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Health Care Business Restructuring for Secured Lenders



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Secured lenders to health care businesses must anticipate and plan for a variety of issues that are unique to health care bankruptcy cases. This article focuses on key issues that arise in health care bankruptcy cases and assumes the reader is generally familiar with the bankruptcy process.

Overview

Health care is an industry in transition. While industry revenues are up due to an aging population, new regulation in this already highly regulated industry, such as the Patient Protection and Affordable Care Act (“ACA,” colloquially referred to as “Obamacare”), is resulting in smaller margins for many participating health care businesses. The ACA contemplates, among other things: (1) additional reporting requirements; (2) mandatory business improvements that will require significant capital expenditures; and (3) a reduction in government aid for certain programs. Complying with

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ACA—and coping with the attendant cost increases—very likely will result in an increase in bankruptcy filings throughout the health care industry as new benchmarks for success are established and tested.

The interplay between health care regulations designed to protect patients and the Bankruptcy Code, which is designed to provide debtors with a fresh start, creates a tension that makes health care bankruptcy cases different from other bankruptcies. Further complicating matters, the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 (“BAPCPA”) added several provisions to the Bankruptcy Code that impose additional duties on health care businesses. Such provisions have made health care bankruptcies even more complex (and often more expensive) than typical bankruptcy cases. For example, the expenses associated with these additional duties receive a claim priority that, in some instances, can prime even a secured lender's lien. Without a strategy for how to deal with a troubled health care business, a bankruptcy case can easily spiral out of control for a secured lender, perhaps eliminating the possibility of a successful outcome.

This article is broken into five parts. The first part examines which health care providers are eligible to file for bankruptcy. The second part addresses issues unique to financing health care receivables with an emphasis on the government's power to set-off or recoup prepetition overpayments with postpetition receivables. The third part discusses a bankruptcy court's jurisdiction over Medicare and Medicaid disputes. The fourth and fifth parts present general considerations about bankruptcy sales that are unique to health care bankruptcy cases.

Finally, we note that this article is intended for lenders who seek to be repaid through the bankruptcy pro-

cess, as opposed to lenders who wish to credit bid for their collateral or otherwise own and operate a health care business post-bankruptcy.

Health Care Business Generally

What Is a Health Care Business?

Whether the Bankruptcy Code's "health care" provisions will apply depends upon whether a borrower is deemed to be a "health care business." The Bankruptcy Code defines "health care business" very broadly to include "any public or private entity," for-profit or not-for-profit, "that is primarily engaged in offering to the general public facilities and services for: (1) the diagnosis or treatment of injury, deformity, and disease; and (2) surgical, drug treatment, psychiatric and obstetric care."¹ The statute also provides a non-exclusive list of entities that are "health care businesses." Some courts have narrowly interpreted what constitutes a "health care business." These courts have held that only businesses that are generally available to the public and provide facilities and services in an institutional, in-patient setting (and not out-patient facilities) qualify as "health care businesses."² Other courts, however, have suggested that a debtor need only have direct and on-going contact with patients to be a "health care busi-

¹ Section 101(27)(A) of the Bankruptcy Code defines a "health care business" as:

(A) any public or private entity (without regard to whether that entity is organized for profit or not for profit) that is primarily engaged in offering to the general public facilities and services for—

(i) the diagnosis or treatment of injury, deformity, or disease; and

(ii) surgical, drug treatment, psychiatric, or obstetric care; and

(B) includes—

(i) any—

(I) general or specialized hospital;

(II) ancillary ambulatory, emergency, or surgical treatment facility;

(III) hospice;

(IV) home health agency; and

(V) other health care institution that is similar to an entity referred to in subclause (I), (II), (III), or (IV); and

(i) any long-term care facility, including any—

(I) skilled nursing facility;

(II) intermediate care facility;

(III) assisted living facility;

(IV) home for the aged;

(V) domiciliary care facility; and

(VI) health care institution that is related to a facility referred to in subclause (I), (II), (III), (IV), or (V) if that institution is primarily engaged in offering room, board, laundry, or personal assistance with activities of daily living and incidentals to activities of daily living.

² *In re Banes*, 355 B.R. 532, 535 (Bankr. M.D.N.C. 2006); *In re 7-Hills Radiology LLC*, 350 B. R. 902, 905 (Bankr. D. Nev. 2006) (focusing on the statutory language defining a health care business as one primarily engaged in offering services and facilities to the general public and declining to appoint a patient care ombudsman in the case of a debtor that performed radiological tests for patients referred by treating physicians). See also *In re Medical Associates of Pinellas L.L.C.*, 2007 BL 5126, 360 B.R. 356 (Bankr. M.D. Fla. 2007) (finding that the debtor, which provided administrative support services and laboratory support to doctors, was not a health care business because it did not offer services generally to the public).

ness." These courts have formulated a four-part test requiring that: (1) the debtor is a private or public entity; (2) the debtor is primarily engaged in offering to the general public facilities and services; (3) the facilities and services are for diagnosis or treatment of injury, deformation or disease; and (4) the facilities are for surgical care, drug treatment, psychiatric care or obstetric care.³

Debtors are responsible for identifying themselves as health care businesses when they file for bankruptcy; however, many are loath to do so due to the additional administrative cost and oversight in the bankruptcy process.⁴ If a debtor does not identify itself as a health care business, then the United States Trustee or a party in interest may move to have the debtor deemed a health care business.

Not All Health Care Businesses Are Eligible to File for Bankruptcy

While most health care providers are eligible to file for bankruptcy protection, there are several exclusions.

Domestic Insurance Companies

A domestic insurance company may not be a debtor under the Bankruptcy Code.⁵ This limitation most often arises with regard to health maintenance organizations ("HMOs").⁶ Courts are divided as to whether HMOs are eligible for bankruptcy. Courts denying HMOs the right to file for bankruptcy protection have held that they are ineligible because they assume "risk" (like insurance companies). Courts holding that HMOs are eligible to file for bankruptcy have found that they don't otherwise qualify as domestic insurance companies.

Municipalities

Under the Bankruptcy Code, a hospital can be deemed a "municipality," meaning it only may file under Chapter 9 and not under Chapter 11 or 7. Under Chapter 9, a "municipality" is defined as a "political subdivision or public agency or instrumentality of a

³ See *In re Medical Associates of Pinellas L.L.C.*, 2007 BL 5126, 360 B.R. 356 (Bankr. M.D. Fla. 2007); see also *In re Alternat Family Care*, 2007 BL 137571, 377 B.R. 754 (Bankr. S.D. Fla. 2007); *In re William L. Saber, M.D., P.C.*, 2007 BL 140806, 369 B.R. 631 (Bankr. D. Colo. 2007). At least one court has held that an individual doctor's office qualifies as a "health care business." *In re William L. Saber, M.D., P.C.*, 2007 BL 140806, 369 B.R. 631 (Bankr. D. Colo. 2007) (finding that a sole-owner, sole-physician plastic surgery office with three additional employees nonetheless qualified as a health care business, noting that, by its use of the word "includes," the listing of entities in the statute is not exhaustive and that the statute does not distinguish between major and minor surgeries).

