

## SPECIAL LEGAL AND BUSINESS ISSUES IN HEALTHCARE LENDING

### Legal Issues: Dwight Meier

#### **I. Setoff/Recoupment: Who controls the case, the Government or the Debtor?**

- A. In re University Medical Center, 973 F.2d 1065 (3d Cir. 1992) (principal holdings: (a) charging by CMS of Medicare receivables generated in one cost year for prior overpayment claims created in a different cost year is a setoff; (b) such setoff claims are subject to operation of bankruptcy law, including operation of the automatic stay)
- B. United States v. Consumer Health Services of America, 108 F.3d 390 (D.C. Cir. 1997) (principal holdings: (a) any CMS charge of Medicare receivables for prior overpayment claims, irrespective of whether overpayment and charged receivable relate to different cost years, is a recoupment; (b) exercise of such recoupment rights is not subject to operation of bankruptcy law, and is not prohibited by operation of automatic stay)

#### **II. UCC Article 9 Priorities/State Comptroller Statutes.**

- A. In re Doctors Hospital of Hyde Park, Inc., 33 F.3d 951 (7<sup>th</sup> Cir. 2003) (in context where state statutory law contains provision giving state setoff claims priority over other claimants, state right to charge Medicaid accounts as setoff against unpaid taxes owed by provider had priority over prior perfected lien of lender in the Medicaid receivables)

#### **III. State Sovereign Immunity ("Seminole Tribe").**

- A. Seminole Tribe of Florida v. Florida, 517 U.S. 44 (1996) ("not been widely thought that the federal antitrust, bankruptcy, or copyright statutes abrogated the states' sovereign immunity")
- B. Krystal Energy Co. v. Navajo Nation, 2004 WL 235453 (9<sup>th</sup> Cir. Feb. 10, 2004) (when Congress enacted §106 of the Bankruptcy Code, it abrogated the sovereign immunity of Indian tribes)
- C. In re Sun Healthcare Group, Inc., 245 B.R. 779 (Bankr. Del. 2000) (based on holding in University Medical Center and Bankruptcy Code §364, court found that: (a) DIP lender could take priming lien in debtor's Medicare/Medicaid accounts that has priority over federal/state setoff claims against such accounts; and (b) granting such a priming lien against states does not violate the state's sovereign immunity).

**IV. Assignment of Claims Act.**

- A. In re Missionary Baptist Foundation of America, Inc., 712 F.2d 206 (5<sup>th</sup> Cir. 1983) (lender's lien in Medicare and Medicaid receivables did not violate anti-assignment provisions of Medicare/Medicaid statutes, and was enforceable)

**Business Issues: Michael Gardullo**

**V. Lockbox Issues.**

A. Operational definitions:

- Lockbox – PO Box
- Lockbox Account – Bank account where lockbox monies are forwarded.
- Springing Lockbox Account – Sweeps to the lender occur upon the deviation of various loan covenants.
- Direct Lockbox Compliance – the payer forwards Medicare, Medicaid and/or Commercial reimbursements directly to the lockbox, or lockbox account.
- Indirect Lockbox Compliance – Medicare, Medicaid and/or Commercial reimbursements are received directly by the borrower or deposited to a non-lockbox account and manually forwarded into the designated lockbox account.
- Cash diversion – Collateral based receipts are not forwarded to the lockbox account and/or borrower. Funds are used for other operating/non-operating purposes and not used to pay down the LOC.

B. The lockbox and lockbox accounts are under the sole dominion, control and ownership of the borrower when dealing with Medicare and Medicaid collateral reimbursements. Medicare and Medicaid Program rules require that reimbursement be provided directly to the provider. As a result, a tri-party agreement is created between the Bank, Provider and Lender to have funds forwarded to the lender under a lockbox arrangement.

C. Medicare and Medicaid lockbox accounts typically have more stringent requirements than a commercial lockbox account. Changes to the account, or redirection of funds under a Medicare/Medicaid lockbox account arrangement typically have shorter notice periods than traditional lockbox accounts.

- Medicare/Medicaid Lockbox account notice period – 10 days
- Commercial Lockbox account notice period – 30 to 60 days

D. Collateral risks:

- Cash diversion.

