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WHAT'S INSIDE

BANKRUPTCY SALE CONSIDERATIONS AND PITFALLS TO AVOID FOR HEALTH CARE PROVIDERS

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Bankruptcy filings in the health care sector continued to pile up in 2024 and there is no respite in sight. Such filings were primarily caused by dramatic increases in labor and other direct costs of operating health care facilities since the COVID-19 pandemic, capital market constraints and insufficient funding, increased pharmaceutical and supply cost pressures, and persistent reimbursement challenges. When a recapitalization (e.g., debt equitization) of the debtor is not feasible, an alternative strategy in many bankruptcies, including health care cases, is to sell the debtor's assets pursuant to section 363 of the Bankruptcy Code. This article explores several issues that can arise before or during a health care bankruptcy sale process and some ways that restructuring practitioners can address such matters for the benefit of all parties-in-interest, especially patients.

Patient Care Ombudsman Reports Can Impact Asset Value and Purchaser Perceptions

Certain provisions were added to the Bankruptcy Code in 2005 related specifically to debtors in a "health care business," as defined in the Bankruptcy Code.[1] Section 333 of the Bankruptcy Code provides that a bankruptcy court shall appoint a patient care ombudsman not later than 30 days after case commencement for a health care business "…unless the court finds that the appointment of such ombudsman is not necessary for the protection of patients under the specific facts of the case."[2] The role of the patient care ombudsman is to "monitor the quality of patient care provided to patients of the debtor," and to represent the interests of patients, with duties that include monitoring current and prospective patient care to ensure that patients are well cared for.[3] Once appointed, at least every 60 days that the debtor is operating a health care facility, an ombudsman must file a report with the bankruptcy court regarding the quality of patient care.[4] If the debtor operates multiple locations in various states, more than one ombudsman may be appointed to monitor each facility.

A patient care ombudsman serves an important patient oversight role, which is crucial when health care facilities are transitioning to new operators following a court-approved sale. Importantly, a negative report could significantly reduce a health care business' marketability, and ultimately the consideration the debtor can expect to receive for the facility in a bankruptcy sale. For example, in the bankruptcy cases for one of the largest accountable care organizations in the United States, two ombudsmen were appointed and filed reports with the Bankruptcy Court for the Southern District of Texas. To complete her first report, one of the ombudsmen traveled with a nurse representative to evaluate the care and general state of each of the debtors' hospital facilities. During her first visit to one facility, the ombudsman noted that she "did not observe any material issues impacting patient care requiring this Court's immediate attention," but, among other things, that staffing at certain hospital "has proved challenging," "each of the Hospitals are in need of repairs and new or repaired equipment," "[c]ertain furniture and infrastructure showed signs of age," and that "[t]he patient census at many of the Hospitals has declined and appears to be partly related to negative press concerning the Debtors' Hospitals." Notwithstanding certain issues that were identified in the ombudsman's first report, the debtors successfully sold, are finalizing sales, or otherwise closed all its hospitals and facilities. It is, however, possible that with a favorable review by the ombudsman, the debtors might have generated more interest in their assets and sold additional properties that were instead closed.

To maximize the value of health care business assets, debtors would be well-served to (a) educate the ombudsman regarding the positive attributes of each of its hospitals and what differentiates it from competitors (e.g., only provider or specialist within a given distance, low-income/high risk patient population), (b) clarify what issues may be an industry-level concerns (e.g., staffing) rather than a debtor-specific problem, and (c) proactively negotiate with its postpetition lender for additional capital expenditure funds in the budget to rectify issues before an ombudsman visit (e.g., remove/replace damaged equipment and furniture, replace/repaint signage), which will increase the asset's value and reduce the purchaser's post-closing expenses. Rather than bemoan the inevitable ombudsman reports, a debtor can leverage a patient care ombudsman to showcase a hospital's unique value proposition to generate more interest during its marketing and sale process.

[1] *See* 11 U.S.C. § 101(27A).
[2] *See id.* at § 333(a)(1).
[3] *See id.* at § 333(b)(1).
[4] *See id.* at § 333(b)(2).