⁴ In one study of 43 bankruptcy cases filed in the first few months after the enactment of BAPCPA that involved health care businesses, only 11 of the debtors identified themselves as health care businesses. Nancy A. Peterman and Suzanne Koenig, *Patient Care Ombudsman: Why So Much Opposition?*, Am. Bankr. Inst. J. 22, 55-56 (Mar. 2006).

⁵ See 11 U.S.C. § 109.

⁶ Similar questions exist as to whether other entities unique to the health care field (PHOs, POs, IDSS, etc.) are insurance companies for purposes of Section 109 of the Bankruptcy Code.

State.”⁷ The requirements for entering Chapter 9 are more burdensome than those for Chapter 7 or 11; thus, public hospitals may be limited in their ability to use bankruptcy as a tool to reorganize.

Not-for-Profit

Not-for-profit health care businesses may file for voluntary relief under Chapters 7 or 11; however, a not-for-profit cannot be the subject of an involuntary petition (a bankruptcy case commenced by creditors against a debtor without the debtor’s permission).⁸ Further, a not-for-profit provider’s Chapter 11 case cannot be converted to a Chapter 7 case unless it consents. This is an important restriction on the rights of creditors and gives significant leverage to a not-for-profit health care provider that has filed a voluntary Chapter 11.

What Does Being a Health Care Business Mean for a Borrower’s Case?

Whether a borrower qualifies as a “health care business” impacts the amount of oversight it will be subjected to in the bankruptcy process, how much it will cost to operate during a bankruptcy, and potential exit strategies. Some of the costs of operating a “health care business” are entitled to so-called “administrative expense priority” in the bankruptcy case. Below is a discussion of the additional oversight, requirements and expenses associated with being a “health care business.”

Patient Care Ombudsman

The Bankruptcy Code requires the appointment of a patient care ombudsman within 30 days after commencement of a “health care business” bankruptcy case, *unless* the court finds that an ombudsman is not necessary for the protection of the patients under the

⁷ Under Section 109(c) of the Bankruptcy Code, an entity may be a debtor under Chapter 9 if and only if such entity:

- (1) is a municipality;
- (2) is specifically authorized, in its capacity as a municipality or by name, to be a debtor under such chapter by state law, or by a governmental officer or organization empowered by state law to authorize such entity to be a debtor under such chapter;
- (3) is insolvent;
- (4) desires to effect a plan to adjust such debts; and
- (5)(A) has obtained the agreement of creditors holding at least a majority in amount of the claims of each class that such entity intends to impair under a plan in a case under such chapter;
- (B) has negotiated in good faith with creditors and has failed to obtain the agreement of creditors holding at least a majority in amount of the claims of each class that such entity intends to impair under a plan in a case under such chapter;
- (C) is unable to negotiate with creditors because such negotiation is impracticable; or
- (D) reasonably believes that a creditor may attempt to obtain a transfer that is avoidable as a preference under Section 547 of the Bankruptcy Code.

⁸ Typically, an involuntary petition can be filed against a company by at least three creditors holding liquidated claims that are undisputed as to both liability and aggregate an amount of at least \$14,425, as indexed under current law. 11 U.S.C. § 303(b)(1).

specific facts of the case.⁹ An ombudsman is required to monitor the quality of patient care, represent the interests of the patients during the bankruptcy case and protect confidential patient records and property. The ombudsman must report to the bankruptcy court every 60 days (with a copy to all parties in interest) regarding the quality of patient care. If the ombudsman determines that the quality of patient care is declining or otherwise being materially compromised, he or she must detail that determination in a written report that must be filed with the court immediately after the determination is made.

The fees of the ombudsman, which may include the fees of any professionals retained by the ombudsman, are paid by the estate¹⁰ and are entitled to administrative expense priority.¹¹

Disposition of Patient Records

Several non-bankruptcy laws protect patient privacy (e.g., the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”)), and debtors are required to continue to comply with these laws once they file for bankruptcy.¹² For example, a debtor is required to store patient records¹³ according to applicable state and federal law, which can be for up to 20 years in the case of minors. These storage costs may be millions of dollars depending upon the number of patients. Courts may require the appointment of a consumer privacy ombuds-

⁹ 11 U.S.C. § 333(a)(1). Courts have applied a nine-factor analysis to evaluate the need for appointment of an ombudsman: (1) the cause of the bankruptcy; (2) the presence and role of licensing or supervising entities; (3) the debtor’s past history of patient care; (4) the ability of the patients to protect their rights; (5) the level of dependency of the patients on the facility; (6) the likelihood of tension between the interests of the patients and the debtor; (7) the potential injury to the patients if the debtor drastically reduced its level of patient care; (8) the presence and sufficiency of internal safeguards to ensure the appropriate level of care; and (9) the impact of the cost of the ombudsman on the likelihood of a successful reorganization. *In re Denali Family Services*, 2013 BL 110612 (Bankr. D. Alaska, Apr. 24, 2013), citing *In re Alternate Family Care*, 2007 BL 137571, *3-4, 377 B.R. 754, 758 (Bankr. S.D. Fla. 2007). No single factor is determinative, and the weight to be given individual factors depends upon the circumstances of the case.

¹⁰ Courts are split on whether the fees of an ombudsman’s legal counsel must be paid by the estate. If the ombudsman is permitted to hire counsel, such costs would be administrative expenses of the estate. Some courts have held that an ombudsman may hire counsel, relying on Section 105 of the Bankruptcy Code. *In re Synergy Hematology-Oncology Medical Associates Inc.*, 2010 BL 208, *2-3, 433 B.R. 316, 319 (Bankr. C.D. Cal. 2010) (court likened the ombudsman to an examiner, which often retains counsel). However, other bankruptcy courts have not permitted an ombudsman to hire counsel. *In re Renaissance Hospital-Grand Prairie Inc.*, 2008 BL 288446, at **2-3, 399 B.R. 442, 445-446 (Bankr. N.D. Tex. Dec. 31, 2008) (court noted that the ombudsman’s concern was with the health of the debtor’s patients, not with the status of the debtor’s estate). *ABI Health Care Insolvency Manual 50* (Leslie Ann Berkoff & Timothy Lupinacci eds., 3d ed. 2012).

¹¹ 11 U.S.C. § 503(b).

¹² See Fed. R. Bankr. P. 6011.

