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Code Red: Healthcare Restructurings on the Rise



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Financial distress – sometimes it is isolated to specific borrowers and other times, it is endemic within an industry. In recent years, energy (e.g., oil, gas, and coal), retail and other industries have suffered widespread losses leading to restructuring and, often, bankruptcies. While healthcare businesses have not been immune, losses and financial distress have spread more widely within the healthcare industry in recent years, a problem exacerbated by the uncertainties over proposed amendments to the Affordable Care Act (the “ACA”), particularly the American Health Care Act (“AHCA”) which won narrow passage by the House. In the last 10 years, over 120 hospitals and healthcare centers filed for bankruptcy protection. (Capital IQ, Statistics on Healthcare Entity Filings, <http://capitaliq.com> (last visited Mar. 8, 2017)). There are numerous pressures on today’s hospitals, skilled nursing homes, hospices and other healthcare providers. These pressures include liquidity constraints (particularly around insurance reimbursements and the impact upon many hospitals should the AHCA be enacted

and replace some of the liquidity to providers provided by the ACA), changes in the delivery of healthcare services (as care shifts from acute/inpatient to more ambulatory/outpatient treatment), and the need for material capital investment to upgrade technology or to reconfigure inefficiently used real estate. These changes directly impact the balance sheet. For example, it is estimated that potentially up to 24 million fewer people will have health care insurance based upon amendments to the ACA. While the ACA cut substantial reimbursements for hospital care previously available through Medicaid (with the expectation that newly-available private insurance under the ACA would compensate for the loss in Medicaid funds), the proposed AHCA (at least as passed by the House) does not restore the prior reductions in Medicaid. This liquidity shortfall will directly and detrimentally impact safety-net and other hospitals who traditionally have a large Medicaid payor mix, creating a larger pool of unreimbursed, uncompensated care. Coupled with funded bank and bond debt and other types of operational liabilities (medical malpractice liability, for one), healthcare providers oftentimes operate “in the red,” and when the hemorrhaging cannot be stemmed, financial and/or operational restructuring results.

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I. Changes in Healthcare Delivery – Identifying the Symptoms

A. Transition to Bundled Payments One material pressure point for healthcare providers concerns availability and maximization of insurance reimbursements (from both private and government payors). Part of this pressure results from the evolution from fee-for-service reimbursement – where each component of a procedure is paid for separately – to bundled payments – where the hospital receives one fixed payment for the entire “episode of care” regardless of the number of procedures or length of stay.

Bundled payments evolved as both private and government payors shifted to value-based care. (Bundled Payments for Care Improvement Initiative: General Information). These fixed payments are calculated based on the average cost of various procedures in the bundled care and the average length of stay for the treatment. If the healthcare provider's actual expenses for that episode of care exceed the bundled payment because of extra inpatient days or additional procedures from complications, the hospital bears the cost (and loss).

For example, a bundled payment for a hip replacement (the episode of care) is calculated based upon a formula that looks at average costs of each procedure, medical professional (such as the orthopedic surgeon, the anesthesiologist, etc.) and all costs associated with the average *length of stay* in the hospital for this procedure. If this patient stays in the hospital for five days instead of the average length of stay of three days or returns to the hospital with a wound infection after being discharged, the hospital receives no reimbursement for the additional patient days or procedures for the recurrent visit. In contrast, under the fee-for-service methodology, the hospital receives reimbursement separately for each surgeon, anesthesiologist, each inpatient day, etc. Excessive length of stay not only affects revenue for that patient, but the hospital suffers the lost opportunity of admitting new patients.

B. Construction of Urgent Care and Standalone Ambulatory Centers As healthcare systems attempt to address length of stay and other reimbursement issues, hospitals examine ways to reconfigure the delivery of services to reduce the need for inpatient admissions. This shift is partially attributable to overcrowding in emergency rooms, especially in low-income areas, where patients use the emergency department of safety-net community hospitals as a substitute for a primary physician. Another driver is that the Center for Medicare and Medicaid Services ("CMS") encourages healthcare providers to shift services to outpatient facilities, which generally provide for lower reimbursement rates than inpatient hospitals. Expansion of urgent care and stand-alone ambulatory care centers resolve some of the issues related to overcrowding. These outpatient facilities take on the less emergent services, allowing the emergency room to run more efficiently by handling only the true emergency cases (especially if the emergency room is also an area trauma center).

