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On Life Support? Selling Health Care Assets in Chapter 11

Written by:

Louis E. Robichaux IV
Bridge Associates LLC; Dallas
lrobichaux@bridgellc.com

Holland O'Neil
Gardere Wynne Sewell LLP; Dallas
honeil@gardere.com

Nanette Beaird
Gardere Wynne Sewell LLP; Austin, Texas
nbeaird@gardere.com

Russell Perry
Bridge Associates LLC; Dallas
rperry@bridgellc.com

The unique operating and regulatory nature of health care businesses demands that buyers and sellers utilize a creative blend of science and art to complete a sale transaction. This article addresses a number of challenges unique to executing health care transactions—principally from a debtor's perspective.

Maintaining Value Before and During the Sale Process

Patient Referrals



Louis E. Robichaux IV

The volume and “quality mix” of patient flow are significant drivers of value in most health care businesses (e.g., most often through physician referrals). In a distressed-hospital setting, the mere mention of a potential sale could adversely impact physician referral patterns. The issue of lost physician support potentially becomes more acute if a physician-owned entity is involved. Typically, a buyer will expect some loss of physician support (*vis-à-vis* pre-sale levels), and may even apply a purchase-price

About the Authors

Louis Robichaux is a managing director in the Healthcare Practice and Russell Perry is a principal at Bridge Associates LLP in Dallas. Holland O'Neil is a partner in Gardere Wynne Sewell LLP's Bankruptcy and Business Reorganization group in Dallas, and Nanette Beaird is an attorney in Gardere's Government Affairs practice in Austin, Texas.

reduction in anticipation thereof. In an effort to best position the debtor for a successful auction, the seller should carefully control the communication to staff/doctors and tightly manage the M&A process in order to minimize operational turbulence.

The seller must attempt to keep the physicians engaged through the sale process by exploring potential new roles that the physician owners might serve

presents several challenges, as “net” A/R contains a number of subjective management estimates and reserves. When a buyer plans to purchase the A/R, the most prudent approach is to set forth a clear methodology in the asset-purchase agreement for determining the net A/R value as of the sale date—along with a clear post-closing adjustment mechanism.

Medical Equipment



Holland O'Neil

In a health care transaction, the medical equipment can be a significant component of the overall value of the ongoing enterprise; such equipment is often leased from third parties. Resolving issues with equipment lessors can be time-consuming and require significant lead time to resolve. A gating consideration is whether the

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with the successful buyer. Quite often, keeping the physician owners engaged and cooperating becomes pure finesse and salesmanship. Inattention can mean the difference between a successful sale and a failed transaction.

Patient A/R

Buyers of health care businesses with sufficient short-term working capital financing often prefer to leave behind the patient accounts receivable (A/R) of a distressed seller. Other times, buyers have inadequate short-term working capital to fund the post-sale build-up of A/R and, thus, seek to acquire the seller's patient A/R as part of the overall transaction. Valuing patient A/R

leases are “true lease” transactions or financed sales transactions. If the former, §365 requirements of assumption or rejection must be determined, including the cost of curing prior defaults and proof of financial wherewithal of the assignee to perform in the future. Considering the market for used medical equipment and the high rate of obsolescence for these types of assets, assumption of equipment leases is often uneconomical.

Many medical equipment leases contain dollar-buyout provisions, renewal options for modest consideration and other indicia of financing arrangements. Restructuring of the business based on the fair market value of the used equipment (*vis-à-vis* an adversary proceeding seeking

to recharacterize) may be far more achievable than if the leases are required to be assumed or rejected and the equipment replaced. Hospital cases, in particular, may have significant equipment leases. Consideration of an alternative dispute resolution (ADR) procedure should reduce the cost of litigating these issues with numerous parties.

Special Considerations in Health Care Asset Sales Combination OTA/APA



Nanette Beaird

An operations transfer agreement (OTA) is typically used to memorialize the allocation of responsibilities and timing of transfer of key elements in the sale of an ongoing health care business.

The parties can combine, into one document, an asset-purchase agreement (APA) and OTA.