¹³ The Bankruptcy Code defines “patient records” as any record relating to a patient, including a written document or a record recorded in a magnetic, optical or other form of electronic medium. 11 U.S.C. § 101(40B).

man to address issues relating to the maintenance and transfer of patient records.¹⁴

If a debtor is liquidating, or no longer can afford the storage costs, the Bankruptcy Code permits the destruction of patient records, provided the debtor complies with extensive notice requirements.¹⁵ These notice requirements include publishing notice in one or more “appropriate” newspapers and providing patients with one year to claim their records.¹⁶ During the first six months of this one-year period, the debtor must attempt to notify each affected patient and his or her insurance carrier by mail of the impending destruction of patient records. If patients do not claim their records within one year, the debtor must notify “appropriate Federal agencies” and request that they accept the records.¹⁷ If no agency accepts the records, then the debtor must destroy the records.¹⁸ The debtor must retain proof of its compliance with the destruction procedures and file a report with the court detailing the process.

The costs incurred in notifying patients of the impending destruction of their records, and in destroying the records, are entitled to administrative expense priority.¹⁹ Depending on the size of the health care business, these expenses may total millions of dollars. If the debtor is administratively insolvent, the costs of destroying these records could potentially be surcharged against a secured lender’s collateral.²⁰

Patient Transfers

If a health care business will close, it is required to transfer its patients to another facility that provides substantially similar care and is within the vicinity. These patient transfers are subject to regulatory oversight (e.g., New York State requires that the Department of Health approve a “closure plan”). Debtors must use “all reasonable and best efforts to transfer patients.”²¹ Further, debtors must provide patients with 14 days’ notice prior to their transfer.²²

Any costs incurred in transferring patients are entitled to administrative expense priority.²³

Issues Unique to Financing Health Care Receivables

Health Care Receivables

A health care borrower’s primary collateral in many cases will be its accounts receivable. By way of background, health care accounts receivable fall into three categories:

1. Government collections (e.g., Medicare/Medicaid);
2. Commercial collections

¹⁴ 11 U.S.C. § 332, *see also*, *St. Vincent’s Catholic Med. Ctrs. of N.Y., et al.*, Case No. 10-11963 (Bankr. S.D.N.Y. Apr. 16, 2010).

¹⁵ 11 U.S.C. § 351.

¹⁶ 11 U.S.C. § 351(1)(A).

¹⁷ 11 U.S.C. § 351(2).

¹⁸ 11 U.S.C. § 351(3).

¹⁹ 11 U.S.C. § 503(b)(8)(A).

²⁰ *See* H.R. Rep. No. 109-31, at 139 (2005).

²¹ 11 U.S.C. § 704(a)(12).

²² Fed. R. Bankr. P. 2015.2.

²³ 11 U.S.C. § 503(b)(8)(B).

(e.g., Blue Cross/Blue Shield, etc.);²⁴ and
3. Self-pay collections (e.g., individuals).

Under Article 9 of the Uniform Commercial Code (“UCC”), health care receivables may be classified as “accounts,” “health care insurance receivables,”²⁵ or “payment intangibles.”²⁶ The categorization of the health care receivable will depend on the source of funding for that receivable.²⁷

Exercising Remedies Against Receivables and the Impact of Anti-Assignment Rules

Exercising remedies on government accounts receivable is complicated because the receivables are subject to related federal and state rules affecting Medicaid and other governmental health care programs, collectively, the “Anti-Assignment Rules.” Subject to a few narrow exceptions, federal law provides that Medicare and Medicaid receivables only can be paid to the individual receiving care or a health care provider, and may not be assigned to another entity (e.g., the provider’s lender) pursuant to an assignment.²⁸ These Anti-Assignment Rules require that Medicare and Medicaid payments be made only to a deposit account over which the health care provider has sole control.²⁹ Any attempt by a borrower to assign Medicare or Medicaid receivables in violation of the Anti-Assignment Rules may result in the termination of the borrower’s provider agreement. On its face, the Anti-Assignment Rules may appear to void any security interest in Medicare receivables; however, courts have routinely held that health care businesses

²⁴ Note, if the account party is a private insurer, direct notification of a security interest in its receivables should be given as an additional method of perfection. Clark, *The Law of Secured Transactions Under the Uniform Commercial Code* ¶ 10.07[1][a].

²⁵ A “health care insurance receivable” is defined as “an interest in or claim under a policy of insurance which is a right to payment of a monetary obligation for health care goods or services provided.” U.C.C. § 9-102(46). Article 9 expressly applies to private health care insurance receivables. *See* U.C.C. § 9-109(d)(8). “Health care insurance receivables” includes health care accounts receivable from commercial payors, but *not* from individual or governmental payors. “This special category of insurance receivable was brought within the scope of Article 9 to facilitate the sale of these receivables by their originators.” Clark, *The Law of Secured Transactions Under the Uniform Commercial Code* ¶ 10.07[1][a].

²⁶ Article 9 defines a “payment intangible” as “a general intangible under which the account debtor’s principal obligation is a monetary obligation.” U.C.C. § 9-102(61).

²⁷ Certain payments made by the government (e.g., Medicare) technically may not be for services rendered by the health care provider, but rather are assignments of payments made to patients who are entitled to receive disbursements from federal or state trust accounts established to provide coverage for medical care. As a result, certain payments from governmental payors are treated as “payment intangibles” under Revised Article 9. For example, Medicare and Medicaid receivables are *not* “health care insurance receivables” because they do not represent an interest in or a claim under an insurance policy. Rather, they are a product of government entitlement programs; the beneficiary is the health care provider and not the patient.

²⁸ *See* 42 U.S.C. § 1395g(c)(1), (c)(2) (setting forth exceptions for assignments established by an order of a court or for payment to billing agents of the Medicare provider).

²⁹ Commercial payors and individuals can make payments directly into a deposit account controlled by the lender.

are permitted to pledge these receivables (and their proceeds) in connection with a loan, provided that the receivable is not paid into an account over which the lender has control.³⁰

Because lenders cannot have control of accounts into which Medicare or Medicaid payments are made, they are not perfected in the account itself. Thus, lenders typically establish a second deposit account under the lender's control into which the governmental payments are swept daily.

Once a borrower files for bankruptcy, a lender must stop the automatic sweeping of cash from the borrower's account due to the Bankruptcy Code's automatic stay. Further, a lender's "floating lien" on after-acquired property is cut off as of the petition date.³¹ This generally means that a lender retains its lien on accounts receivable generated *before* the petition date (even if they are collected after the bankruptcy is commenced), but loses its lien on accounts receivable generated *after* the petition date. The debtor, however, cannot use the cash it has on hand or from accounts receivable generated before the petition date (i.e., the lender's cash collateral) without the lender's consent. Thus, debtors and lenders typically will enter into cash collateral agreements, adequate protection stipulations or debtor-in-possession ("DIP") financing arrangements (discussed below) that provide the debtor with the use of the lender's cash collateral in exchange for replacement liens on the debtor's postpetition receivables and cash.