Transfer of Pertinent Agreements to a Purchaser

Health care companies are commonly parties to complex agreements, which can be of significant value for the going concern of a health care operation. For example, when a purchaser of a health care provider intends to be paid by the Centers for Medicare and Medicaid Services ("CMS") for services provided to Medicare patients, the debtor will need to transfer its Medicare provider agreement and provider number to the purchaser.[5] Without a provider number, a purchaser cannot be paid by CMS. There are numerous considerations when attempting to transfer a Medicare provider agreement and provider number to a purchaser, such as:

- **Jurisdiction:** Does the bankruptcy court have jurisdiction to determine whether a purchaser may acquire the provider agreement/provider number and that CMS must recognize the transfer and pay the purchaser for services provided to Medicare patients? Some courts have held that bankruptcy courts do not have jurisdiction over CMS determinations under the Medicare Act.[6] Without such subject matter jurisdiction, health care providers and key stakeholders will need to strongly reconsider whether a chapter 11 filing in the specific court is prudent.
- **Asset or Executory Contract:** If the provider agreement is deemed an executory contract, then all unpaid CMS claims against the debtor, such as overpayments to the debtor by CMS, must first be cured. On the other hand, if it is deemed an asset because statutes and regulations (rather than agreements) dictate the parties' rights and duties, then it can be sold free and clear of all liens, claims, and encumbrances under section 363(f) of the Bankruptcy Code.[7]

[5] A provider number confers enrolled status on a health care provider, while a provider agreement is a uniform document not subject to negotiation or alteration. *See* Centers for Medicare & Medicaid Services, Health Insurance Benefit Agreement, Form CMS-1561 (2025), available at www.cms.hhs.gov/cmsforms/downloads/cms1561.pdf.

[6] *See In re Bayou Shores SNF*, LLC, 2016 WL 3675462 (11th Cir. July 11, 2016) (bankruptcy court does not have jurisdiction to adjudicate CMS matters because 42 U.S.C. § 405(h) requires exhaustion of administrative remedies prior to judicial review of CMS determinations under the Medicare Act).

[7] *Compare In re Verity Health System of California, Inc.*, 2019 WL 4729457 (Bankr. C.D. Cal. September 26, 2019) (provider agreement not a contract); *In re Center City Healthcare, LLC*, Case No. 19-11466 (KG) (Bankr. Del. Sept. 5, 2019) (same); *In re B.D.K. Health Mgmt., Inc.*, 1998 WL 34188241 (Bankr. M.D. Fla. Nov. 16, 1998) (provider agreement deemed an asset) with *In re Vitalsigns Homecare, Inc.*, 396 B.R. 232 (Bankr. D. Mass. 2008) (executory contract to harmonize the Medicare and bankruptcy statutes).

- **Liability Transfer:** Whether or not the liabilities associated with the provider number, which travels with the provider agreement so that CMS will pay for Medicare services, transfers with the provider agreement.

- **Setoff and Recoupment:** Whether a new provider agreement is created each year between a provider and CMS. For example, if the court finds that a new provider agreement is entered into each year, the purchaser's assumed liability could be limited to only the current year's provider agreement (if deemed an executory contract or not eligible for section 363(f)). On the other hand, if the provider agreement is deemed to continue each year, then the purchaser could be liable for overpayments CMS paid the debtor/seller within the previous six years.[8]

If applicable, it is crucial that debtors understand how their filing jurisdiction has ruled on CMS provider agreements and provider numbers before filing for bankruptcy. Ruling differences among courts could be significant and might determine whether provider agreements, and underlying health care businesses, will be sold in bankruptcy.

