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New Regulations and Reimbursement Schemes Create Challenges for Distressed Health Care Providers, Opportunities for Others

By Felicia Gerber Perlman and Matthew Kriegel

In 2014, the hospital and health care services subsector saw continued consolidation as larger hospital systems acquired smaller health care services providers. Many of the acquired providers — often small and midsized hospitals and hospital systems — suffered from financial distress, and acquisition by a financially strong counterparty may have been their only way to survive.

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Ironically, among the causes of distress in the health care services subsector are the recent efforts to improve the quality of care in the U.S. while reining in its rapidly growing cost. 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)[1] 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 Reduction Program[2] 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, as have the costs of treating many patients, 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.

[1] 42 U.S.C. § 18001 et seq. (2010).

[2] *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3025 (2010). Section 3025 of the PPACA implemented the Hospital Readmissions Reduction Program through an amendment of Section 1886 of the Social Security Act, 42 U.S.C. § 1395ww.

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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, the industry is expected to see additional consolidation 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.

Chapter 11 Sale Not Without Challenges, But Often Best Option For Distressed Providers Seeking Sale

Chapter 11 affords a debtor with rights and protections designed to allow it to effectuate a value-maximizing transaction for the benefit of its creditors and interest holders. Immediately upon commencing a Chapter 11 case, the debtor is protected by the automatic stay from, among other things, creditor actions to collect.[3] At the same time, the Bankruptcy Code provides mechanisms for a debtor to obtain new, post-petition financing.[4] Protections from creditor actions and sufficient funding to continue operations together provide at least two distinct advantages to the debtor. First, debtor's management will have both the financial resources and the time to focus on patient care instead of pressure from creditors. In addition, the debtor will have a limited ''runway'' to market and sell its assets for the highest available price. To ensure that the runway is sufficient, the debtor must of course carefully consider its liquidity needs over the course of its Chapter 11 case and size its post-petition financing facility accordingly.

Although Chapter 11 may provide the means to maximize the value of the debtor's assets, it does not come without costs or absolve a health care operator of its nonbankruptcy obligations.

1. Debtors Face Increased Scrutiny From Outsiders

One of the most immediate repercussions of commencing a Chapter 11 case is that bankruptcy shines a spotlight on the debtor. New constituencies, including the U.S. Trustee, the official committee of unsecured creditors,[5] and possibly other committees or ad hoc groups if appointed by the U.S. Trustee,[6] will have the opportunity to scrutinize a debtor's actions.[7] Not only are ongoing business operations of the debtor likely to be examined, but past transactions may be reviewed and challenged.[8] The expenses associated with these parties' participation in the debtor's Chapter 11 case are borne by the debtor's estate.[9]

Where the debtor is a health care operator, the debtor's ability to care for patients will also be closely monitored. Among the health care related amendments to the Bankruptcy Code contained in the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 was the addition of Section 333 of the Bankruptcy Code, which requires that a bankruptcy court presiding over a Chapter 11 case of a ''health care business''[10] order, ''not later than 30 days after the commencement of the case, the appointment of an ombudsman to monitor the quality of patient care and to represent the interests of the patients of the 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.''[11] The patient care ombudsman (PCO) is charged with ''monitor[ing] the quality of patient care provided to patients of the debtor'' and reporting to the bankruptcy court regarding the same.[12] Like other professionals, she is compensated by the debtor's estate.[13]

Health care is a highly regulated industry, and many health care providers — hospitals in particular — are already subject to careful oversight by various regulators. In some instances, bankruptcy courts have found appointment of a PCO to be unnecessary where a PCO's monitoring and oversight function is duplicative of ex-

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[3] 11 U.S.C. § 362.

[4] 11 U.S.C. § 364.

[5] 11 U.S.C. § 1102 (''as soon as practicable after the order for relief under [C]hapter 11 of this title, the United States trustee shall appoint a committee of creditors holding unsecured claims and may appoint additional committees of creditors or of equity security holders as the United States trustee deems appropriate'').

[6] *Id.*

[7] An official committee has certain statutory powers, including the rights to ''consult with the trustee or debtor concerning the administration of the case'' and to ''investigate the acts, conduct, assets, liabilities and financial condition of the debtor, the operation of the debtor's business and the desirability of the continuance of such business, and any other matter relevant to the case and to the formulation of a plan.'' 11 U.S.C. § 1103(c).

[8] Transactions made while the debtor was insolvent or that caused the debtor to be insolvent can be unwound. *See, e.g.*, 11 U.S.C. § § 547, 548.

