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Health Care Financing: Issues Affecting Lenders

Health Care Facility Financing-CHOW Requirements Impact Deal Timing3

Health Care Financing: Security Interests in Deposit Accounts containing Medicare/Medicaid
Receivables5

Financing a Health Care Entity Purchase Using Due Diligence to Spot Risk7

Recoupment and Setoff Issues For Health Care Lenders.....9

Health Care Facility Financing-CHOW Requirements Impact Deal Timing

March 27, 2012 By Timothy Mitchell

Banks and other financial institutions need to understand how federal and state laws may impact closing a lending transaction in connection with a change of ownership ("CHOW") of a health care facility ("HCF"). Various laws implicated in a CHOW frequently include federal Medicare laws and state licensing, certificate of need, and Medicaid laws.

Under Medicare regulations, a CHOW is defined as any of the following: (a) in a partnership, the removal, addition or substitution of a partner, unless the partners expressly agree otherwise as permitted by state law; (b) in a sole proprietorship, the transfer of title to property to another party; (c) in a corporation, the merger of the corporation into another corporation, or the consolidation of two or more corporations, either of which results in the creation of a new corporation; or (d) a lease of all or part of the HCF. Commonly encountered CHOW transactions include asset sale and purchase transactions and lease transactions where the purchaser/lessee agrees to accept assignment of the current operator's Medicare provider agreement and number. (Note: It is possible for Medicare and Medicaid purposes for a purchaser/lessee to enroll as a new

provider and not accept assignment of the Medicare and Medicaid provider agreements. However, that process will require substantially more time and will disrupt operations (and cash flow) of the HCF and is not, as a general rule, pursued by purchasers/lessees.) For Medicare purposes, a CHOW must be reported within 30 days of the effective date of the change. The Medicare administrative contractor will review the HCF's submission and make a recommendation for enrollment of the provider to the Centers for Medicare & Medicaid Services ("CMS"). If CMS approves the recommendation, it will issue a "tie-in" notice indicating the provider has been enrolled and may begin billing.

Certain issues may increase the time period for receiving the tie-in notice from CMS. First, to the extent the current operator of the HCF has any outstanding notice of non-compliance or deficiencies, the operator must submit a plan of correction acceptable to CMS before the CHOW will be processed (and the new operator must pursue that plan of correction to completion). Second, it is possible for CMS to require a compliance survey in connection with a CHOW. Either of these issues may

considerably increase the timing of closing the CHOW and the lending transaction. In addition, CMS recently implemented new requirements for providers to validate their enrollment in the Medicare program. The screening requirements in connection with this validation requirement varies by provider type according to which class of providers have historically engaged in fraudulent and abusive practices. Satisfying these additional requirements may also involve additional effort and time.

If a CHOW exists under applicable Medicare regulations, it likely also implicates a change of ownership or operator for purposes of state licensing, certificate of need, and Medicaid laws. Generally, most state HCF licenses are not assignable. Consequently, a purchaser/lessee is typically required to submit an application for a license to operate the HCF to the state health department and that license must be approved prior to effecting the CHOW. Typically, the license approval requires 30-60 days. In addition, if the HCF is subject to state certificate of need laws, the underlying transaction might require a notice of intent, or it might be advisable to seek a determination of reviewability or, in rare cases, it might require a new certificate of need. A notice of intent or a request for reviewability determination will typically be 30-60 days, but a new certificate of need will significantly

extend the timetable for closing the transaction. Finally, a CHOW for Medicare purposes is also a CHOW under applicable state Medicaid regulations. Similar to the Medicare process for a CHOW, the purchaser/lessee must apply for participation in the Medicaid program and generally accept assignment of the current operator's Medicaid provider agreement and number. Generally, an application and notice is required to be filed at least 45 days prior to the effective date of the CHOW. Similar to the Medicare process, any outstanding licensing deficiencies or Medicaid certification deficiencies will delay the closing of the transaction until plans of correction are accepted by applicable state agencies.