Transition Service Agreements

Given the complexity of many health care businesses, transition service agreements may be necessary before a potential purchaser executes a binding term sheet or asset purchase agreement to acquire a debtor's assets. Such agreements can be crucial in pursuit of the debtor's efforts to preserve the value of the company and ensure uninterpreted service to patients. For example, in the *CareMax* cases in the Bankruptcy Court for the Northern District of Texas,[9] the debtor intended to transfer its valuebased management services organization business, operated through three Accountable Care Organizations (the "ACO Business"), to a purchaser selected before the petition date (the "ACO Purchaser").[10] The ACO Purchaser previously purchased an associated service company from a previous unrelated bankruptcy case, which provided critical services to the ACO Business, including services necessary for submitting data in connection with the debtors' participation in the Medicare Shared Savings Program (the "Services").[11] Without the Services, the value of the ACO Business would have been significantly adversely impacted and its continued operation would have been unlikely.[12]

To preserve the ACO Business' value ahead of the debtors' confirmation hearing to consummate the ACO Purchaser's $10 million purchase of the ACO Business, the debtors and ACO Purchaser entered into a transition services agreement for the debtors to receive the Services in exchange for paying certain fees (which would be waived upon consummation of the ACO Business sale).[13] The *CareMax* debtors accordingly requested authority to assume the transition services agreement, which was granted on December 19, 2024.[14]

Health care debtors and counterparties to business-critical agreements should strongly consider establishing transition frameworks to preserve business value for the benefit of each counterparty and patients. More than other industries, health care businesses must strictly adhere to local, state, and federal laws and regulations while maintaining a high level of care and safety for patients. Although it may initially cost several thousand dollars more when documenting the sale, it is wise to draft a separate transition service agreement rather than include certain transition provisions in the asset purchase agreement. With a separate transition service agreement, parties are much more likely to fully contemplate and simplify transition issues and avoid the inevitable post-closing disputes (and associated costs) arising from unclear language in the asset purchase agreement (e.g., what party will file patient claims, what party will pay employees, when does third-party contract liability transition to the purchaser). The proactive transition service agreement in the *CareMax* cases demonstrates a forward-thinking mindset and focus on preserving estate value for the benefit of all parties-in-interest and patients.

Bidding Creativity to Reduce the Prospect of Health Facility Liquidation

After receiving qualifying bids, debtors may need to strategically explain to the bankruptcy court why a perceivably weak bid (e.g., nonbinding bid from an insider with excessive bid protections) should be approved by the court for the benefit of all parties-in-interest, including patients. Such a bid could establish a floor value for a debtor's assets and possibly elicit further interest in the debtor's assets. In the bankruptcy cases in the Bankruptcy Court for the District of Delaware for a digital health company with between $100 million to $500 million in liabilities, the debtors attempted to get court approval to consummate a non-binding bid. Specifically, the debtors received a non-binding bid for the debtor's equity interest in a subsidiary that provided behavioral inpatient and outpatient treatment programs from the subsidiary's former chairman. The purpose of the non-binding bid may have been to encourage at least some of the 50 parties that executed nondisclosure agreements to reconsider

[8] *See* 42 C.F.R. § 422.326(f).
[9] *In re CareMax, Inc.*, Case No. 24-80093 (MVL) (Bankr. N.D. Tex. 2024).
[10] *See id.* Docket No. 23.
[11] *Id.* at ¶ 1.
[12] *Id.*
[13] *Id.* at ¶ 1.
[14] *Id.* at Docket No. 250.

whether to submit a true going concern bid and keep the treatment facility open for patients who may not have access to alternative healthcare services. The bankruptcy court, however, denied the debtor's request to perform under the bid's terms because, *inter alia*, the bid was an "uncommitted" indication of interest subject to further diligence and contained excessive protections for the bidder in the form of a $750,000 breakup fee, $500,000 expense reimbursement cap, exclusivity period of four weeks, and a right of first refusal during the exclusivity period.

The decision provides helpful guidance when health care debtors are struggling to solicit a going concern bid for a particular facility or business line. First, rather than proceed with a non-binding bid, a debtor could construct a binding bid with termination provisions (e.g., termination if sale is not closed after a certain date) or certain closing conditions (e.g., the buyer obtaining regulatory approvals). Although the bidder should intend to close, the bid could provide needed flexibility to the interested party and could still achieve the goal of reinvigorating the bidding process or generating alternative proposals, such as a joint venture with the initial bidder.