Healthcare providers gain a competitive advantage by investing in outpatient facilities because they can offer faster and more affordable alternatives to emergency rooms. Outpatient facilities also provide a "better" payor mix because urgent care centers require patients to pay upfront, as they are not bound by the Emergency Medical Treatment and Labor Act (the "EMTLA"), which requires a hospital to treat anyone that comes into an emergency department regardless of their ability to pay. (American College of Emergency Physicians, EMTALA). This greatly curbs the healthcare system's reimbursement risk. Urgent care centers located near or affiliated with a hospital system can also serve as a feeder for patients into that hospital. However, these efficiencies are not gained without cost. Development and construction of an urgent care center requires significant investment and capital expenditure. Healthcare systems looking to make this transition re-

quire several years of planning (and approvals) and potentially the incurrence of additional funded debt to finance the construction of an urgent care center. In Saint Vincent's Manhattan, the debtors secured a purchaser for their real estate that paid \$260 million and, in coordination with a healthcare partner, agreed to develop the first free-standing emergency department in New York City. It was only after over a year of negotiation, regulatory approval and zoning approval, that the purchaser was able to move forward with construction. The healthcare component to the largely real estate transaction enabled the deal to move forward.

Despite the short-term costs, as healthcare systems continue to face financial pressures, the number of urgent care and stand-alone ambulatory facilities are growing at a rapid pace. According to the Urgent Care Association of America, there are approximately 7,500 urgent care centers in the United States. (Urgent Care Association of America, Industry FAQs).

C. Overcapacity The historic delivery of healthcare has also led to overcapacity that large footprint hospitals cannot sustain. While emergency rooms may suffer overcrowding, many hospitals have substantial unused (excess) beds from lower inpatient admissions. With advancements in technology and medicine, coupled with insurance reimbursement pressures, more services are performed on an outpatient basis or, when patients are admitted, the length of stay is shorter. Fewer or shorter admissions means that many older hospitals – built and staffed at a time when more people were admitted and for longer periods – simply have too many beds. A hospital may have 400 "paper beds" – meaning that they are licensed to admit 400 patients – but have a capacity of only 220 patients at peak times. If there are two or three hospitals in a community with a similar pattern of excess bedding, there could be hundreds of unused beds and a physical infrastructure that is outdated or obsolete. To combat some of the reimbursement obstacles, some hospitals have used part of the excess capacity as "treat and release" or "observation" beds where a patient can be treated, watched and released without the need for inpatient admission.

For example, in New York, the New York State Department of Health commissioned a "feasibility study" to address overcapacity and other efficiency issues in central and northeastern Brooklyn. (Northwell Health, The Brooklyn Study: Reshaping The Future Of Healthcare (Oct. 2016)). The results of the study provide for a collaborative corporate governance structure for four community-based hospitals (each in varying degrees of financial need or distress), which is slated to take up to seven years and cost hundreds of millions of dollars to implement. As part of this comprehensive change, material funding will be made available from the state. This example shows that reconfiguration of healthcare providers is a complex process, requires assessing the needs of the surrounding community, and cannot be accomplished quickly (or cheaply). Therefore, hospitals can suffer from overbedding for several years before a real solution can be implemented – which means that interim funding sources need to be negotiated and obtained, whether private funding sources or public (state funds through Medicaid, grants or other sources).

D. EHR/EMR Systems Part of the evolution in the delivery of healthcare relates to the implementation of Electronic Health Records (EHR) or Electronic Medical Re-

cords (EMR) systems. EMS/EMR provide for quick access to patient medical records and improve the overall efficiency of the healthcare system. (HealthIT.Gov, What is an Electronic Medical Record (EMR)?). Other cost savings include assistance with necessary compliance with HIPAA, FACTA, HITECH, and other state and local laws and regulations, decreased costs associated with medical storage, increased efficiency associated with access to patient records and easier transfer of patient records in the event of a closure/transfer of the healthcare facility. EHR/EMR systems also help flag potentially dangerous drugs and verify medication dosages. (HealthIT.Gov, Medical Practice Efficiencies & Cost Savings). A 2010 survey by the Center of IT Leadership found the U.S. Department of Veteran Affairs, an early adopter of EHR/EMR systems, saved \$4.64 billion by preventing adverse drug events. (HealthIT.Gov, Why Adopt EHRs?). As an incentive, the Federal government has implemented reimbursement programs to promote the use of EHR/EMR technology. “Over 144,000 payments totaling \$7.1 billion have already been issued to professionals and hospitals by the [CMS].” (*Id.*)

Healthcare systems that have EMR/EMS do caution that implementation of the system entails a timely and costly process. It typically takes a healthcare system approximately 18-24 months to fully adopt an EHR/EMR system. At the early stages of implementation, healthcare businesses may undergo disruptions in revenue and collections. Healthcare providers making these types of transitions should account for such disruptions in their projections.