[9] *See* 11 U.S.C. § 330(a).

[10] Pursuant to Section 101(27A) of the Bankruptcy Code, ''[t]he term ''health care business'' (A) means any public or private entity (without regard to whether that entity is organized for profit or not for profit) that is primarily engaged in offering to the general public facilities and services for (i) the diagnosis or treatment of injury, deformity, or disease; and (ii) surgical, drug treatment, psychiatric, or obstetric care.'' 11 U.S.C. § 101(27A).

[11] 11 U.S.C. § 333(a)(1).

[12] *Id.* at § 333(b).

[13] 11 U.S.C. § 330(a)(1). However, because Section 333 of the Bankruptcy Code does not expressly authorize the PCO to retain counsel and other professionals to assist her in the discharge of her duties, there is some debate as to her ability to do so. *Compare In re Synergy Hematology-Oncology Medical Assocs., Inc.*, 433 B.R. 316, 319 (analogizing role of PCO to role of examiner and permitting PCO to retain counsel) *with In re Renaissance Hospital-Grand Prairie Inc.*, 399 B.R. 442, 447-48 (Bankr. N.D. Tex. Dec. 31, 2008) (rejecting analogy and limiting role of PCO's counsel).

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isting oversight and patient protections.[14] However, where the debtor is a hospital or provides treatment for acutely ill patients, the U.S. Trustee and/or state regulators may resist the debtor's efforts to obtain a waiver. Whether a PCO is appointed or the debtor continues to operate under the oversight of regulators who closely monitor patient care and outcomes and governmental and non-governmental payors who reimburse accordingly, a debtor should ensure that it continues to operate at the highest possible level in Chapter 11.

2. Chapter 11 Does Not Obviate Patient Confidentiality Obligations

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)[15] created, among other things, strict rules relating to the protection of patients' personally identifiable health information. A health care provider that fails to comply with HIPAA can face stiff financial penalties.[16] Chapter 11 does not absolve a health care provider its obligations under HIPAA or similar laws, and a debtor must remain vigilant that it is adhering to those obligations while operating in the ''fishbowl'' of Chapter 11, where public disclosure and transparency is paramount. The Bankruptcy Code requires that debtors publicly file, among other things, a list of all of their creditors, schedules of all of their assets, liabilities, income and expenses, and a summary of their recent financial history, transactions, and operations.[17] In a sale transaction, they must file schedules of executory contracts to be assumed and cured by the purchaser. If the creditors or counterparties include patients or former patients, disclosure of their names and addresses may violate HIPAA. At a minimum, personally identifiable health information should be redacted from public filings and materials shared with other constituents — e.g., the U.S. Trustee or any official committee — to avoid improper disclosure.

Recent cases have demonstrated that the federal government has been closely observing Chapter 11 cases and stepping in as necessary to ensure compliance with HIPAA. In the Laboratory Partners, Inc. Chapter 11 proceedings,[18] for example, the U.S. Secretary of Health and Human Services (HHS) objected to the proposed sale of the debtors' laboratory testing services business, which included customer lists that likely included customers' protected health information.[19] HHS argued that under HIPAA, such information may only be sold with customer authorization, unless the purchaser is a ''covered entity'' under HIPAA.[20] Although the purchaser of the assets represented and warranted that it was a ''covered entity'' and the sale was ultimately approved,[21] HHS's involvement in the case illustrates the scrutiny that a health care provider may face and the importance of complying with patient confidentiality obligations during Chapter 11.

3. Potential Increased Liquidity Risk From Recoupment Of Overpayments

Health care providers usually receive payments from Centers for Medicare & Medicaid Services (CMS) for services rendered. A provider may receive overpayments, as a result of the inadvertent submission of duplicate claims for reimbursement or the submission of claims for excluded services or services that are determined to not be medically necessary. CMS has several means to recover overpayments outside of bankruptcy. Particularly relevant in the context of a health care provider's Chapter 11 proceedings is CMS's right to recoupment — i.e., to repay itself by withholding future payments.