The OTA/APA should cover major issues such as: (1) assets, operations and liabilities being transferred or assumed; (2) purchase consideration; (3) timing of transfer; (4) transfer of employees (including WARN Act issues); (5) regulatory filings/requirements; (6) partitioning/collection of accounts receivable; (7) ownership of, and access to, business and patient records; (8) transfer and custody of patient funds/property; (9) responsibility for filing final cost reports; (10) proration of operating costs; (11) establishment of new vendor/contractor relationships, including resolution of vendor deposits and letters of credit; (12) assignment of contracts; (13) agreements and leases; (14) electronic fund transfers (EFT) and bank account control issues; and (15) any other conditions to closing.

Medicare/Medicaid “Change of Ownership” Issues

Regardless of the identity of the legal entity that is currently billing under a particular Medicare provider agreement, the Centers for Medicare and Medicaid Services (CMS) functionally takes the position that the provider agreement has a life of its own until effectively terminated by CMS or the provider. Practically speaking, CMS disavows any duty to match or offset overpayment claims or reimbursement credits to any particular entity in the “chain of title”¹

¹ Although useful in discussing the “single provider” concept, “chain of title” is a misnomer in the sense that the provider agreement cannot, in CMS’ view, be bought or sold.

of a provider agreement. As noted in a recent *ABI Journal* article,² even though the Medicare statutes prohibit the sale of a Medicare provider number upon a change of ownership (CHOW), the provider agreement is *automatically assigned* to the new owner. See 42 CFR §489.18(c) and *U.S. v. Vernon Home Health Inc.*, 21 F.3d 693, 694 (5th Cir. 1994). As long as a provider agreement, and its concomitant provider number,³ is not terminated, CMS views the agreement as essentially having a separate “corporate” life—one that allows CMS essentially to ignore the private contractual dealings between buyers and sellers, and impose upon the purchasing entity choosing to accept (or failing to terminate) the agreement upon the CHOW, any liabilities, known or unknown, that have already attached to the agreement, as well as, of course, any future liabilities arising after the CHOW.



Russell Perry

In contrast, Medicaid agreements are administered at a state level, and issues of successor liability and duties of a successor are treated differently from state to state. States can provide for the preservation of a state’s security against overpayments pending filing of a final cost report by stopping payment on a Medicaid contract held by the existing provider as soon as information regarding a pending CHOW is received.

Separately licensed health care facilities generally have distinct Medicare and Medicaid provider agreements (and therefore separate provider IDs), irrespective of ownership structure or common management. Cost-report settlements are resolved on an individual provider basis, rather than on a portfolio basis. In structuring the APA, debtors should be aware of this concept, as well as the limitation of Medicare and Medicaid to recover cost-report overpayments only on an individual provider basis, and not on a portfolio basis. The concept of separateness does not necessarily extend to commercial and managed-care payors as “corporate level” contracts are commonly utilized.

² See “Transfer of Medicare Provider Numbers in Bankruptcy: Executory Contract or Saleable Asset,” by Frank A. Oswald and Howard P. Magaliff, *ABI Journal*, May 2009.

³ Although generally the same number stays with the provider agreement, there are certain situations in which a new number is assigned by CMS. See the State Operations Manual at 3210.4(C).

Medicare Provider Agreement NOT Assigned to the Buyer

Generally, a provider agreement with its potential liabilities and credits is “automatically” assigned to the new provider in a CHOW. See 42 CFR §489.18(c). However, the successor provider at a Medicare-certified facility may refuse to accept assignment of the previous owner’s provider agreement, which means that the existing provider agreement terminates as of the CHOW date. The CMS State Operations Manual⁴ provides that “the [facility’s new owner’s] refusal to accept assignment must be put in writing by the new owner and forwarded to the Regional Office 45 calendar days prior to the CHOW date to allow for the orderly transfer of any beneficiaries that are patients of the provider.” See §3210.5A, CMS State Operations Manual. When a health care business is sold in connection with a bankruptcy, it may be difficult or impossible to meet those notice requirements. The State Operations Manual states that “it is the responsibility of the prospective purchaser to know that it can refuse to accept assignment of the provider agreement and that it should formally indicate its choice in that regard. If, however, the CHOW goes into effect without a refusal or acceptance of assignment on record, the Regional Office concludes that the agreement has been automatically assigned to the new owner and completes processing of the CHOW.” *Id.*