■ *Why Lenders Should Care:* Continuing to sweep cash from a borrower's cash management account after the borrower files for bankruptcy can expose a lender to litigation for violating the automatic stay. Absent bankruptcy court approval, lenders who sweep cash post-bankruptcy likely will be forced to disgorge that cash, may face court sanctions and certainly will aggravate the bankruptcy judge. The best approach for a lender is to negotiate a cash collateral or DIP financing order that will provide specific protections for its collateral (discussed below).

Setoff and Recoupment of Overpayment

Setoff and recoupment are the most significant risks a health care lender secured by government receivables

may face. These are equitable remedies that may permit the government to stop future payments to the debtor for services rendered—in some cases without court approval—which may result in the lender having advanced funds against receivables that have been reduced or eliminated altogether.

The Government's Procedure for Paying Providers

1. Medicare, the Center for Medicare and Medicaid Services ("CMS") and health care providers enter into provider agreements that govern a health care provider's participation in the Medicare/Medicaid program.
2. CMS contracts with private insurance companies, known as fiscal intermediaries, to facilitate reimbursements to the health care providers.³²
3. The fiscal intermediaries distribute reimbursements to health care providers in interim amounts based on the estimated cost of providing care for Medicare beneficiaries.³³
4. At the end of each fiscal year, health care providers submit a report to the fiscal intermediary, and the intermediary reconciles the actual costs incurred by the health care provider against the estimated costs already paid.³⁴
5. If the payments made are *less* than the costs actually incurred by the provider, then the government pays the provider the difference.
6. If the payments made are *more* than the costs actually incurred by the provider, then the government is entitled to recover the overpayments.

Recovery of Overpayments

The government has two principal means to recover overpayments: (1) setoff; and (2) recoupment.³⁵

1. **Setoff:** Setoff is a right to offset debt owed to another party by claims against that party.³⁶ A creditor may exercise its setoff rights only if there is a *mutual debt* between the creditor and the debtor (i.e., same parties on both sides) *that arose before*

³⁰ See, e.g., *In re Missionary Baptist Found. of America*, 796 F.2d 752 (5th Cir. 1986) (anti-assignment rules were not intended to prohibit the granting of a security interest in governmental receivables where health care provider had control over initial payment from the governmental entity); *DFS Secured Health Care Receivables Trust v. Caregivers Great Lakes, Inc.*, 384 F.3d 338 (7th Cir. 2004) (held "nothing suggests that Congress intended to prevent health care providers from assigning receivables to a non-provider."); *but see, Credit Recovery Systems LLC v Hieke*, 158 F.Supp. 2d 689 (E.D. Va. 2001) (held that the right to receive direct payments from the government cannot be assigned, effectively preventing a secured lender from exercising its remedies without a court order); see also Clark, *The Law of Secured Transactions Under the Uniform Commercial Code* ¶ 10.07[1][b] (noting that state decisions involving Medicaid reach similar conclusions.).

³¹ 11 U.S.C. § 552(a) ("Except as provided in subsection (b) of this section, property acquired by the estate or by the debtor after the commencement of the case is not subject to any lien resulting from any security agreement entered into by the debtor before the commencement of the case.").

³² 42 U.S.C. § 1395h; 42 C.F.R. § 413.64.

³³ 42 U.S.C. § 1395g; 42 C.F.R. § 413.60, 413.64.

³⁴ Medicaid reimbursements are often similarly governed under state law through provider agreements that provide for estimated payments followed by an annual reconciliation.

³⁵ The overpayment collection process typically begins with a demand letter and an opportunity for the health care provider to respond to the asserted overpayment. Recoupment procedures will begin 41 days after the first demand letter is sent. Repayment plans may be available if a health care provider cannot repay the overpayment in full within 120 days. If a health care provider disagrees with a determination that it must repay an overpayment, it may file an appeal with the fiscal intermediary. See <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/OverpaymentBrochure508-09.pdf>.

³⁶ *Citizens Bank of Maryland v. Strumpf*, 516 U.S. 16, 18-19 (1995) ("The right of setoff allows entities that owe each other money to apply their mutual debt against each other, thereby avoiding the absurdity of making A pay B when B owes A.") (citation omitted).

the commencement of the bankruptcy case.³⁷ The debts held by the creditor and the debtor do not need to arise from the same transaction; however, they must both arise prepetition, and the claims and the debts must be mutual obligations that are valid and enforceable.³⁸ A creditor with a setoff right is treated as a secured creditor to the extent of its right of setoff.³⁹ However, a creditor must seek court authorization prior to exercising its right of setoff.⁴⁰

2. Recoupment: Recoupment is the right to reduce the amount of a claim or debt owed to a debtor.⁴¹ Recoupment may only arise out of the *same transaction* or occurrence that gives rise to the liability sought to be reduced.⁴² Several courts have characterized the government's postpetition recovery of prepetition overpayments as recoupment.⁴³ This is particularly problematic for lenders because if an overpayment is determined to have been made by the government before the bankruptcy case under the applicable provider agreement, postpetition receivables arising under that same provider agreement against which the lender advanced loans may be retained by the government and may not be available for payment to the lender.⁴⁴

Difference Between Setoff and Recoupment

While recoupment and setoff are similar concepts, they are different in that: (1) recoupment must be based on a *single* transaction, whereas set-off may involve mutual debts arising from *different* transactions; and (2) unlike setoff, recoupment does not require that both debts arise prepetition.

Most courts have held that the automatic stay does not apply to recoupment because funds subject to re-

coupment are not property of the debtor's estate.⁴⁵ Thus, the government may exercise its right of recoupment without court approval. Because recoupment does not require relief from the automatic stay, it is the government's and financial intermediaries' preferred means of recovering overpayments.

The Government as Unitary Creditor

Further complicating a lender's analysis, courts have held that the federal government is a single creditor for setoff mutuality purposes. Thus, the federal government can set-off prepetition amounts that it owes to a debtor under the Medicare program against prepetition amounts that the debtor owes to, for example, the IRS. Thus, any amounts owed by the government to the debtor are susceptible to setoff against amounts the debtor owes to the government *in any capacity*.⁴⁶

Under many state laws, the result is the same.⁴⁷ In fact, several states have statutes that expressly permit the state to set-off against any amounts owed to any of its agencies, and that statutory right is deemed an implied term of any contract between the state and the health care provider.⁴⁸

Setoff and recoupment can result in a governmental agency's unsecured claim priming a lender's secured claim. For example, if a governmental agency has a general unsecured claim against the debtor, the government may set-off that claim (dollar for dollar) against Medicare or Medicaid receivables owed to the debtor.

