapter 9 relief after the 2013 petition date of HCHD.

the institution of electronic health recordkeeping.<sup>87</sup> It has, however, been freed of insupportable amounts of prepetition debt through the process of Chapter 9, and it is now able to timely pay its post-bankruptcy debts and ongoing costs of operation as they become due. Thus, HCHD case shows that at least in those states that authorize their political subdivisions to seek its relief, Chapter 9 of the Bankruptcy Code can provide a comprehensive means to relieve rural public hospital insolvency.<sup>88</sup> And, as also shown in this case, a key to success is the donation or waiver of fees by the lawyers—the performance of the legal services on a *pro bono* basis.

Over the past half-century, the American Bar Association and all state-wide bar organizations have exhorted lawyers to participate in the representation of indigent persons free of charge, the endeavor that is generally referred to as “*pro bono publico*.”<sup>89</sup> Legal academics have noted, however, that while “[p]ro bono work has been of crucial importance in filling the gaps” in legal services for low income individuals, “the amounts currently provided come nowhere near to addressing national needs or to filling the bar’s own aspirations to public service.”<sup>90</sup> In the specific instance of bankruptcy law and the lawyers needed to represent individual debtors, a bankruptcy judge wrote that “the inability of . . . the ‘working poor’ to obtain legal representation . . . in bankruptcy-related matters can have devastating consequences not only for those directly affected, but also for society at large.”<sup>91</sup>

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<sup>87</sup> Debtor’s Proffer of the Testimony of Brent Fuller at 6, *In re Hardeman Cnty. Hosp. Dist.*, 540 B.R. 229 (Bankr. N.D. Tex. 2015), ECF No. 304.

<sup>88</sup> Brendan G. Best & Paul R. Hage, *Retooling for Chapter 9: How Municipal Bankruptcy Differs from Chapter 11*, 26 J. CORP. RENEWAL 16, 19 (1993) (“Chapter 9 is a powerful tool and, in the right circumstances, is useful in providing municipalities the breathing spell and control necessary to focus on improving their finances and operations while, most importantly, providing essential services to their residents.”).

<sup>89</sup> *Pro bono publico*, BLACK’S LAW DICTIONARY (10th ed. 2014) (defining the phrase to mean “[f]or the public good”).

<sup>90</sup> Deborah L. Rhode, *Senior Lawyers Serving Public Interests: Pro Bono and Second-Stage Careers*, 21 PROF. LAWYER 1, 24–25 (2011).

<sup>91</sup> Nancy C. Dreher, *Bankruptcy Pro Bono Programs: The Judge’s Role*, JUDGES’ J. 13–14 (1996). See also Andrew P. MacArthur, *Pay to Play: The Poor’s Problems in the BAPCPA*, 25 EMORY BANKR.

The consequences of the inability to afford to employ bankruptcy counsel are greatly magnified when the insolvent debtor is not an individual, but a *public hospital in a rural area*. As one veteran hospital administrator has recently written:

For the communities who los[e] a local hospital, it [i]s very personal. It mean[s] a loss of jobs, a blow to pride in their local community, less ability to attract new job creating businesses and above all, a loss to a closer source of care during a medical emergency.<sup>92</sup>

So, it is a worthy project for bankruptcy lawyers to undertake the debtor's counsel role in Chapter 9 cases in order to help save insolvent rural public hospitals.

Although unaddressed in legal literature, the gratuitous rendition of legal services to an insolvent rural public hospital ought to well satisfy the legal ethic of "voluntary pro bono publico service" as specifically prescribed by the American Bar Association in Rule 6.1 of the *Model Rules of Professional Conduct*, which provide in pertinent part:

Rule 6.1 Every lawyer has a professional responsibility to provide legal services to *those unable to pay*. In fulfilling this responsibility [for pro bono service], the lawyer should:

(a) . . . (2) provide a substantial majority of [his or her] hours of legal services . . . without fee or expectation of fee to [, among other types of worthy clients,] *governmental . . . organizations* in matters that are designed primarily to address the needs of persons of limited means; and (b) provide . . . any additional services through (i) delivery of legal services at no fee or substantially reduced fee to . . . "*governmental . . . organizations* in matters in furtherance of their organizational purposes, where the payment of standard legal fees would significantly deplete the organization's economic resources or would be otherwise inappropriate.<sup>93</sup>

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DEV. J. 407, 435 (2009) (adding that under the 2005 amendments to the Bankruptcy Code, "[w]ith the added cost and difficulty of finding representation, more poor individuals will seek the aid of the limited number of pro bono attorneys").

<sup>92</sup> Tim Size, *What Rural Health's "Early Days" Tell Us About Today*, TOMAHHOSPITAL.ORG (Jan. 19, 2017), <http://www.tomahhospital.org/news-events/268-rural-health-s-early-days>; see *supra* text accompanying notes 7-8.

<sup>93</sup> MODEL RULES OF PROF. CONDUCT r. 6.1(a)-(b) *cmt.* 6, 11 (AM. BAR ASS'N 2017) [hereinafter ABA MODEL RULES]. A comment to the rule adds that the "term 'governmental organizations' includes, but is not limited to, public protection programs and sections of governmental or

These two prongs of Rule 6.1, the quoted subdivisions (a)(2) and (b)(i), are capacious and overlapping in ambit, and both clearly identify governmental units as appropriate *pro bono clients*.