Second, when presenting the "binding bid" to the bankruptcy court, the debtor should detail the equitable considerations associated with the bid, namely to keep the health care facility open to continue treating its patients. This public good, especially in rural communities with minimal health care access, is far superior to the alternative – liquidation and reduced health care services to the impacted community. With a binding bid from a non-insider, defensible bid protections (without an exclusivity period and right of first refusal), and/or an explanation of the importance of the facility to the community, a health care debtor can potentially bolster interest in its less desirable assets by incorporating a variation of the strategy utilized by the digital health company debtors in Delaware.

Monitoring Administrative Solvency

With such high stakes in health care cases impacting not only creditors, but also patients and the communities where the provider is located, it is crucial that there be no administrative insolvency concerns, at the very least not during the marketing and sale process. However, health care debtors are not immune to administrative insolvency concerns. Two recent cases demonstrate the bleak reality that may await a health care case after completing a Section 363 sale process. For example, in November 2024, the Bankruptcy Court for the Southern District of Texas granted a national healthcare operator's motion to establish procedures to manage administrative expense claims after admitting that absent a new agreement with its postpetition DIP lender, the debtors did not have enough liquidity to pay all of their administrative expense claims, which included approximately $290 million of DIP claims (i.e., superpriority administrative expense claims) and tens of millions of dollars in other claims.

Another recent example of administrative expense concerns arose in the *Jordan Health Products I, Inc.* bankruptcy cases in the Bankruptcy Court for the District of Delaware,[15] where the official committee of unsecured creditors raised concerns related to the debtors' administrative solvency.[16] As part of a global settlement between the DIP lender, debtors, and committee, the parties agreed to additional funding to pay all administrative claims as part of the final order to approve the debtors' postpetition financing.[17] The Jordan Health Products debtors contended that "absent the settlement, these estates could be rendered administratively insolvent" and that the settlement "provides reasonable comfort that all administrative expenses will be paid."[18]

As both cases demonstrate, health care debtors must be proactive in their negotiations with their postpetition lender to ensure access to adequate liquidity to pay postpetition expenses that preserve patient care and safety. The threat of administrative insolvency can immediately derail an otherwise promising marketing and sale process and cause the demise of a going concern sale that could benefit all parties-in-interest, including patients. Patient safety must be top-of-mind with business preservation and asset maximization during prepetition financing negotiations. For example, although some hospital practice groups may not be as profitable as others, patients rely on the availability of all such groups, and health care debtors must obtain financing for each group regardless of its profitability. Accordingly, health care bankruptcies demand that the debtor and postpetition lender thread the needle to obtain acceptable postpetition financing/cash collateral authorization to ensure that, at a minimum, the provider can maintain safe and dependable services for its patients. Without such alignment, a debtor should consider whether chapter 11 is the proper process to wind down the provider.

[15] *See In re Jordan Health Products I, Inc.*, Case No. 24-12271 (TMH) (Bankr. D. Del. 2024).
[16] *See id.* at Docket No. 150.
[17] *See id.* at Docket No. 287.
[18] *See id.* at Docket No. 215 at ¶¶ 21-22.

Takeaways

There are numerous factors to consider during a bankruptcy sale process, some of which bankruptcy practitioners should be especially mindful of in health care bankruptcies. For example, some health care specific considerations that can simultaneously maximize estate value and protect and preserve patient care include leveraging an ombudsman report to highlight a provider's operating strengths, navigating the transfer of CMS provider agreements and execution of transition service agreements, advocating for the approval of a going concern bid to generate additional third-party interest, and negotiating an acceptable postpetition budget to stave off administrative insolvency during a sale process. With an abundance of health care filings expected to continue, these issues will remain relevant. Quickly identifying these issues can avoid late scrambles and allow debtors to proactively address and resolve such matters.

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