⁴⁵ See, e.g., *In re Doctors Hospital of Hyde Park Inc.*, 337 F.3d 951, 954 (7th Cir. 2003) (held that health care lender's right in the receivables is subject to the government's right for recoupment on the ground that the government "never owed the [health care provider] the full amount of the accounts receivable because it had overpaid, and so the full amount was not the [health care provider's] to assign to the [lender]. Recoupment of that amount merely confirmed the assignee's debt to the express terms of the contract between the account debtor and the assignor."); *In re Malinowski*, 156 F.3d 131, 133 (2d Cir. 1998). Some lower courts, however, have held that recoupment may be subject to the automatic stay. *In re Klinberg Schools*, 68 B.R. 173, 178 n.8 (N.D. Ill. 1986), aff'd 837 F.2d 763 (7th Cir. 1988) (suggesting that automatic stay applies to recoupment); *In re Heafitz*, 85 B.R. 274, 280 (Bankr. S.D.N.Y. 1988) (holding that a party must seek relief from court to exercise right to recoupment).

⁴⁶ See e.g., *In re Alliance Health of Fort Worth, Inc.*, 240 B.R. 699 (N.D. Tex. 1999), aff'd 200 F.3d 816 (5th Cir. 1999) (held that federal government may set-off amounts that Health and Human Services owed to the debtor under the Medicare program by amounts the debtor owed to the IRS); *In re Nuclear Imaging Systems*, 260 B.R. 724 (Bankr. E.D. Pa. 2000) (held that federal government acting in capacity as reimbursor of health care providers is same entity as government tax collector for purposes of setoff). The Fifth Circuit has determined that even a subordinated claim can be used to set-off a claim by the bankruptcy estate against a creditor even though the subordinated claim could not itself share in the dividends. *Rochelle v. United States*, 521 F.2d 844, 855 (5th Cir. 1975), cert. denied, 426 U.S. 948 (1976).

⁴⁷ See, e.g., *In re Doctors Hospital of Hyde Park, Inc.*, 337 F.3d 951 (7th Cir. 2003) (held that Illinois permitted to set-off amounts owed to hospital against taxes owed to Illinois Comptroller under state statute).

⁴⁸ Clark, *The Law of Secured Transactions Under the Uniform Commercial Code* ¶ 10.07[1][c].

³⁷ 11 U.S.C. § 553(a).

³⁸ *Strumpf*, at 18-19 ("Although no federal right of setoff is created by the Bankruptcy Code, [Section] 553(a) provides that, with certain exceptions, whatever right of setoff otherwise exists is preserved in bankruptcy.").

³⁹ 11 U.S.C. § 506(a).

⁴⁰ 11 U.S.C. § 362(a)(7).

⁴¹ See 5 Collier on Bankruptcy ¶ 553.10 (16th ed. 2010) (internal quotation omitted).

⁴² *Id.*; see also *University Medical Center v. Sullivan (In re University Medical Center)*, 973 F.2d 1065, 1079-80 (3d Cir. 1992) ("Recoupment is the setting up of a demand arising from the same transaction as the plaintiff's claim or cause of action, strictly for the purpose of abatement or reduction of such claim.").

⁴³ See, e.g., *In re Holyoke Nursing Home Inc.*, 372 F.3d 1 (1st Cir. 2004); *United States v. Consumer Health Services of America Inc.*, 108 F.3d 390, 395 (D.C. Cir. 1997); *In re Doctors Hospital of Hyde Park Inc.*, 337 F.3d 951 (7th Cir. 2003); *In re District Memorial Hospital of Southwestern North Carolina Inc.*, 297 B.R. 451 (Bankr. W.D.N.C. 2002); *State of Illinois v. Daiwa Special Asset Corp.*, 291 B.R. 453 (N.D. Ill. 2002).

⁴⁴ Note that certain commercial receivables also carry set-off and recoupment risks. For example, many forms of managed care are set up with a capitation-payment model in which the health care provider receives a monthly fee per managed care member in exchange for agreeing to treat the members. However, in some situations, those capitation payments are subject to offsets or recoupments against future payments if a higher-than-expected number of members seeks treatment elsewhere.

Timing for Exercise of Setoff and Recoupment

There are two situations in which the government or a fiscal intermediary may act:

1. Evidence of Financial Trouble: If there is reliable evidence that: (a) the provider is financially troubled; and (b) an overpayment has been made, then, after compliance with certain procedural requirements (i.e., 15 days' notice), the government may suspend payments to a health care provider.⁴⁹
2. Evidence of Imminent Bankruptcy: If there is reliable evidence that insolvency proceedings will shortly be instituted, the government may suspend payments, even if there has been no determination that an overpayment exists. Thus, in the case of an impending bankruptcy, the government may make a "preemptive withholding" without regard to its procedural requirements.⁵⁰

How to Limit Setoff and Recoupment in Bankruptcy

Lenders and borrowers should have a plan for managing the government's and commercial providers' attempts to recoup and set-off against health care receivables before the health care provider enters bankruptcy. If a consensual resolution cannot be reached before the borrower files, however, the following are some ways to mitigate this significant risk.

Utilize the Bankruptcy Code's Anti-Discrimination Provision

Health care providers have argued that the government's withholding of postpetition reimbursements violates the Bankruptcy Code's anti-discrimination provision.⁵¹ The Bankruptcy Code provides, among other things, that the government may not revoke, suspend or refuse to renew a license or permit solely because a debtor is in bankruptcy or was insolvent before the commencement of the bankruptcy case. In order to prove the government's actions violate the anti-discrimination provision, a health care provider must demonstrate that: (1) the provider agreements are government licenses; and (2) the government's exercise of remedies was done "solely because" of the provider's bankruptcy.

⁴⁹ See 42 C.F.R. § 405.370.

⁵⁰ See 42 C.F.R. § 413.64(i). Note that if a court determines that the withholding of payments was a permissible recoupment, then such withholding would not constitute a preference because recoupment does not involve a "transfer," which is a necessary element of a preference. See *In re Yonkers Sanitarium, Inc.*, 34 B.R. 385 (S.D.N.Y. 1983).

⁵¹ 11 U.S.C. § 525; see *Health Care Financing Admin. v. Sun Health Care Group, Inc.* (*In re Sun Health Care Group, Inc.*), 2002 U.S. Dist. LEXIS 17868 (D. Del. Sept. 4, 2002); *Hiser v. Blue Cross of Greater Philadelphia* (*In re St. Mary Hosp.*), 89 B.R. 503, 504 (Bankr. E.D. Pa. 1988) ("the two fundamental principles pervading all bankruptcy law—equality of treatment of creditors and providing a 'fresh start' to a beleaguered debtor—cut strongly in favor of the debtor. . . principally due to the impact of 11 U.S.C. § 525(a) upon this controversy, the debtor cannot be compelled to pay prepetition obligations to [Human and Health Services] as a condition for continued participation by Human and Health Services in the Medicare program").