In most CHOW transactions involving a HCF, the purchaser/lessee and seller/lessor carefully coordinate all of the notices and filings required under applicable federal and state laws so that all necessary approvals and licenses will be issued and/or effective on the scheduled closing date. Generally, lenders do not have a direct role to play in obtaining such approvals or licenses. If all proceeds smoothly, lenders should expect that process to take 60-90 days. However, additional delays will be encountered if the existing operator or HCF has any outstanding deficiencies cited by federal or state regulatory agencies.

Health Care Financing: Security Interests in Deposit Accounts containing Medicare/ Medicaid Receivables

March, 20, 2012 By Amy Strang

Lenders making secured loans to health care providers with Medicare and Medicaid receivables should be aware of limitations on their ability to perfect security interests in such borrowers' deposit accounts. Secured lenders may perfect security interests in their borrowers' accounts receivable (and identifiable cash proceeds therefrom) by filing UCC financing statements, but when proceeds of those accounts receivable are received by borrowers and deposited into borrowers' deposit accounts, security interests in the deposit accounts themselves can be perfected only by obtaining "control" over the deposit accounts pursuant to § 9-104(2) of the UCC. In order to perfect such security interests in deposit accounts, revolving credit facilities are, therefore, typically subject to deposit account control agreements. In a deposit account control agreement, the borrower, the secured lender and the depository bank agree that the depository bank will comply with instructions from the secured lender directing disposition of the funds in the deposit account, without further consent by the borrower. This arrangement enables the secured lender to obtain control over

the deposit account, thereby perfecting its security interest in the deposit account pursuant to UCC §9-312(b).

Loans to health care providers who receive Medicare and Medicaid payments, however, pose special problems for secured lenders seeking to perfect their security interests in deposit accounts. Medicare/ Medicaid anti-assignment regulations provide that no payment to be made to a provider of services under Medicare may be made to any other person under assignment (42 U.S.C. 1395g(c)) and no payment for any care or service provided under Medicaid to an individual may be made to anyone under assignment other than such individual or the person or institution providing such care or service (42 U.S.C. 1396a (32)). According to the Centers for Medicare and Medicaid Services (CMS) Intermediary Manual §3488.2, payments due to a provider of services may be sent to a bank for deposit in the provider's account, but only if the check is in the name of the provider and the provider certifies that: (i) "the bank is neither providing financing to the provider nor acting on behalf of another party in

connection with the provision of such financing," and (ii) "the provider has sole control of the account, and the bank is subject only to the provider's instructions regarding the account." This means that any instruction given by a borrower who is a health care provider to its depository bank to transfer funds from the borrower's deposit account, in which Medicare and Medicaid payments are deposited, to the account of its secured lender must be revocable by the borrower. Because the depository bank must be subject only to the borrower's instructions regarding the deposit account, it cannot also be subject to instructions from the secured lender, and an arrangement satisfying the Medicare/Medicaid anti-assignment regulations, therefore, cannot give a secured lender "control" of the provider's deposit account under UCC §9-104.

Many secured lenders find a partial solution to this perfection problem through the use of an arrangement commonly referred to as a "Double Lockbox." In a Double Lockbox arrangement, the health care provider borrower, secured lender, and depository bank enter into a revocable control agreement in which the borrower gives revocable instructions to the depository bank to transfer funds received in the borrower's Medicare/Medicaid deposit account to an account held by the secured lender on a daily basis. Because the

borrower's instructions are revocable, a Double Lockbox arrangement is permissible under the Medicare/Medicaid anti-assignment regulations. Although it does not perfect the secured lender's security interest in the borrower's Medicare/Medicaid deposit account, the daily transfer of funds allows the secured lender to diligently monitor the deposit account and become aware if no funds are being swept, providing the best outcome available without violating the anti-assignment regulations.

Depository banks must be subject only to health care providers' instructions regarding deposit accounts containing Medicaid/Medicare receivables, so any deposit accounts of health care provider borrowers that contain only receivables from commercial insurers or other non-Medicare/Medicaid sources may be subject to traditional deposit account control agreements. If a borrower maintains such a non-Medicare/Medicaid deposit account, its revocable control agreement may provide that the depository bank transfer the funds received in the borrower's Medicare/Medicaid deposit account to its non-Medicare/Medicaid deposit account, which is subject to a control agreement perfecting the secured lender's security interest, rather than to an account held by the secured lender.

