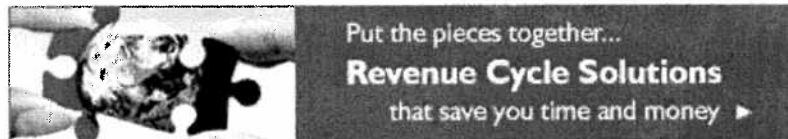




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Financial Meltdown: Key Legal Issues for Healthcare Organizations

Paul DeMuro

Bad debt is rising while cash on hand is declining. Hospitals should understand the legal implications of the economic downturn.

Some of the implications of the economic downturn and credit crisis are obvious, including the failure to meet certain debt covenants, thereby placing an entity in technical default under its debt documents. A healthcare organization may have experienced a decline in its reserves because of losses in the stock and/or bond market. (Certain district and governmental hospitals may not have experienced declines to the same extent where they are prohibited by statute from investing in equities.) These declines in reserves may cause certain healthcare entities not to meet the reserve requirements of their debt documents.

The economic downturn has resulted in many prospective patients deferring elective surgeries. Many who have lost their jobs no longer have health insurance coverage. Those who do have health insurance may experience an increase in their copayment and deductible amounts. As a result, many healthcare organizations are experiencing greater bad debts and increasing requests for charity care. Thus, cash on hand at many healthcare organizations has declined along with its liquidity. As a result, many covenants can be breached.

Forbearance Agreements

If a healthcare organization cannot be brought into compliance with its debt covenants, or before a certain trigger date, it may have to negotiate with a lender, bond insurer, letter of credit bank, and/or bondholders for a forbearance agreement. Part of those negotiations may be over whether a turnaround consultant must be retained, who to retain, the nature of the engagement, etc. As part of those discussions, current healthcare management might try to convince its lenders and others that such a turnaround consultant is not necessary because management has the situation under control and the costs associated with the turnaround consultant are not necessary. Some considerations include what contract or contracts might the troubled healthcare organization enter into with the consultants. What will be the deliverable for

the consultants, and in what time frame? How will the compensation of the consultants be structured, and how will they interface with management?

Another consideration may be that the financially troubled organization may look for a “financial partner.” Such a financial partner might be a lender that will refinance the healthcare organization’s debt on more favorable terms, a not-for-profit healthcare system with which the troubled organization might “affiliate” by becoming part of such system, or an investor-owned healthcare system that might acquire the financially troubled organization. Such entities face a plethora of legal issues.

Management and the board of directors of the financially troubled organization must ensure that it acts consistent with its fiduciary duties (including the duties of care, loyalty, and obedience of purpose) in exploring its alternatives. In doing so, it will be necessary to determine if the healthcare organization is in the “zone of insolvency” to determine to what stakeholders and/or creditors its fiduciary duty will be owed. The organization should consult with experienced counsel in such situations..

Whether a new lender, a not-for-profit organization, or an investor-owned health system is identified as a potential financial partner, the troubled financial organization often must convince the current lenders that a new financing transaction will be accomplished, or that the affiliation with the not-for-profit entity or the sale to the investor-owned entity will be closed. Often, the troubled healthcare organization needs to negotiate a forbearance agreement with its lender to ensure that the lender does not declare a default, and agrees not to take certain other steps for some period of time, subject to specified conditions. If a healthcare organization cannot successfully negotiate a forbearance agreement, it might consider whether it would make sense to file for bankruptcy to reorganize its operations, whether in a traditional or prepackaged manner.

The parties to a forbearance agreement likely will include all lenders, bond insurers, letter of credit banks, and bondholders, if there are such multiple parties. A default with one lender or entity generally results in cross-defaults with the others. Obviously, the troubled healthcare organization should try to negotiate a forbearance such that the lenders will not trigger a default under the debt documents.

The negotiation of a forbearance agreement often results in the creation of new covenants that must be met during the term of the forbearance agreement. Such covenants can include maintaining cash reserves above a particular level and approval over certain transactions. The forbearance agreement might be for a short period of time, and in contemplation of the lender’s debt being paid off through a recapitalization, new lenders, the proceeds from an affiliation or sale, or some form of restructuring or management change. Compliance with forbearance agreements can be quite difficult because of the constraints often put on the healthcare organization.

A financially troubled organization exploring a transaction with a healthcare system may look to negotiate with a not-for-profit entity with which it might affiliate or an investor-owned entity regarding a commitment of resources to its community and/or to its facilities going forward. Such commitments might include enhancing the troubled organization’s current facilities, expanding them, adding new services, ensuring the provision of emergency and/or trauma

department services, and the provisions of certain charity care, etc. It is important to note that these desires on the part of the financially troubled organization may conflict with the desires of the lenders negotiating the forbearance agreement. Such negotiations take time, can affect the funds available to pay off the lender, and result in certain regulatory hurdles, e.g., the transfer of any certificates of need (CONs).