Obtain Protections in a Financing Order

A discussion of financing orders and protections that lenders may obtain is included below.

Equitable Balancing

A debtor may attempt to limit the government's recoupment right by arguing that recoupment eliminates its chance for a fresh start, which is the purpose of the Bankruptcy Code. Recoupment is an equitable common law doctrine, rather than a statutory right, and thus arguably should be subject to the Bankruptcy Code's equitable powers.

■ *Why Lenders Should Care:* A government's right of setoff or recoupment may prime a secured lender's lien, thereby reducing the collateral available to satisfy the lender's claim.⁵² What is worse, even an unforeseen governmental entity, such as the IRS, may set-off amounts owed by a debtor against amounts the government owes to the debtor under its provider agreements.

Debtor-in-Possession Lending

Permitting the use of a lender's cash collateral and DIP loans can provide several important protections for lenders, including protecting a lender from the government's and commercial providers' attempts to set-off and recoup prepetition overpayments. Being a DIP lender also ensures that the lender has a voice in the direction of the case and the disposition of its collateral. However, as set forth below, lenders must focus on an exit strategy more than they might for DIP loans made in other industries where collateral values govern to a greater degree. Among other things, the extensive regulation of the health care industry and the significant amount of time it may take to close a sale or reach the effective date of a plan of reorganization can keep a lender involved in a case longer than it otherwise might anticipate.

Financing Orders Can Provide Significant Collateral Protections

In addition to the typical collateral protections that a lender may obtain in a financing order, such as adequate protection of its prepetition liens and claims, a financing order may include language minimizing set-off and recoupment risk by expressly stating that the lenders' rights and liens prime the government's interest.⁵³ An example of such limiting language is included in Exhibit A to this article. If the court will not enter a financing order containing such express language, the lender should work with the government to define the parameters of potential setoffs or other reductions to receivables so that all parties in interest will know what receivables may be included in (or must be excluded from or reserved against) the borrowing base.

⁵² *In re Metropolitan Hospital*, 131 B.R. 283 (E.D. Pa. 1985) (bondholders secured by receivables owing to the hospital and the government battled over their claim priority; court upheld government's ability to set-off against overpayments received by the debtor prepetition, holding that the bondholders had "knowledge" or should have known from the beginning of the government's potential setoff right).

⁵³ See, e.g., *In re Sun Health Care Group, Inc.*, 245 B.R. 779, 782-83, 785 (Bankr. D. Del. 2000) (restrictions imposed upon governmental payors asserting setoff or recoupments rights).

Risks Associated with Financing

While a lender typically benefits from providing DIP financing or permitting the use of its cash collateral, there are some risks. In addition to potential setoff and recoupment, discussed above, it is possible—even likely—that it will take longer for a debtor to collect postpetition payments than it did prepetition. Fiscal intermediaries may take longer to pay in order to determine whether to suspend payments at the outset of the case while any overpayments are being identified. The government may stop payments to a health care provider while it determines whether it has made any overpayments that are eligible for setoff or recoupment. This slowdown in payments may be obviated if first-day orders entered in the bankruptcy case plainly set forth each party's right to setoff and recoupment.

Plan for the Worst in the Budget

It is vital for a secured lender to understand the potential costs and expenses that may be associated with closing a health care facility prior to making a DIP loan or permitting the use of its cash collateral. While it may not be the provider's intention at the start of the case, the health care business (or some portion of it) may be required to close if the bankruptcy case does not progress as expected or in order to shed an underperforming asset. As discussed above, there are several costs associated with closing a health care business that are entitled to administrative expense priority and that must be considered when creating a budget. If those administrative expenses cannot be paid by the estate, it is possible that the lender's collateral may be surcharged.⁵⁴

Jurisdiction over Medicare/Medicaid Disputes

Both Medicare and Medicaid contain extensive dispute resolution mechanisms that require providers to exhaust administrative remedies before they can turn to a court. Bankruptcy courts, on the other hand, have exclusive jurisdiction over property of a debtor's estate. This tension between the required administrative remedies of Medicare and Medicaid and the bankruptcy court's exclusive jurisdiction over a debtor's estate are critical to lenders because the forum in which a dispute will be heard likely will determine whether (and how quickly) a bankrupt borrower can continue to receive governmental payments. The government often will argue that its administrative process must be completed in order to liquidate a provider's right to payment, whereas a health care debtor will argue that the bankruptcy court is the proper forum for this determination.

Decisions on this important issue go both ways. Several decisions hold that a bankruptcy court has no jurisdiction over Medicare disputes, concluding, among other things, that: (1) there is no bankruptcy jurisdiction to review an administrative determination of Medicare overpayments, which only can be determined through the government's audit review process;⁵⁵ (2) the automatic stay does not apply to the government's

⁵⁴ 11 U.S.C. § 506(c).

⁵⁵ See, e.g., *In re St. Mary Hosp.*, 123 B.R. 14 (Bankr. E.D. Pa. 1991); *In re Visiting Nurse Ass'n of Tampa Bay, Inc.*, 121 B.R. 114 (Bankr. M.D. Fla. 1990); *In re Clawson Med. Rehabilitation & Pain Care Ctr.*, 12 B.R. 647 (E.D. Mich. 1981); *In re St. John's Home Health Agency Inc.*, 173 B.R. 238 (Bankr. S.D. Fla. 1994); 42 U.S.C. § 1395oo; 42 C.F.R. § 405.1801–405.1877.

withholding of reimbursement; and (3) no jurisdiction exists to extend a health care provider's time to comply with Medicare filing deadlines in connection with the government's dispute process.⁵⁶ According to these decisions, the absence of an immediate avenue of relief for a financially strapped debtor is a consequence of doing business in a heavily regulated field.

On the other hand, several courts have determined that they are vested with jurisdiction to deal with Medicare/Medicaid issues, holding that a bankruptcy court has: (1) the right to issue a preliminary injunction against the exclusion of a provider from participating in the Medicare program; (2) jurisdiction over Medicare claims;⁵⁷ and (3) the power to enforce the automatic stay against the government's recoupment rights where the recoupment issue is not inextricably intertwined with any dispute concerning the reimbursement determination.⁵⁸ These courts hold that bankruptcy court jurisdiction and the overall rehabilitative goal of the bankruptcy process take precedence over Medicare administrative jurisdiction.⁵⁹

■ **Why Lenders Should Care:** Adjudication of Medicare disputes is important because continuous receipt of government receivables likely will be vital to a health care provider's ability to operate. Whether the government has the unilateral authority to stop making payments or to revoke or not reissue a provider agreement will affect whether a health care provider can reorganize at all. Debtors and lenders should be cognizant of how courts have treated disputes regarding Medicare and Medicaid when determining the forum in which the health care provider intends to file for bankruptcy.