Financing a Health Care Entity Purchase Using Due Diligence to Spot Risk

March 8, 2012 By Ted Fisher

When financial institutions fail to conduct the right kind of due diligence prior to financing the purchase of a health care entity, bad things can happen. Too often, banks focus their due diligence too narrowly, missing red flags that may result in over-estimation of value.

Here are some key points to think about when planning and doing due diligence.

Know the Business

Health care entities are special creatures in the market. They are highly regulated delivery systems, dependent on government, private and/or third party payers. They expose lenders to layers of risk that can go undetected when due diligence is conducted superficially. Due diligence of a health care entity should dig into a company to find out how it works, where its strengths lie, and what weaknesses it has. Inquire about and understand the nature of the health care services delivered. Ask that the services be specifically described. Identify the local labor pool available and quantify labor resources and costs – key elements for a health care provider. Understand the payer mix to determine how the business is reimbursed, what the reimbursement

and payment sources are, and how reliant the business is upon each source.

Understand the market economy and the up or downward trends that are present.

Know Its Reputation

Health care entities, especially those that engage in medical specialties, rely heavily upon referrals from consumers and professionals. A bad or marginal reputation will not be transformed magically into a good reputation because a health care entity has a new owner. Identify and check referral sources to understand the reputation of the entity being sold. Often in smaller or closely held businesses, the owner is the source of the reputation. When the business is sold and the former owner is gone, referral sources may diminish, resulting in deteriorating occupancy rates.

Understand the Assumption of Risk

A seller that receives reimbursement from Medicare has been assigned a Medicare number. When the business is sold, the Medicare number attaches to the new owner, unless the new owner applies for and receives a new number from the Centers for Medicare and Medicaid

Services (CMS). Application for a new number can add time and contingencies to transactions. When the buyer assumes the seller's provider number, the buyer assumes the record of compliance violations and the sanctions and fines that accompany the number, and CMS will pursue the new owner (i.e., the holder of the provider number) for a remedy. CMS will not chase the seller. Indemnification provision in lending agreements provide little solace in the face of a CMS enforcement onslaught. If compliance problems are identified in the due diligence process, discussions with regulators may be required to understand the severity of the problem and the impact the problem may have upon the business. Negotiations with the regulators may not be out of the question.

Determine Its Billing and Revenue Projection Accuracy

Projected revenues are sometimes overstated because accountants who prepare statements relied upon by lenders may not take into account the collectability of accounts receivable. Revenue projections and the collectability of claims submitted to payers are influenced by a number of factors. First, the amount billed may not be the amount third party payers have contracted to pay. Second, projected revenues may not adequately take into

account collection and bad debt histories. Third, claims may be submitted with a high degree of inaccuracy, resulting in denials or substantial delays in payment, effecting in turn estimates of per-day revenues – an especially important factor in the valuation of nursing homes and long term care centers. Due diligence is required to determine what discounts the health care entity has agreed to and how that might effect projected revenues; whether projected collections have been overstated and bad debt has been understated, and if the claims submitted have a history of being incorrect.

Identify Building and Licensing Issues

In many states, change of ownership of certain health care entities requires re-licensure. The licensing process may bring to light the fact that the facility is in noncompliance with code but has received waivers from the state that release the seller from the requirement to repair and upgrade or that grant a delay. Waivers sometimes are not transferrable upon sale, resulting in nasty surprises for the new owner or lender when confronted with unanticipated but mandated costs during the re-licensing process. A review of the existing license along with waivers and exceptions related to building code requirements will minimize this risk.

Recoupment and Setoff Issues For Health Care Lenders

March 2, 2012 By Jack R. Pigman

Health care lenders and others evaluating or relying on the financial strength of a healthcare provider need to think about the potential recoupment and setoff of claims against Medicare/Medicaid receivables of the provider.