Delay in Payments to Vendors and Delays in Capital Expenditures

Trying to meet the conditions of a lender providing a forbearance agreement or trying to conserve cash to ensure the ability to continue to meet certain debt covenants also can create other legal considerations. For example, a healthcare organization seeking to preserve cash may not pay its vendors in a timely manner. This approach can trigger certain rights of the vendors under the applicable contract or purchase order. These rights might include the charging of penalties and interest, and/or the providing of certain products and services in the future on a COD basis.

Healthcare providers may attempt to defer capital expenditures. Provided that their decisions are made with respect to those capital expenditures that have not already been committed through contract, the result may merely be loss of the ability to compete with other organizations with state-of-the-art facilities and equipment or develop new services for such purposes. When a healthcare organization seeks to curtail a capital project already committed, there can be legal ramifications of same. For example, the vendors may have certain rights against the healthcare organization for breach of contract and be entitled to a number of different remedies.

A healthcare provider that contractually commits to the purchase of an electronic health record (EHR) system may face specific time frames for periodic payments at the time of defined milestones in the contract. The vendor may have expended certain resources in preparing to meet those milestones. The healthcare provider may not be contractually permitted to just halt the development and the delivery of the EHR system. The result of the healthcare organization's failing to cooperate with the implementation of such EHR system and to make timely payments could have the effect of the healthcare organization being liable for damages for beach of contract.

Many healthcare organizations are planning on or in the process of remodeling and construction programs. The longer the delays in construction, generally the greater the costs. Where healthcare providers have entered into certain construction contracts, including those attempting to employ the principles of lean construction, the healthcare provider's failure to timely pay for and proceed with the project may result in further costly delays and the ability of the contractor to seek certain remedies. All such contracts should be reviewed carefully before making a decision to "slow down" construction. Not only may there be potential breach of contract considerations, but also the additional costs may result in the healthcare provider not being able to complete the project, absent additional borrowing, which may not be available, or substantial fund-raising, which may not be realistic.

A further consideration may be a healthcare organization having to discontinue a particular program or service as a result of minimizing its capital expenditures. There may be state and local laws governing how an

organization might close a particular service, including notice to the community and hearings. Healthcare organizations will need to comply with such legal requirements.

If the healthcare provider has made representations and warranties about the project, its costs, and completion, it will want to ensure that they are correct. It also may have an obligation to update them. If it does, it will want to make sure they are realistic and consistent with a revised workable plan of finance. A healthcare provider would not want to raise money from prospective donors, advising them of a project that will be built if there is no reasonable expectation that it can be built, given the financial considerations.

Charity Care Policies

Healthcare providers that developed charity care policies in response to the public and congressional outcry about their charges, class action lawsuits, their zeal to retain their tax-exempt status, if they are tax-exempt, or just because it may be the right thing to do, are starting to find that many more patients are seeking to take advantage of these charity care policies because of their family's economic circumstances. A question may arise as to whether the healthcare organization can continue to comply with the charity care policies it developed in better economic times. If it does not, it may be subject to lawsuits alleging breach of any settlement agreement or alleging it should not retain its tax-exempt status, if it is a tax-exempt entity.

With health plans continuing to raise their cost sharing amounts, such as copayments and deductibles, and declining economic conditions, patients with insurance will find it more difficult to meet those cost sharing amounts with the result that the bad debts of healthcare providers are likely to increase. If a healthcare organization could even tighten its charity care policies such that many of those who previously would have been eligible for charity care are no longer eligible, it may merely be transferring what would have been charity care into bad debts with the result that the tax-exempt entity may have difficulty justifying its tax-exempt status and why its property should not be subject to taxes and/or alternative assessments.

Healthcare organizations may find that as fewer individuals have healthcare coverage, their emergency departments (EDs) will be stressed even more than is the case today. The result may be greater difficulty in seeing patients on a timely basis, greater subsidies to ED physicians, and more difficulty in meeting an organization's EMTALA obligations. Hospitals that should seek to two-tier their ED departments, and provide urgent care, if they are not doing so, facilitate the development of "medical homes" throughout the community may not have the resources to do so, further threatening their economic survival and increasing potential malpractice and EMTALA liability.

Freezing Salaries and Staff Reductions

Healthcare organizations facing financial difficulties may seek to freeze salaries of their employees, cut staff, and enter into other actions that may have labor relations implications, particularly if they are subject to collective bargaining agreements. Across-the-board cuts in staff can result in decreases in professional or allied health practitioners in areas where shortages exist. The result can be higher costs rather than lower costs through the increased use of

locum tenens (physicians) and travelers (nurses). Contracts for same will have to be negotiated. Severance and/or termination obligations for departing employees will have to be addressed, along with whether a healthcare organization has all the necessary funds to meet its termination obligations. If the costs are too high, will a healthcare organization stage such payoffs to enable the financial organization to continue to meet certain debt covenants? Thus, careful consideration should be given to freezing salaries and layoffs and to both their business and legal effect.