These changes serve as a backdrop to the various ways the healthcare sector can increase efficiency and cut costs. On the other hand, changes affecting reimbursement rates and increasing costs affect a growing number of distressed healthcare businesses. Providers with significant funded debt and other liabilities associated with running a healthcare business find their balance sheets are no longer sustainable. In the wake of these financial pressures, healthcare providers need to consider how they will restructure or monetize their assets. Oftentimes, this means the business needs to consider a divestiture of assets or services. In doing so, both the healthcare business and potential investors must take into account various legal and operational considerations for an in court or out of court restructuring or divestiture.

II. Legal and Operational Considerations – The Proposed Course of Treatment

When businesses suffer, a common course of action is to excise the underperforming parts to enhance the survivability of the balance – no easy or quick procedure for a healthcare business. Divestiture of assets or services of a healthcare entity are complex. The Bankruptcy Code adds an overlay of additional requirements to the myriad of federal, state and local laws and regulations affecting healthcare businesses and, if applicable, non-profits. A comprehensive diligence of a healthcare business is two-fold. First, all parties to the transaction must review and understand the regulatory approval necessary for transfer/closure of a healthcare business. Second, the company and the purchaser must diligence and minimize liabilities, many of which are unique to healthcare businesses.

A. Approval of Transfer or Closure of Healthcare Business Transfer or closure of any healthcare facility requires simultaneous coordination with multiple local, state and federal agencies. Before beginning the approval process, the healthcare business or the purchaser of the business should identify which agencies require approval, understand what the approval process entails, approximate the length of the process and determine whether a hospital plan of closure must be filed and approved by the state. The important point to remember is even if the healthcare business has filed for bankruptcy and has received court approval of transfer/closure of the business, it is still required to seek regulatory approval. In taking into account the time to complete a transaction, adequate funding must be available to operate pending any sale or transfer of services – and, in bankruptcy, this must be a factor to setting realistic milestones under a “DIP loan” for bankruptcy financing.

Where the process involves the conversion of the use of real estate from healthcare use to another purpose, land use restrictions must be considered. It is not unusual for hospital property to be zoned for use limited to providing healthcare services, thereby requiring rezoning for an alternative use. For example, in New York City, requests for rezoning are subject to the city’s Uniform Land Use Review Procedure (“ULURP”). (New York City Department of City Planning). The ULURP process could take months (if not years) to obtain rezoning approval. In the Saint Vincent’s Manhattan bankruptcy, it took the purchaser over 200 public meetings over the span of over one year to ultimately obtain rezoning.

A buyer or existing provider looking to reconfigure the existing facility needs to verify that the excess property can be converted to another purpose to generate liquidity. A lender to a healthcare provider – assuming that it has marketable collateral (e.g., a mortgage) – may find that zoning restrictions impede transfer (and therefore limits value if the property is not being used for healthcare purposes).

Not-for-profit hospitals have additional layers of approval in order to transfer/close their facilities. For example, most states require a not-for-profit hospital to obtain approval by the state’s Attorney General. This process can be lengthy and result in stringent requirements by the Attorney General. When the Daughters of Charity, a not-for-profit hospital system in California, undertook a sale process, it took nearly two years to complete the sale in part because of the rigorous approval process. The California Attorney General imposed a 78-page list of conditions, causing the first buyer to back out. Ultimately, the Attorney General approved a sale to another buyer who agreed to take on some of the attorney’s general’s conditions, including the continued operation of the hospital as a not-for-profit for a period of years.