Bankruptcy Sale Considerations

Significant M&A Activity in Bankruptcy

The volume of hospital merger and acquisition transactions increased by more than 300 percent in the years between 2008 and 2010, due to factors that include health care reform, lack of access to capital, the need to gain leverage in negotiating with payors, and increased participation by private equity in the health care industry.⁶⁰ Bankruptcy affords a unique opportunity for ac-

⁵⁶ See, e.g., *In re Orthotic Ctr., Inc.*, 193 B.R. 832 (N.D. Ohio 1996); *In re Berger*, 16 B.R. 236 (Bankr. S.D. Fla. 1981).

⁵⁷ These courts hold that they have jurisdiction under 28 U.S.C. § 1334 despite the requirement under the Social Security Act, which precludes judicial review of any "claim arising under" the Medicare statute prior to the exhaustion of administrative remedies. 42 U.S.C. § 405(h).

⁵⁸ See, e.g., *In re Richmond Paramedical Servs., Inc.*, 94 B.R. 881 (Bankr. E.D. Va. 1988), *aff'd*, 1989 U.S. Dist. LEXIS 18058 (E.D. Va. 1989); *In re Shelby County Health Care Servs. of AL, Inc.*, 80 B.R. 555 (Bankr. N.D. Ga. 1987); *In re University Med. Ctr.*, 973 F.2d 1065 (3d Cir. 1992).

⁵⁹ *In re University Med. Ctr.*, 973 F.2d 1065, 1072-74 (3d Cir. 1992); *In re Town and Country Home Nursing Servs.*, 112 B.R. 329 (9th Cir. 1992); *In re First American Health Care of Georgia*, 208 B.R. 985, 989-90 (Bankr. S.D. Ga. 1996); *In re Rusnak*, 184 B.R. 459 (Bankr. E.D. Pa. 1995); *In re Tidewater Mem'l Hosp., Inc.*, 106 B.R. 876, 880 (Bankr. E.D. Va. 1988), *aff'd*, 1989 U.S. Dist. LEXIS 18058 (E.D. Va. 1989); *In re Rowan*, 15 B.R. 834 (Bankr. N.D. Ohio 1981), *aff'd*, 747 F.2d 1052 (6th Cir. 1984).

⁶⁰ *ABI Health Care Insolvency Manual* 69 (Leslie Ann Berkoff & Timothy Lupinacci eds., 3d ed. 2012).

quirers because they may obtain significant assets free and clear of liens and other obligations. For this reason, bankruptcy is a popular venue for M&A activity and a chief means for lenders to be repaid.

Sale Considerations

There are several factors that lenders should consider when working with a borrower to structure an asset sale.

Highest Bid May Not Win Auction

In most bankruptcy cases, the highest bidder wins the auction. However, in health care provider bankruptcy cases, courts also consider the preservation of the provider's services in the community. One example is the case of *In re United Healthcare System, Inc.*⁶¹ In this case United Healthcare System ("United"), a not-for-profit, operated a children's hospital and an acute care facility in Newark, New Jersey. In dire straits, United solicited bids for its assets, and four bidders responded. The Commissioner of Health and Senior Services of New Jersey (the "Commissioner"), citing the urgent need to continue health care services to the community, required that the sale be completed in one month. United's Board of Trustees (the "Board"), working with the Commissioner, selected a bidder ("St. Barnabas") that had a significant presence in New Jersey. To facilitate the sale, the Commissioner provided a Certificate of Need authorizing the closing of the hospital and granted St. Barnabas a license to operate the children's hospital. St. Barnabas, however, wanted to avoid assuming many of United's liabilities, and thus, the purchase agreement required that United file for bankruptcy so that the assets could be sold in a 363 sale.

United filed for bankruptcy and immediately sought bankruptcy court approval of its proposed private sale to St. Barnabas. One of the bidders whose bid was not selected, however, objected to the sale and submitted an unsolicited bid that it asserted was higher and better than the one proposed by United and St. Barnabas. After a four-day hearing, the bankruptcy court concluded that the St. Barnabas sale could not be approved because, among other things, the Board's decision to award the sale to St. Barnabas "was not a sound business judgment" and "'defeated the ability of [the Bankruptcy] Court to carry out its function to obtain a fair price for the debtor's assets for the benefit of the creditors of this estate.'" ⁶²

The district court highlighted the need in cases such as this to consider the public health and pointed out that the accelerated timetable was mandated by the Commissioner. Thus, the district court concluded that it could not "mechanically apply bankruptcy principles of 'highest and best' offer."⁶³

⁶¹ *In re United Healthcare Sys.*, 1997 U.S. Dist. LEXIS 5090 (D.N.J. Mar. 26, 1997).

⁶² *Id.* at *9.

⁶³ *Id.* at *21 ("Courts are not experts in public health and safety issues and this Court bows to the knowledge of the Commissioner in those areas. If the Commission felt that there was a public need for the Children's Hospital to be operated as a unit in northern New Jersey, federal courts should accept it as such.").

License to Operate/Assignability

Transferring a license to operate will be restricted to a limited group of buyers. The licensor will need to approve the transfer of the license to the proposed purchaser/assignee of that license. This will restrict the number of potential buyers for a health care provider (at least as a going concern).

Regulations

Marketing efforts must be restricted to parties that will satisfy regulatory approval criteria. The sale of many health care businesses and their assets to a third-party purchaser often requires approval from a state department of health.⁶⁴

For-Profit

A bankruptcy asset sale may permit a for-profit debtor to avoid some regulatory hurdles in connection with a sale under a plan of reorganization. For example, the Bankruptcy Code provides that "notwithstanding any otherwise applicable non-bankruptcy law," (i.e., state law) a plan may provide for the sale of all or any part of the property of the estate, either subject to or free of any lien.⁶⁵ Thus, a plan could provide for a sale to occur *without* regulatory agency approval, which might otherwise be required by state law.⁶⁶ Note that any such proposed sale likely would result in significant litigation from interested parties and could restrict the buyer's ability to operate upon consummation of the sale.

Not-for-Profit

Unlike for-profit entities, bankruptcy asset sales of not-for-profit health care businesses must comply with otherwise applicable non-bankruptcy law, whether the sale is pursuant to Section 363 of the Bankruptcy Code or a plan of reorganization.⁶⁷ Complying with state law and regulations may negate some of the benefits of conducting a 363 sale by limiting the number of potential buyers. For example, in New York, a not-for-profit health care business may only sell its assets to another not-for-profit; however, in New Jersey, a not-for-profit may sell its assets to a for-profit entity. Thus, it is critical that lenders and their counsel understand the interplay of bankruptcy law and state and federal health care regulations when financing a health care business.

