# Health Care Sector Creates Challenges for Distressed Providers, Opportunities for Others

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In 2014, the health care industry continued to see a high level of M&A activity, with announced transactions approaching $440 billion globally by the end of November. In the United States, consolidation continues to occur in the hospital and health care services subsector, often involving distressed health care providers. For many distressed providers — often small and midsized hospitals and hospital systems — acquisition by a financially strong counterparty is the only way to survive.

Ironically, recent efforts to improve the quality of care in the U.S. and rein in its rapidly growing cost are creating new pressures that threaten the ability of many providers to keep their doors open. Government and private payment models continue to transition away from traditional fee-for-service arrangements, which compensate providers for each procedure or service performed, and move toward value-based payment models. Value-based payments focus on quality of care — efficiency and results — rather than quantity of care. Consistent with this approach, the Patient Protection and Affordable Care Act (PPACA) and other health care regulations and reimbursement schemes incentivize cost-cutting *(e.g.*, allowing providers, through Accountable Care Organizations, to retain a portion of the cost savings they achieve in caring for patients) and penalize poor patient results (*e.g.*, providers' reimbursement rates are reduced under the PPACA's Hospital Readmissions Reductions Program for excess patient readmissions). In short, value-based payment models are designed to eliminate unnecessary treatment and improve care by shifting the risk of excessive costs and poor outcomes to providers. The focus on efficiency and good results encourages quality outpatient care, rather than hospital admissions and procedures, when appropriate. As a result, patient admission rates have decreased, resulting in lower revenue per patient for many providers.

Adapting to the new regime is a significant challenge. Facilities originally designed to accommodate higher numbers of admitted patients now have excess capacity and cannot shrink their footprints or high fixed costs without significant investment. Moreover, to succeed within a value-based payment model, health care providers must invest in technology and other capital improvements to increase efficiency and improve patient outcomes.

Larger hospital systems can spread these costs over a broader revenue base. They also are better able to negotiate more favorable private payor contracts and to decrease expenses through bulk purchasing. In addition, to offset the loss of revenue under value-based payment models and the substantial costs of new technology, many hospitals and other providers are attempting to increase revenues by providing additional services (*e.g.*, home health care, long-term care or rehabilitation). The value-based payment model favors this horizontal integration and the ability to provide a broad range of services to address the entire spectrum of care. The economies of scale for larger systems are significant, and smaller, capital-constrained hospitals and hospital systems have struggled to keep up.

As the transition to value-based payments continues over the next several years and these pressures intensify, we expect to see significant consolidation in the industry and an increase

in the number of distressed sales of hospitals and other health care providers. Larger and healthier systems seeking to expand their footprint and revenue base will have the opportunity to acquire assets, practice groups and patients at distressed prices.

For distressed providers, selling through Chapter 11 is often the best option, but debtors must be aware of many issues. The automatic stay and other protections afforded to a debtor in Chapter 11 provide time to market assets and effectuate a transaction. For example, a Chapter 11 debtor faces scrutiny by the bankruptcy court, creditors, customers, and other stakeholders and parties in interest. Chapter 11 does not absolve a health care provider of its obligation to strictly protect patient information under state and federal laws, and care must be taken to avoid inadvertent disclosure while operating in the "fishbowl" of Chapter 11. In addition, providers must plan for new costs, including those of a patient care ombudsman (charged with reporting to the bankruptcy court on patient care issues in health care provider Chapter 11 cases). For health care providers highly dependent upon Medicare revenue, the government's ability to recoup prior overpayments and significantly impact liquidity must be carefully considered.

For a purchaser, acquiring assets in Chapter 11 also may be advantageous. It can pick and choose the assets it will acquire and the liabilities it will assume, often making a Chapter 11 transaction more appealing than an out-of-court transaction. But Chapter 11 creates uncertainties for a purchaser as well. For example, because bankruptcy asset sales are subject to higher and better offers, a potential purchaser that has a fully negotiated deal with the debtor remains subject to the risk that it will be outbid at auction. Price is not the only factor in selecting the winning bid. A health care debtor can consider other factors, such as the impact on patients, the availability of services in the community post-sale and, in the case of a nonprofit, the impact of the sale on the nonprofit's mission. If the purchaser is selected as the highest or otherwise best offer, transferring Medicare provider numbers and obtaining regulatory approvals become key closing issues. And as in an out-of-court sale, antitrust concerns remain an issue.

Given the trends in this sector, buyers must continue to navigate these issues in pursuit of valuable assets while sellers seek relief from distress.