Effect on Compliance Plans, Community Outreach, and Healthcare Education

Likely but most unfortunate casualties of these economic times is the depth and breadth of compliance programs, community outreach, and health education programs. When cuts are considered, why not cut or delay some of the compliance and privacy training and delay implementation of monitoring or a review, community outreach, and health education, as they are not seen as generating any revenue? If personnel in such areas have departed a healthcare organization, why not delay replacing them? There may be a short-term cost savings, but the long-term costs may be much greater as a result of employees not receiving adequate compliance training, problems not caught early, prospective patients not receiving needed health education, etc.

Litigation

Healthcare providers often find themselves in disputes with managed care plans. The result can be litigation in the courts where providers are fortunate enough not to have agreed to arbitration provisions, or arbitration where they have. In their zeal to “settle” these matters, healthcare organizations may agree to accept amounts from such health plans in settlement lower than they typically would have accepted and to more egregious terms than they otherwise might have considered. The result could be less monies realized by the healthcare organization, further disputes, and more litigation.

A likely result of the economic times is more lawsuits by patients, vendors, joint venture participants, and the like, whether or not covered all or in part by insurance. Additional lawsuits represent new costs, and where possibly covered by insurance, a potential lawsuit against the insurance company, if it refuses to cover the matter.

Effect on Physician Relations

Healthcare organizations that once survived and thrived as a result of vibrant physician practices and groups in their community may determine it necessary to find some way to “bail out” financially troubled physician groups. Can a healthcare organization permit physician groups that are in financial trouble because of departing physicians, increasing expenses, decreasing reimbursement, and no financial wherewithal to recruit replacement physicians, to disappear? Physicians will seek more hospital financial assistance whether through increased on-call payments, medical directorships, or just the purchase of their practices. The regulatory ramifications of assisting such physician groups and physicians should be considered, including the Medicare and Medicaid fraud and abuse considerations, Stark self-referral issues, and when the healthcare organization is tax-exempt, tax-exemption

considerations.

Representations, Warranties, and Conflicts of Interest

One can be sure that the representations, warranties, and disclosures made by a healthcare organization will be scrutinized at some time in the future if a financially troubled healthcare organization is unable to pay its debt.

Government regulators, lenders, and bondholders will want to ensure that the healthcare organization has made the necessary and proper disclosures. If not, and the financial position of the healthcare organization deteriorates, legal actions may be filed against the entity and certain individuals making such representations and warranties.

As government regulators, lenders, and bondholders scrutinize the representations and warranties, they also will scrutinize any potential conflicts of interest that management and the board of directors of the healthcare organization may have. The effects of such conflicts of interest will be to have not only any transactions that might have been entered into scrutinized, but also the actions of such individuals with such conflicts of interest. Where conflicts of interest exist, there may be a myriad of legal ramifications, including repudiation of certain transactions, as well as findings of liability.

Executive Compensation

Executive compensation has increasingly been a hot button for healthcare and other organizations. Recently, it was noted that where the rebuttable presumption of reasonableness under the IRS provisions may have been relied on, perhaps this area will be delved into further. Few things are more precious to executives than their compensation. The financial crisis will exacerbate such focus and healthcare organizations should be able to demonstrate not only that they have passed the test for rebuttable presumption of reasonableness, but also that the compensation of their executives is reasonable and fair market value. Having a healthcare organization's human resources director set the compensation of the CEO to whom he or she reports will not suffice. An independent committee of the board of directors or the board itself should make such determinations with the assistance of consultants and experts in such matters who are not beholden to the CEO and the human resources department for much of their consulting work. The failure to approach executive compensation in this manner can lead to increased scrutiny of same and questions about whether a healthcare organization should be entitled to its tax-exempt status, if it has one.

Recommendations

Key finance personnel at healthcare organizations should be intimately familiar with the provisions of the debt/bond documents and the covenants set forth therein. They should be tracking compliance and when they are likely to trigger a covenant to plan for same. They should retain counsel expert in financial issues to assist them, and such counsel should know their debt/bond documents and how to address issues as they might arise. It is insufficient to merely have regulatory counsel who concluded at the time of the closing of the debt or bond transaction that there were no known regulatory impediments to closing, and if the healthcare organization is tax-exempt, that its activities are consistent with that status. Counsel should be expert in financial issues and be

able to assist finance personnel in navigating through the documents, and working with such personnel to anticipate issues in advance, and if necessary, assist in negotiating with lenders for forbearance or other agreements, if such becomes necessary.

Financial personnel should ensure that senior management is abreast of any key considerations that might affect the healthcare organization as a result of the financial meltdown. It may be too late to bring issues to senior management and then to the board of directors if a healthcare organization is already in default under its debt/bond documents. As concerns come to the forefront, they should be discussed with senior management, and plans put in place with legal counsel to determine how to address the considerations, including the implementation of a turnaround plan, potential retention of a management consultant, and/or discussions with the lenders.

Such actions are consistent with the fiduciary duty of financial personnel, senior management, and the board of directors of a healthcare organization. It is much easier to address potential problems before they occur, rather than to wait until a default is experienced.

Paul R. DeMuro, JD, FHFMA, CPA, is a partner, Latham & Watkins LLP, San Francisco and Los Angeles, and a member of HFMA's Southern California Chapter (paul.demuro@lw.com).

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