The impact of recoupment on liquidity can be very significant for debtors heavily reliant on Medicare revenue. Engaging directly with CMS to negotiate a less drastic means of repayment may be possible. In addition, depending upon the date of a Chapter 11 filing relative to the end of a Medicare plan year, the jurisdiction where a debtor's case is filed may limit CMS's right of recoupment. In certain jurisdictions, including the Third Circuit, each plan year constitutes a ''single transaction'' for purposes of recoupment.[22] In these jurisdictions, in order to recover prior years' overpayments by withholding future payments, CMS would be required to seek modification of the automatic stay to effect a setoff.[23] Other jurisdictions, by contrast, view all activ-

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[14] Bankruptcy courts typically apply a ''totality of the circumstances'' test for determining whether a patient care ombudsman should be appointed. In *In re Alternate Family Care*, the Bankruptcy Court for the Southern District of Florida outlined nine non-exclusive salient factors that the court would analyzing in making this determination: (1) the cause of the bankruptcy; (2) the presence and role of licensing or supervising entities; (3) debtor's past history of patient care; (4) the ability of the patients to protect their rights; (5) the level of dependency of the patients on the facility; (6) the likelihood of tension between the interests of the patients and the debtor; (7) the potential injury to the patients if the debtor drastically reduced its level of patient care; (8) the presence and sufficiency of internal safeguards to ensure appropriate level of care; and (9) the impact of the cost of an ombudsman on the likelihood of a successful reorganization. 377 B.R. 754, 758 (Bankr. S.D. Fla. 2007). Other factors that courts consider include: (10) the high quality of the debtor's existing patient care; (11) the debtor's financial ability to maintain high quality patient care; (12) the existence of an internal ombudsman program to protect the rights of patients, and/or (13) the level of monitoring and oversight by federal, state, local, or professional association programs which renders the services of an ombudsman redundant. *In re Valley Health System*, 381 B.R. 756, 761 (Bankr. C.D. Cal. 2008).

[15] Pub. L. 104-191, 100 Stat. 2548 (1996).

[16] *See* 42 USC § 1320d-5.

[17] 11 U.S.C. § 521.

[18] *In re Laboratory Partners, Inc., et al.*, Case No. 13-12769-PJW (Bankr. D. Del. 2013).

[19] *In re Laboratory Partners, Inc., et al.*, Case No. 13-12769-PJW (Bankr. D. Del. Dec. 18, 2013).

[20] *Id.*

[21] *In re Laboratory Partners, Inc., et al.*, Case No. 13-12769-PJW (Bankr. D. Del. Feb. 18, 2014).

[22] *See, e.g.*, *Univ. Med. Ctr.*, 973 F.2d 1065, 1080-81 (3d. Cir. 1992).

[23] The automatic stay bars a creditor from effectuating setoff. *See, e.g.*, *Malinowski v. New York State DOL (In re Malinowski)*, 156 F.3d 131 (2d Cir. 1998). In contrast, the automatic stay does not restrict a creditor's to exercise recoupment. *See, e.g.*, *Kosadnar v. Metropolitan Life Ins. Co. (In re Kosadnar)*, 157 F.3d 1011, 1016 (5th Cir. 1998). ''[S]et-off claims are subject to the automatic stay of 11 U.S.C. § 362 and are substantively limited by the by the Bankruptcy Code [under 11 U.S.C. § 553]. Recoupment, in contrast, comes into bankruptcy law through the common law, rather than by statute . . . and is not subject to the limitations of [S]ection 553 or the automatic stay. . . . The automatic stay is inapplicable, because funds subject to recoupment are not the debtor's property.'' *Malinowski*, 156 F.3d at 133.

ity under a provider agreement as a single transaction, and would permit CMS to recoup overpayments from any period.[24] While all amounts owed to CMS must ultimately be repaid when the provider agreement is assumed under a plan of reorganization or in a sale of the debtor's assets, filing in a favorable jurisdiction may provide a debtor with additional liquidity during its Chapter 11 proceeding.

Purchasers Can Realize Significant Benefits From Acquiring Assets In Chapter 11, But Must Consider Risks As Well

Potential purchasers also must be aware of the issues that can arise when acquiring assets in Chapter 11. One key advantage is that a purchaser can generally 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. It can acquire the assets it chooses to buy ''free and clear'' of any interest in those assets.[25] Although Chapter 11 provides significant benefits to purchasers, it does not eliminate — and at times, may increase — the risks and uncertainties associated with a transaction.