Written Policies vs. Actual Practice

It is important to remember that any government program is operated by individual regulators who often retain an important degree of discretion regarding the details of how their program will operate with regard to a bankrupt client. It is always advisable to contact CMS to discuss any needed variation in usual CMS practice. For example, timing of recoupment amounts and any offset by pending credits can sometimes be negotiated. It may even be fruitful to discuss from which entity, in the “chain of title” for a particular provider agreement, CMS will first seek recoupment of any outstanding amounts. Since bankruptcy impacts the normal procedures (and timelines) utilized by CMS and its contractors, it is important to not only review and become familiar with the directives in the CMS Medicare Financial Management

⁴ Available on the Centers for Medicare and Medicaid Services’ Web site at www.cms.hhs.gov/manuals/downloads/som107c03.pdf.

Manual (see Chapter 3: Overpayments, Section 140, Bankruptcy), but to be aware of CMS attitudes with regard to any administrative freeze that might be placed on payments to a provider. These issues can make or break the sale of a health care business in bankruptcy because they affect the timing and flow of critical income streams to a facility.

Medicare/Medicaid Cost Report and Recoupment Issues

Successor Liability

As noted, assignment of a Medicare provider agreement (whether intentional or by failure to properly reject) can result in successor liability to the purchaser of a health care business. Sometimes buyers attempt to contract around this successor liability. Such an attempt by a buyer to deny liability was considered in February 2009 by the U.S. Bankruptcy Court for the Northern District of Texas in a chapter 11 proceeding involving the sale of skilled nursing facilities in Texas. The buyers sought payment (or reimbursement) from the plan agent for CMS's recoupment of Medicare payments based on prior alleged overpayments to the seller and to the seller's predecessor. The buyers relied on theories of statutory and equitable subrogation.

The court rejected both the buyers' 11 U.S.C. §509 statutory subrogation argument and the buyers' equitable subrogation argument because neither basis for subrogation is available to a party who satisfies a debt for which that party was primarily obligated, and the recoupment liabilities were assumed when the buyers assumed the provider numbers. In granting summary judgment to the plan agent, the court, in an unpublished decision, noted that nothing in the OTA can contradict controlling federal law, but also, that the OTA recited that the facilities were purchased "as is, where is" by the buyers. *In re Senior Mgmt. Servs. of Treemont Inc., et al.*, Case No. 07-30230 (Bankr. N.D. Tex. Feb. 27, 2009).

Cost Report Receivables and Overpayments

Since most health care providers are now paid by Medicare and Medicaid under various forms of "prospective payment" methodologies⁵ (versus the "cost based" reimbursement schemes of the past), the magnitude of yearly overpayments or underpayments have decreased substantially. Nonetheless, there are reimbursement items that are subject to "true-up" upon filing of

the annual cost report. For hospitals, these items include reimbursement for disproportionate share, Medicare bad debt and graduate medical education. Generally, these annual settlements are considered separate and distinct from "accounts receivable" and are frequently retained by the seller even if A/R is sold.⁶

Medicare and Medicaid cost reports are generally filed annually.⁷ There is ordinarily a requirement to file a "stub period" cost report if a change of ownership occurs during the cost report year.⁸ The APA should clearly address which party is responsible for meeting cost report filing requirements.

Post-sale Collection of A/R

Resolution of A/R retained by the seller is one of the most important aspects of the OTA. In practice, collection of A/R in an "ordinary course environment" always yields a higher value than selling the A/R to a third-party. The buyer is usually in the best position to collect the retained A/R, particularly if the seller's billing and collection employees were included in the transferred operations. It is critical that an agreement to collect the retained A/R be reached early in the overall OTA negotiation process, and not dealt with as an afterthought. Note that until the buyer's CHOW process has been finalized by Medicare and Medicaid (typically 75-90 days), all EFT payments for both pre-and post-sale A/R will continue to flow to the seller's bank accounts. After the buyer's CHOW has been finalized, all EFT payments will then flow to the buyer's bank accounts. Obviously, the OTA must contain a clear methodology for identifying and segregating collections of pre- and post-sale A/R.