- Borrower fails to notify payers of the “new remit to address” for Medicare, Medicaid and commercial reimbursements, which typically results in low direct lockbox compliance. When indirect lockbox compliance exists, Medicare, Medicaid and Commercial funds are either received at the facility or deposited into a non-lockbox account and manually forwarded by the borrower to the lockbox account for subsequent sweeps to the lender. This practice allows the borrower to easily divert collateral proceeds from the lender for purposes other than paying down the LOC.
- Significant indirect lockbox compliance.
- Lockbox compliance is only tested through independent audits. With “springing lockboxes”, if compliance is not tested regularly, the lender will not know the level of expected compliance if default occurs.
- Lockbox account statements are not readily provided to the lender on a consistent basis for compliance review purposes.
- The tri-party agreement notice period for Medicare and Medicaid lockbox accounts is typically only 10 days, which allows the borrower to re-direct funds from the lockbox account.
- Monies/reimbursements outside of the direct collateral pool (i.e. DSH payments, grant payments, cost settlement payments, private pay receipts) are not forwarded to the lockbox account.

## VI. Gross v. Net Billings.

- A. Gross or Net accounts receivable A/R Aging used for borrowing base purposes?
- Net – Contractual adjustments taken at the time of billing
    - ❖ Results in a higher liquidity factor for borrowing base purposes.
  - Gross – Contractual adjustments taken at the time of payment
    - ❖ Results in a lower liquidity factor for borrowing base purposes.
  - Assuming that the appropriate liquidity factors can be determined on a net and gross basis, collateral availability should not differ when calculated from a net or gross A/R aging.
- B. Why would a provider bill and record charges at gross collectible amounts?
- Easier to have one “Master Charge Structure” and write contractual adjustments off at the time of payment rather than estimating contractual adjustments at the time of billing only to revise them when the payments arrive.
  - A/R system may not be capable of estimating collectible amounts.
  - At times various Commercial payers will pay gross claims at a higher rate than if the amount were billed at net.
- C. Why would a provider bill and record charges at net collectible amounts?

- Gives a more timely accurate depiction of the true net collectible value of accounts receivable.
  - If the provider is reimbursed from a fee schedule and negotiated rates from commercial payers, the actual amount to be collected is known, which eliminates the need to estimate contractual adjustments.
  - Supports and reconciles to true net revenue.
- C. What are liquidity factors and why does it matter when a Gross or Net A/R aging is used for borrowing purposes?
- Liquidity factors are payer specific percentages developed from the relationship between actual cash collected and charges recorded.
  - Liquidity factors are used to calculate the net realizable value of accounts receivable.
  - Liquidity factors take into consideration contractual adjustments and bad debts. The liquidity factors for a gross A/R aging will consider contractual adjustments and bad debt. Theoretically, liquidity factors for a net A/R aging only considers bad debts, because contractual adjustments are taken when the charge is billed.
- D. What happens if a provider changes their recoding methodology?
- The A/R aging may be a hybrid of gross and net charges, which makes it difficult to determine the true net collectible value of the asset.
  - For borrowing base purposes, the liquidity factors would require revision to calculate the true collectible value of the asset.
  - Largest risk from a lending perspective is the conversion from a net A/R aging to a gross A/R aging. If liquidity factors are not revised, over-advancements may occur.
  - Cannot properly assess the true liquidity until collections are remitted under the new recording methodology.
- E. What happens if a provider records their A/R agings at gross and chooses to increase their "Master Charge Structure"?
- Medicare and Medicaid are primarily prospective payers, with the exception of a few cost reimbursed provider types (specialty hospitals, psych hospitals, etc.). Increases in the "Master Charge Structure" would not result in increased reimbursement for these payers.
  - The rationale for the increase in the charge structure is to renegotiate and get reimbursed higher commercial/managed care and private pay rates. Although some commercial payers will increase reimbursement, many will continue to pay at historical levels. (Some negotiated commercial pay rates are based upon gross charges)
  - Lenders typically need to revise their liquidity factors downward for the "Master Charge Structure" change. If liquidity factors remain unchanged,

the creditor could be over-advancing on charges billed under the new charge structure.

G. From a lending perspective, it is preferable to advance on a net A/R aging.

**VII. Impact of Clinical Performance on Collateral.**

A. For skilled nursing facilities, poor annual, complaint or interim survey results can do the following:

- Prevent Medicare and Medicaid payment on new admissions during the period of non-compliance (DPNA)
- Impose lump sum or daily Civil Monetary Penalties (CMPs) that could be offset against future collateral payments and have a material effect on cash flow
- Result in the termination of their Medicare and Medicaid provider agreements rendering existing Medicare and Medicaid collateral worthless
- Lead to a reduction in census/occupancy levels given that historical survey results are publicly assessable and often times considered by the guardians of potential residents.