Recoupment

Recoupment, which is the netting of two related claims which is the function of a single, unitary transaction between the parties, occurs in the normal course of business and is not stayed by the automatic stay in a bankruptcy proceeding. For example, if Party A sells 100 widgets to Party B, and Party B discovers that four of the widgets were not delivered, Party B will deduct (recoup) the invoice amount of each unit in making payment to Party A.

In dealing with Medicare/Medicaid recoupment issues in bankruptcy, two general approaches have been taken by the Circuit Courts of Appeal with respect to the netting of overpayments against accounts due to the provider.

In the Third Circuit, which includes Delaware, the Court has applied an integrated transaction test, which means

generally that any recoupment of Medicare/Medicaid payments is viewed as yearly payments and therefore the government can only recoup overpayments against payments due for a single year. Most of the Circuit Courts have adopted a “logical relationship test” in which Medicare/Medicaid overpayments and any payments due are all part of the same transaction even if they are not in the same year or the services are not rendered to the same patients. States are also permitted to recoup amounts owed for hospital and bed taxes by withholding certain Medicare/Medicaid payments otherwise due. Some courts have gone so far as to provide that Medicaid recoupments can be made across service categories, such as nursing service overpayments being recouped from payments due for laboratory services.

Setoff

Unlike recoupment, which occurs in the ordinary course of business, Section 362 of the Bankruptcy Code provides an automatic stay against any act to setoff. While the right of setoff is codified in Section 553 of the Bankruptcy Code, before a setoff may occur, relief from the

automatic stay must be obtained from the Bankruptcy Court. Setoff, as opposed to recoupment, involves the mutuality of obligations owed between the parties rather than analysis of a single, unitary transaction between the parties. For example, if Party A borrows money from Party B bank, and Party A deposits funds with Party B in an account, there are two debtor/creditor relationships which are established. The bank (Party B) can setoff on the funds owed to Party A against the loan owed by Party A to Party B.

In the context of insolvency, whether inside or outside of bankruptcy, the Courts have generally treated claims of the United States as a single creditor and, therefore, the U.S. can setoff debts owed to a health care provider by one agency against claims that another agency has against the provider. Thus, for example, under the single creditor or unitary payment doctrine, the U.S. can offset taxes owed by a Medicare/Medicaid provider against payments due to the provider.

There appears to be a split of case law on whether the unitary setoff right of the government has priority over a security interest even if the secured creditor has provided the relevant federal or other governmental units with actual notice of the security interest held by the secured party.

Debtor-in-Possession Financing Orders

In Chapter 11 bankruptcy cases, debtor-in-possession lenders often will try to obtain an assignment of and a security interest in Medicare/Medicaid accounts, and thereby limiting or eliminating the recoupment or setoff rights of the government. Section 362(B)(28) of the Bankruptcy Code provides that the automatic bankruptcy stay does not preclude the Secretary of Health and Human Services from excluding a specific provider from participation in the Medicare program or any other federal health care program. Thus, if lenders try to “prime” or otherwise create rights with respect to Medicare/Medicaid receivables, ultimately the Secretary of Health and Human Services can exclude the debtor-in-possession from participation in Medicare or other federal health care programs and thereby negate any priming or other provisions in favor of DIP lenders in a Court order which are inconsistent with the rights of the government.

CONCLUSION

As in most ongoing, normal business relationships, there are routine adjustments made based upon over or under shipments, quality issues, mistakes in billing and various forms of credits and allowances. Lenders to Medicare/Medicaid providers need to be acutely aware of the recoupment rights under those programs. In addition, there is

always the risk that the Medicare/Medicaid receivable could be offset by the U.S. government based upon the tax liability or other sums due and owing by the health care provider to the government. In the bankruptcy context, the rules may vary on recoupment depending upon the judicial circuit the bankruptcy case is pending in. There also exists the possibility that, under certain circumstances, states may recoup for obligations owing and certainly both the

federal government and state governments have setoff rights which are expressly acknowledged both in and out of the bankruptcy context. Finally, orders entered in bankruptcy cases in favor of a debtor-in-possession lender to a health care provider which would result in an assignment of or security interest in the provider's Medicare/Medicaid receivables can be overridden by the simple act of excluding the provider from participation in federal health care programs.