Further, not-for-profit directors possess an additional fiduciary duty of obedience to ensure that the charitable mission of the hospital is upheld. Bankruptcy courts have placed a heavy emphasis on the charitable mission when evaluating whether the sale of a healthcare business or assets should be approved. In an ordinary bankruptcy, such as a retail bankruptcy, courts will generally approve a section 363 sale as long as the Bankruptcy Code’s requirements have been met and the

debtor is obtaining the highest offer. However, bankruptcy courts have recognized that a higher price does not necessarily yield the best use of healthcare assets and therefore need not be the “winning bid” in a sale of a healthcare business as a going concern. (See *In re United Healthcare Sys., Inc.*, No. 97-1159, 1997 BL 8656 (D.N.J. Mar. 26, 1997)). If bidder A offers a higher price but commits to retain fewer patient care services it may lose out to bidder B who has committed to maintain more (or at least more critical) care to serve the community’s needs. The concept of charitable mission was central in Daughters of Charity because preserving the system’s mission of charity care was central to the transaction.

B. Comprehensive Diligence of Healthcare Business In addition to understanding the approval process, an investor should engage in comprehensive diligence of potential liabilities when determining how to structure an acquisition or a standalone restructuring. This includes issues which are not specific to healthcare businesses, such as pension issues (including withdrawal liability), control group issues, union/collective bargaining agreement issues and WARN Act compliance. Of more unique relevance to healthcare businesses, one must diligence issues crucial to structuring the turnaround or sale including: (1) evaluating potential exclusion or termination of provider agreements; (2) assessing potential overpayment liability; and (3) evaluating pending medical malpractice litigation.

1. Exclusion and Termination of Provider Agreements Provider agreements represent the single most important asset of any healthcare system. Reimbursement revenues for services rendered to patients flow directly (and materially) from provider agreements. Hindrance to receiving reimbursements causes cash flow problems in the near- and long-term. There are two major types of provider agreements: (i) private pay agreements with private insurers and (ii) government payor agreements with Medicaid and Medicare. In some cases, a private insurance company may serve as a third party payor to manage government reimbursement programs.

For many community-based hospitals, nursing homes and healthcare providers, substantial revenues come from government payor agreements – typically driven by a lower income patient population. Actual or threatened loss of these payor agreements has caused healthcare providers to seek the protection of the automatic stay under the Bankruptcy Code. However, such relief may not apply or may not address liquidity issues caused by imminent recoupment or offset by the government.

In general, the government has two remedies for breaches or violations of governmental provider agreements: exclusion and termination. Exclusion is a serious remedy for egregious acts (i.e., fraud or criminal activity) and results in an exclusion period running from one to more than five years during which a provider may not participate in Medicare and Medicaid. 42 U.S.C. § 1320a-7. A specific provision of the Bankruptcy Code, section 362(b)(28), expressly allows the government to “exclude” a medical provider during the pendency of a bankruptcy case without violating the automatic stay. 11 U.S.C. § 362(b)(28).

Termination is a lesser remedy and is generally temporary and allows a provider to be reinstated if they can

demonstrate they have cured the default. 42 U.S.C. § 1395cc(b). The nuance in the law pertains to this remedy because the Bankruptcy Code does not expressly exempt termination from the automatic stay, as it does exclusion. However, there is a growing body of case law that addresses termination of provider agreements on two distinct grounds.

First, courts have found termination is a valid exercise of CMS’s police power, which is in turn exempt from the automatic stay pursuant to section 362(b)(4) of the Bankruptcy Code. 11 U.S.C. § 362(b)(4). In a recent case, *In re Parkview Adventist Medical Center*, the First Circuit upheld the CMS’s power to terminate the provider agreement because the provider voluntarily notified CMS of its pending closure and therefore it would no longer qualify as a hospital. (*Parkview Adventist Med. Ctr. v. United States*, 2016 BL 395994, 842 F.3d 757, 764 (1st Cir. 2016)). The court reasoned that “CMS has a strong policy interest in seeing that Medicare-program dollars are not spent on institutions that fail to meet qualification standards.” *Id.*

Second, some courts have held that the bankruptcy court does not have the jurisdiction to enjoin the government from terminating a Medicare or Medicaid provider agreement. For example, in *In re Bayou Shores*, CMS moved to terminate the nursing home’s provider agreements on account of significant lapses in patient care. (828 F.3d 1297 (11th Cir. 2016)). In an effort to prevent termination, *Bayou Shores* filed for chapter 11 protection. The Eleventh Circuit held that section 405(h) of the Medicare Act limits the bankruptcy court’s authority to review CMS’s decision to terminate a provider before the debtor exhausts all available administrative remedies. *Id.* Bayou filed a writ of certiorari in February 2017 so it remains to be seen whether the Supreme Court will take on the case. If the Supreme Court takes on this case, the ruling will be particularly relevant for healthcare providers that seek to use the Bankruptcy Code to avoid or otherwise speed up the potentially lengthy process of exhaustion of administrative remedies before a provider disputing issues such as recoupment or offset can seek judicial relief.

