The New Wave of Hospital Bankruptcies

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In 2002, the collapse of National Century Financial Enterprises (NCFE), one of the nation's largest healthcare lenders, suddenly left dozens of hospitals without financing and touched off a wave of hospital bankruptcies throughout the country. Five years later, in September 2007, The Los Angeles Times reported that in Los Angeles and Orange Counties alone, nearly two dozen private hospitals, accounting for up to 15 percent of the beds in the region, were "in dire financial straits and in danger of bankruptcy or closure."

The current financial crisis for hospitals is not the result of a single triggering event or even a lack of available financing. Instead, it reflects profound industry changes that make it increasingly difficult for small and mid-size hospitals to operate profitably. Among the factors contributing to the current crisis are freezes in Medicare reimbursement rates, reductions in Medicaid and Medi-Cal payment rates, increasing numbers of uninsured patients, federally mandated requirements to accept indigent emergency room patients, and a chronic nursing shortage that raises the costs of in-patient care. There is also growing competition from ambulatory surgery centers and specialty hospitals that divert some of the most profitable business away from general acute care hospitals, as well as off-shore surgery facilities that perform complex surgeries at dramatically lower rates.

In California, these trends are exacerbated by the costs of a state-mandated increase in nurse staffing ratios and the seismic retrofit requirements imposed on hospitals after the 1994 Northridge earthquake. The impact of the seismic retrofit requirements varies according to the age and configuration of individual hospital buildings but will inevitably cost some hospitals tens of millions of dollars while forcing others to close. There is also increasing uncertainty regarding the amount and timing of payments to those hospitals that qualify for the Disproportionate Share Hospital (DSH) program of the California Department of Health Services based on their acceptance of a "disproportionate share" of indigent patients.

Amid all the gloom and doom, however, there are some bright spots. Healthcare is unquestionably a growth industry in the United States due to an aging population, technological advances, and the growing social consensus in favor of universal access to healthcare. Those hospitals that survive the crisis will be able to take advantage of these trends, and there appears to be no shortage of willing buyers for most troubled hospitals, both in and outside of bankruptcy. Additionally, the credit crunch in other industries has not yet seriously constricted the supply of specialized financing for hospitals. Although financing to hospitals tends to be expensive, a broad variety of financing alternatives is available, including asset-based loans, factoring of healthcare receivables, HUD mortgages, real property sale and leaseback arrangements, equipment leases, and bond financing.

We are already experiencing an increase in hospital bankruptcies under Chapter 11 of the Bankruptcy Code and under Chapter 9 for governmental entities such as healthcare districts that operate hospitals within their jurisdictions. Some of these hospitals will emerge from bankruptcy as viable business concerns, to the long-term benefit of their creditors, employees, patients, owners, and the community, because of the powerful restructuring options available under the bankruptcy laws, including rejection of unfavorable contracts and leases, restructuring of both secured and unsecured debt, and sales of assets free and clear of liens, claims, and encumbrances. These tools also facilitate operational changes that can reduce or eliminate financial losses, such as sale and leaseback of real estate, downsizing of facilities to match low patient census, elimination of non-essential services provided by outpatient facilities, outsourcing of non-core services (e.g., food service, maintenance, security, payroll, and HR administration), conversion to a non-profit corporation to enable solicitation of donations and municipal funding, or a joint venture or lease to a clinic, urgent care center, or Federally Qualified Health Center (FQHC) so that lower acuity patients can be diverted from unnecessary and unprofitable emergency room visits.

Hospital bankruptcies are, however, both complex and expensive. This is in part due to unsettled issues of law in several key areas. Among the issues currently facing bankruptcy professionals and the courts:

- *Recovery of Medicare Overpayments*. There is a split in the federal circuits as to whether the government can recover pre-petition Medicare overpayments, by deducting them from post-petition Medicare payments due to the hospital, or whether recovery is stayed by the automatic stay provisions of bankruptcy law. The Third Circuit has held that recovery is stayed, while the First, Ninth, and D.C. Circuits

have held that it is not. The United States Supreme Court has yet to rule on the issue.

- *False Claims Act Litigation*. Another issue is whether civil actions by the government under the federal False Claims Act (FCA), including false claims under Medicare, are stayed by the filing of a bankruptcy case. One position is that an action under the FCA is an exercise of governmental police power and therefore not stayed. The opposite position contends that a civil FCA action is like any other civil action for monetary damages and is therefore stayed by a bankruptcy filing. This issue is related to the question of whether, as a result of the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 (BAPCPA), FCA claims are non-dischargeable in the bankruptcy of a corporate or other business entity.

- *Patient Care Ombudsman*. The position of Patient Care Ombudsman (PCO), created under BAPCA, has made healthcare bankruptcies even more expensive by adding a new layer of bankruptcy professionals. Bankruptcy courts are struggling with questions of whether entities in bankruptcy are healthcare providers that require the appointment of a PCO, as well as the nature and scope of the duties of a PCO if one is appointed.

- *Other Issues*. Other issues that arise in hospital bankruptcies include, but are certainly not limited to, the makeup and size of the unsecured creditors' committee, valuation of secured creditors' collateral, the use of Medicare receivables as collateral for financing transactions, valuation of excess hospital real estate subject to zoning restrictions, assignability of provider agreements and other contracts, and a plethora of federal and state regulatory issues.

Because of the significance of the issues raised in this article, Buchalter Nemer has formed a Healthcare Financial Solutions practice group comprised of senior lawyers experienced in both healthcare and creditors' rights and insolvency matters. Members of this group have hands on experience dealing with issues facing hospitals, lenders, factors, bondholders, third party payors, equipment lessors, suppliers, physicians, real estate owners and developers, and labor and employment matters.

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