For three reasons, insolvent rural public hospitals ought to be well qualified to receive—and bankruptcy lawyers should be willing to provide—*pro bono* legal services for municipal bankruptcy relief under this fundamental ethic of the legal profession.<sup>94</sup> First, the statutory purpose of this governmental organization, HCHD, and indeed of all hospital districts in Texas,<sup>95</sup> is to “provid[e] medical and hospital care for the district’s needy inhabitants” and “operat[e] hospital facilities” for the residents. Second, such purposes are stymied by a financial condition of insolvency. And third, access to the legal curative for such financial ailment, Chapter 9 bankruptcy, may simply be otherwise unavailable to a rural public hospital due to the rates for legal services charged by qualified bankruptcy practitioners.

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public sector agencies.” *Id.* at cmt. 3.

<sup>94</sup> Sandra S. Varnado & Dane S. Ciolino, *Reconsidering Lawyers’ Ethical Obligations in the Wake of a Disaster*, 19 PROF. LAWYER No. 4 at 9, 17 (2009) (emphasis added) (arguing that “the Preamble to those same rules provides stronger fodder for the idea that a lawyer is obligated by his ethical duty to offer *pro bono* advice and assistance at all times”); ABA MODEL RULES, *Preamble and Scope* [1] & [6] (stating that “[each lawyer is] a public citizen having special responsibility for the quality of justice,” and lawyers “should be mindful of deficiencies in the administration of justice and of the fact that the poor, and sometimes persons who are not poor, cannot afford adequate legal assistance”).

<sup>95</sup> See TEX. SPEC. DIST. LOCAL LAWS CODE §§ 1001–1122. The laws of other states are similar. See, e.g., CAL. HEALTH & SAFETY CODE 32.121(j) (“To establish, maintain, and operate, or provide assistance in the operation of, one or more health facilities or health services . . . for the benefit of the district and the people served by the district.”); REV. CODE WASH. 70.44.003 (“[T]o authorize the establishment of public hospital districts to own and operate hospitals and other health care facilities and to provide hospital services and other health care services for the residents of such districts and other persons.”); FLA. STAT. ch. IX, § 154.302 (“[T]he Legislature declares that the state and the counties must share the responsibility of assuring that adequate and affordable health care is available to all Floridians. Therefore, . . . the ultimate financial obligation for the out-of-county hospital care of qualified indigent patients [is] on the county in which the indigent patient resides.”); 70 ILL. CIV. STAT. § 910/2&3 (“The establishment, maintenance and operation of safe and accessible hospitals within the State of Illinois and the creation of Hospital Districts having powers necessary or desirable for the establishment and continued maintenance and operation of such hospitals are declared and determined to be in the interest of public health. . . . ‘Hospital’ means any hospital for in-patient and out-patient medical or surgical care of persons in need thereof.”).

Representing a rural public hospital in Chapter 9 is something that the bankruptcy lawyers who normally conduct Chapter 11 business reorganization practice—the lawyers of the mid-to-large sized law firms—could do well. These mid-to-large sized firms frequently support and participate in *other* types of pro bono matters, so hopefully more of their pro bono efforts could be directed toward insolvent public hospitals. One advocate for intensifying bankruptcy practitioners' pro bono efforts has written that "even attorneys with large creditor practices can find ways, without conflicts, to do pro bono."<sup>96</sup> Some commentators have even taken the position that larger law firms have a "special responsibilit[y]" to "exceed the minimum pro bono standard promulgated by the ABA."<sup>97</sup> Indeed, the larger the law firm, the larger the likelihood of having enough experienced staff of bankruptcy lawyers and legal assistants to be able to provide the full measure of Chapter 9 representation for insolvent rural public hospitals.<sup>98</sup>

## CONCLUSION

In the specific instance of HCHD, the revivification of the Hospital was enabled if not assured by the compound prescription of the Chapter 9 process together with my law firm's pro bono contribution of professional services. Hopefully HCHD case may serve as a model of a new way<sup>99</sup> for lawyers to fulfill the mandates of their profession in

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<sup>96</sup> George B. Cauthen, *Make a Difference: Volunteer for Ch. 7 Pro Bono Cases*, 24 AM. BANKR. INST. J. No. 5 at 10, 53 (June 2005) (emphasis added).

<sup>97</sup> Esther F. Lardent, *Structuring Law Firm Pro Bono Efforts*, in THE LAW FIRM AND THE PUBLIC GOOD 81 (Robert A. Katzmann, 1995).

<sup>98</sup> The author submits, based upon experience, that finding a law firm to undertake a rural public hospital's Chapter 9 case pro bono is likely going to be more difficult than locating a firm to accept the hospital as a paying client. Some ingenuity and resourcefulness may be required, but a good starting point for the hospital is to confer with its normal outside healthcare law firm, which may be able to provide the bankruptcy representation itself, or will likely know experienced Chapter 11 lawyers in other law firms to solicit for the role.

<sup>99</sup> See *Pro Bono Clearinghouse*, AM. BAR ASS'N, [http://www.americanbar.org/directories/pro\\_bono\\_clearinghouse.html?q=%22Chapter+9%22+bankruptcy+%22pro+bono%22&hq=&num=10&sort\\_by=relevance&fromdate=&todate=&](http://www.americanbar.org/directories/pro_bono_clearinghouse.html?q=%22Chapter+9%22+bankruptcy+%22pro+bono%22&hq=&num=10&sort_by=relevance&fromdate=&todate=&)

the instance of financially distressed rural public hospitals who simply cannot afford bankruptcy counsel. By following both the example of pro bono lawyering exemplified in HCHD case and invoking the process for financial relief under Chapter 9, a greater number of insolvent public hospitals could be rescued, and in return, those hospitals can continue to serve all in need of healthcare in their communities for years to come.

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<sup>1</sup> On January 4, 2018, the author used the search term “‘Chapter 9’ bankruptcy ‘pro bono’”; the report of the database indicated no prior pro bono efforts in the representation of a municipal debtor in a Chapter 9 case.