Hill-Burton Obligations

The Hill-Burton program is a federal loan and grant program that provides for the construction and modernization of not-for-profit and public health care facilities. Recipients of Hill-Burton funds obligate themselves to: (1) provide uncompensated care for either 20 years or perpetually; (2) provide community service, including participation in Medicare and Medicaid; and (3) complete certain compliance reporting. The government may recover grant funds used for the construction or

⁶⁴ See, e.g., N.Y. Pub. Health Law Section 2801-a, et seq.

⁶⁵ 11 U.S.C. § 1123(a)(5)(D).

⁶⁶ *Id.*; see also 11 U.S.C. § 1123(a)(5) (giving broad authority for using an unrestricted list of possible means in a plan for its implementation); *In re Public Serv. Co. of New Hampshire*, 108 B.R. 854, 890-91 (Bankr. D.N.H. 1989) (holding that 11 U.S.C. § 1123(a)(5) preempts state regulatory law).

⁶⁷ See § 363(d)(1), 541(f), 1129(a)(16). Note, however, that BAPCPA failed to amend § 1123(a).

modernization of a facility if, within 20 years after completion of the construction or modernization, the facility is: (1) sold or transferred to an entity that is not qualified for a grant or not approved as a transferee by the state agency; or (2) ceases to be a public or other not-for-profit hospital, outpatient facility, facility for long-term care or rehabilitation facility. A “transfer” occurs when the facility is conveyed to another entity through lease, merger, bankruptcy, foreclosure or other arrangement.

The government is entitled to recover a portion of the original grant funds based generally on the percentage of federal funds used in construction or modernization of the facility. Under certain circumstances, the government may waive its recovery rights. Regardless of the government’s failure to participate in a bankruptcy case, the government may recover grant funds from a transferee and any subsequent transferee.

Sale Closing Delays

Regulatory approval of a sale often will occur after the approval by the bankruptcy court. This means that the time between the bankruptcy court’s approval of a sale and when the sale can close may take several months, or longer. In the *St. Vincent’s* bankruptcy case, the sale did not close until more than one year after the bankruptcy court authorized the sale. Thus, a lender may be stuck in a health care case longer than it otherwise would be in the sale of other assets, and, if the lender is providing DIP financing, may be required to provide additional interim financing.

Final Medicare Report

If a final Medicare report is not filed within 45 days of the closing of a health care facility, the facility’s final Medicare payment may be forfeited.

Other Issues for Lenders to Consider

Malpractice Insurance

Physicians will be concerned about whether they will continue to be covered by the health care provider’s insurance policies. If an indemnification obligation arises out of a prepetition employment agreement, then the employee only has a general unsecured claim for that obligation. To continue operations, the health care facility may need to restructure its insurance policies to provide continuing coverage (i.e., tail coverage). Secured lenders often will be requested to fund this coverage. Communication with physicians is critical to ensure that they understand their coverage and continue to work with the facility.

Critical Vendors

Lenders must work with management to identify vendors and suppliers that have contracts that do not require them to continue to provide goods or services and are necessary for patient care. The borrower may be able to renegotiate contracts with these vendors to improve liquidity in exchange for requesting that the court approve the payment of their prepetition fees after the filing of the bankruptcy case. There also may be certain contracts that can be replaced or terminated.

Social Considerations

Unlike loans in other industries, lenders may face significant community and political pressure to continue funding, even if the health care debtor is struggling in bankruptcy.

Regulatory Considerations

Closing the sale of a health care provider may require state authorization after approval by the bankruptcy court, which may create significant delays in sale closings and require additional interim funding.

Exhibit A

DIP Order Language Limiting Governmental Right to Recoupment and Setoff:

■ *In re Christ Hospital*, Bankr. D.N.J. Case No. 12-12906, Final DIP Order, Mar. 5, 2012, D.I. 161, ¶ 15. Governmental Offset and Other Rights: The authority of any governmental unit (as defined in the Bankruptcy Code), including without limitation HHS, DOH, and DMAHS, and the departments, divisions and agencies thereof, to collect prepetition and postpetition overpayments from the Debtor, shall be governed by this Final Order. A governmental unit, including departments, agencies, or any fiscal intermediaries thereof (“Governmental Entity”) shall have no right to recoup provider reimbursement overpayments that were made to the Debtor from any amounts due to the Debtor other than to recoup such overpayments that arise under the same provider agreement, or comparable applicable statutes, regulations or arrangements, and in the same provider cost-year as the amounts due to such Debtor arose. No person, including but not limited to Governmental Entities, will be permitted to obtain a lien which is equal or senior to the liens of the Agent on the Collateral. Nothing contained herein shall: (1) limit the right of a Governmental Entity to seek relief from the automatic stay pursuant to Section 362 of the Bankruptcy Code in order to exercise its right of setoff in respect of prepetition underpayments against prepetition overpayments, or postpetition underpayments against postpetition overpayments; or (2) prejudice the recoupment rights of a Governmental Entity in connection with the Debtor’s assumption of its contract with such entity (including the Debtor’s Medicare Provider Agreement). HHS shall be required to promptly remit to the Debtor any amounts which represent offsets by HHS in contravention of the Interim Order, as modified by this Final Order.

■ *In re KidsPeace Corp., et al.*, Bankr. E.D. Pa. Case No.13-14508, Interim DIP Order, May 23, 2013, D.I. 56, ¶ 16. Limitation on Governmental Entities: The authority of any governmental unit (as defined in the Bankruptcy Code), including without limitation HHS, all applicable Pennsylvania and other State Medicaid and health agencies, and the departments, divisions and agencies thereof (a “Governmental Entity”), to collect prepetition overpayments from the Debtors shall be governed by this Interim Order. A Governmental Entity shall have no right to recoup provider reimbursement overpayments that were made to a Debtor from any amounts due to such Debtor other than to recoup such

overpayments that arise under the same provider agreement or comparable applicable statutes, regulations, or arrangements, and in the same provider cost-year as the amounts due to such Debtor arose. No person, including but not limited to Governmental Entities, will be permitted to obtain a lien which is equal or senior to the liens of the Agent on the Collateral.

***But see* DIP Order Language Preserving Government Right to Setoff:**

■ *In re St. Vincent's Catholic Medical Centers of New York, et al.*, Bankr. S.D.N.Y., Case No. 10-11963, Final DIP Order, May, 17, 2010, D.I. 285, ¶38. United States Departments and Agencies: As to the United

States, its agencies, departments or agents, nothing in this Final Order or the DIP Documents shall discharge, release or otherwise preclude any valid right of setoff or recoupment that any such entity may have.

■ *In re Interfaith Medical Center, Inc.*, Bankr. E.D.N.Y., Case No. 12-48226, Interim Cash Collateral Order (no DIP), Dec. 4, 2012, D.I. 38, ¶ 35. United States Departments and Agencies: As to the United States, its agencies, departments or agents, nothing in this Interim Order shall discharge, release or otherwise preclude any valid right of setoff or recoupment that any such entity may have.