In the absence of direction from the Supreme Court at this point, *Parkview* and *Bayou* caution healthcare providers and potential investors not to rely on the Bankruptcy Code as a shield from termination of its provider agreements or efforts to force continued funding in the face of a dispute without having exhausted the administrative appeals processes.

2. Recoupment of Overpayments Annual audits of reimbursement payments cause another pressure point on both liquidity and liability. Reimbursement payments are made based upon projections subject to true up following the submission of relevant payment information. For example, CMS – which oversees government pay contracts – will look to see whether a provider has been over or underpaid in any given year – which is referred to as a cost report year. A review of each cost report year can result in overpayment liabilities or underpayment credits. A finding of underpayment is obviously beneficial to healthcare providers but is a rarity.

The more common result is an overpayment resulting in recoupment by the government. The central issue surrounding recoupment is whether reimbursement payments made from any one cost report year arise from transactions wholly distinct from reimbursement

payments made for subsequent cost report years. This becomes further conflicted in the bankruptcy context because there is no provision in the Bankruptcy Code dealing with recoupment, but property subject to recoupment is not protected by the automatic stay because funds subject to recoupment are not property of the estate. (See *e.g.*, *United States v. Consumer Health Servs. of Am. Inc.*, 108 F.3d 390, 396 (D.C. Cir. 1997)). A minority number of jurisdictions, including the Third Circuit, have held that cost report years are all deemed separate transactions and recoupment is not appropriate among different years. (See *e.g.*, *In re Univ. Med. Ctr.*, 973 F.2d 1065, 1080 (3d Cir. 1992)). However, the majority view of recoupment of Medicare and Medicaid provider overpayments is that the right of recoupment is an equitable defense whereby claims arising out of the same transaction may be reconciled. In other words, cost report years are simply for efficiency purposes and all years are part of the same transaction. (*Consumer Health Servs. of Am. Inc.*, 108 F.3d at 393-94). Investors should beware and diligence potential overpayments because this can result in significant material liability that results in offsets of future receivables and typically rears itself in asset sales and could raise issues of successor liability for the buyer.

3. Pending Medical Malpractice Litigation Distressed healthcare businesses often face significant medical malpractice liability. If the provider has filed for bankruptcy, the automatic stay must be lifted to proceed with any pending litigation. Oftentimes providers are willing to consent to a lift of the stay if the plaintiff agrees to limit recovery to the hospital's insurance policy limits. An important consideration for any investor is whether the healthcare provider has third-party insurance or is self-insured. If the healthcare business is self-insured, investors should take the potential risk into consideration when valuing the transaction.

While the Bankruptcy Code will treat medical malpractice claims as general unsecured claims, the stigma surrounding tort liability oftentimes requires healthcare providers to analyze alternative means to address such

liabilities. Investors need to be mindful not only of the hospital's direct liabilities but also those of physicians and medical staff that they have indemnified. The stay does not automatically extend to the physicians and medical staff and therefore the lifeblood of the healthcare provider may be exposed to significant liability they expect the hospital to backstop. Furthermore, the public perception of medical malpractice claimants failing to have some form of recourse has led to trusts being created for the benefit of claimants, the contribution of insurance policy proceeds and the commitment by investors to ensure that those former patients that have been harmed received some remuneration. One technique used is to create a fund into which medical staff contributes money (or recoveries on account of their claims against the provider-debtor in bankruptcy) and "channel" plaintiff claims against the non-debtor medical staff into this dedicated fund in exchange for a release of claims against the medical staff. These types of solutions and the cost commitment surrounding them should be weighed in connection with any financial restructuring.

III. Prognosis

Changes in the healthcare industry in recent years coupled with uncertainty surrounding the Affordable Care Act have placed the healthcare industry on a critical watch list. Some of the underlying changes are a result of policy but many are on account of changes in the delivery of healthcare. The transition to bundled payments and large hospital footprint have left some healthcare providers (and communities) with hundreds of empty hospital beds. Although the growing number of urgent care centers and implementation of EMR/EHR systems increase overall efficiency at hospitals, it is doubtful this is enough to curb the downhill trajectory of many healthcare systems. In the face of this changing landscape, healthcare providers and potential investors must be attuned to legal and operational considerations unique to the healthcare sector.