Regulatory Approvals: Brief Listing

Required regulatory approvals vary according to the type of health care entity being sold. Sale of a hospital, for example, would include, in addition to filing any Medicare and Medicaid applications, notification to and approval by the state agency in charge of licensure (as distinct from government payor certification), CLIA registration, application to the DEA and

other pharmacy-related regulators in the state, filings with state radiation control regulators as applicable, and fire marshal, food service and boiler registration notifications. Contact with any applicable accreditation organizations is also desirable.

Medical Records: State Law Considerations

Custody of patient medical records should be addressed in the OTA and a responsible person should be designated as the custodian of those records with the place of retention specified. Further, to the extent the outgoing provider retains any responsibility for cost report preparation, or must otherwise defend any action related to a patient or patients receiving care during the tenure of the provider, conditions of access to the records by the outgoing provider should be spelled out by the parties. Specific requirements for the quality and retention of medical records vary according to each state's law and in many cases by type of health care business.

Medical Records: Bankruptcy Code Provisions

Section 351 of the Bankruptcy Code addresses the disposal of patient records. It provides a mechanism for a trustee to dispose of such records if the estate lacks sufficient funds to pay storage costs in the manner required by state or federal law. This statute involves a 365-day process and should be carefully followed; likewise, the cost of maintaining such records for this period should be determined. Obviously, buyers of a going-concern health care business are in the best position to take possession of a debtor's patient files.

Review by Patient Care Ombudsman

It has been well chronicled in the pages of the *ABI Journal* that the specific roles and responsibilities of court-appointed patient care ombudsman (PCO) continue to evolve. Debtors should be aware that PCOs may consider a detailed review of asset sales within their purview, citing concerns over patient privacy and the patient care track record of the buyer.

Selling Nonprofit Assets

Attorneys general (AGs) in numerous states have become increasingly involved in the disposition of nonprofit health care operations and have premised their involvement by asserting that the "assets of a nonprofit health care system are held not by a private corporate property, but pursuant

⁵ One notable exception is hospitals with a designation of "critical access facility," which are reimbursed on a cost basis.

⁶ Recall that Medicare has a "single provider" view. Therefore, if any interest in Medicare A/R or cost report settlements are retained by the seller, beware that Medicare will not acknowledge this partition and will view the buyer as the sole counterparty for all payments or recoveries once the provider agreement has been assigned. *CMS Provider Reimbursement Manual*, Part 2, Chapter 1, §102.

⁷ Cost report year can be determined by the provider and need not correspond to a calendar year. *CMS Provider Reimbursement Manual*, Part 2, Chapter 1, §102.

⁸ Exception being a provider's ability to file a 13-month cost report. Slippage of more than a month into a subsequent cost report year usually triggers the requirement to file a stub period cost report.

to a constructive or implied charitable trust for the benefit of the community or communities that the nonprofit organization serves.”⁹ For instance, in New York there is a two-prong statutory standard applied to nonprofit asset sales: (1) that the consideration and terms of the transaction are fair and reasonable to the corporation, and (2) the purposes of the corporation or the interests of its members will be promoted.¹⁰ In addition to these statutory standards, there are other requirements including, *inter alia*, board approval and creditor notification. Lastly, the use of proceeds from the sale of real estate acquired through charitable donations (as opposed to debt issuance) will receive a higher degree of scrutiny from regulators, and may be severely limited. This intervention by various states’ AG offices, particularly with multi-site transactions, must be carefully considered in chapter 11 cases as well.¹¹

Bottom line—there is no cookie-cutter template for all health care transactions. The above should be useful in guiding a debtor’s consideration of the myriad unique issues involved in selling a complex, ongoing health care business. ■

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⁹ “The ‘Charitable Trust’ Doctrine: Lessons and Aftermath of Banner Health,” by Harold L. Kaplan, Patrick S. Coffey & Rosemary G. Feit, *ABI Journal*, May 2004..

¹⁰ A Guide to Sales and Other Dispositions of Assets Pursuant to Not-For-Profit Corporation Law §§510-511 and Religious Corporations Law §12, January 2007.

¹¹ Texas Attorney General’s office was particularly active in *In re Benevolent Ass’n of the Christian Church (Disciples of Christ), et al.*, Case No. 04-50948-RBK (Bankr. W.D. Tex.).