1. Multilateral Chapter 11 Sale Process Creates Uncertainties For Purchasers

A sale of a health care operator outside of bankruptcy is generally a bilateral negotiation between the buyer and the seller. The seller generally retains control over the process and determines on its own whether an offer is acceptable. Sales transactions in Chapter 11, by contrast, are multilateral. In addition to the buyer and seller, the creditors' committee, U.S. Trustee, prepetition and postpetition lenders, the PCO, any equity committee or other ad hoc groups (if applicable), a consumer privacy ombudsman (if appointed), and the court will all be involved in the sale process. These parties, along with any additional parties-in-interest or creditors, may contest the debtor's bidding procedures or proposed sale. They may have their own ideas as to the best use of the debtor's assets or what constitutes the highest or otherwise best offer for the debtor's assets.

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, impact of the sale on the nonprofit's mission. As a result, even a bidder with the highest offer may not be the winning bidder.

2. Labor Unions May Exert Influence on Chapter 11 Sale Process

Labor unions may create significant uncertainty for a purchaser of a healthcare operator's assets in a number of ways. Section 1113 of the Bankruptcy Code, which provides special procedures and tests for rejection or modification of collective bargaining agreements (CBAs) in Chapter 11 cases, may enable the debtor to undertake value-maximizing transactions that would otherwise be unavailable. But it does not give a debtor free rein to do as it pleases. To reject a CBA, the debtor must meet the stringent requirements of Section 1113 by showing, among other things, that the proposed modifications are necessary to permit reorganization and that the modification treat all parties fairly and equitably (i.e., it must not disproportionately place the burden of saving the debtor's business on labor).[26]Even if the debtor meets the high standard for obtaining Section 1113 relief and imposes the modifications it needs to effectively reorganize, it is not out of the woods. Nothing prohibits a union from exercising its right to strike. Through deprivation of jurisdiction over union strikes under the Norris-LaGuardia Act, 29 U.S.C. § § 101-10, 113-15, a union can even strike to seek reinstatement of an agreement that has just been rejected.[27] In addition, the need for regulatory approvals for the transfer of a healthcare business can also provide unions with an alternative method to challenge a disfavored sale.[28]

3. Defaults Under Assigned Medicare Provider Agreements Must Be Cured

A majority of jurisdictions treat Medicare provider agreements as executory contracts subject to assumption and assignment in bankruptcy.[29] Prior to assumption of an executory contract, Section 365(b)(1) of the Bankruptcy Code requires that any defaults under the contract, including pre-petition amounts owed to the counterparty, must be cured. Generally, a purchaser will not have a practical alternative to accepting assignment of a provider agreement. Absent a provider agreement, a health care provider cannot receive payments from Medicare. Obtaining a new provider agreement

[24] *See, e.g.*, *Holyoke Nursing Home, Inc. v. Health Care Financing Admin. (In re Holyoke Nursing Home, Inc.)*, 372 F.3d 1, 3-4 (1st Cir. 2004); *Sims v. United States Dep't. of Health & Human Serv. (In re TLC Hospitals, Inc.)*, 224 F.3d 1008, 1010-12 (9th Cir. 2000); *United States v. Consumer Health Servs. Of Am., Inc.*, 108 F.3d 390, 395 (D.C. Cir. 1997); *In re AHN Homecare, LLC*, 222 B.R. 804, 811-12 (Bankr. N.D. Tex. 1998).

[25] 11 U.S.C. § 363(f).

[26] *In re Century Brass Products, Inc.*, 795 F.2d 265, 273 (2d Cir. 1986); *In re William P. Brogna & Co.*, 64 B.R. 390, 392 (Bankr. E.D. Pa. 1986).

[27] *See Briggs Transp. Co. v. Int'l Bhd. of Teamsters*, 739 F.2d 341 (8th Cir. 1984).

[28] *See infra* notes 32-33 and accompanying text.

[29] *See, e.g.*, *In re Univ. Med. Ctr.*, 973 F.2d 1065, 1076 (3d Cir. 1992) (''A Medicare provider agreement easily fits within th[e] definition [of an executory contract]''); *In re Heffernan Mem. Hosp. Dist.*, 192 B.R. 228, 231 n.4 (Bankr. S.D. Cal. 1996) (''A Medicare provider agreement is an executory contract''); *In re St. Johns Home Health Agency, Inc.*, 173 B.R. 238 n.1 (Bankr. S.D. Fla. 1994) (''This Court concludes, as have most that address the issue, that the [p]rovider [a]greement is an executory contract subject to assumption or rejection by a debtor-in-possession''); *but see*, *e.g.*, *In re BDK Health Mgmt Inc.*, 1998 WL 34188241 (Bankr. M.D. Fla. Nov. 6, 1997) (holding that Medicare provider numbers are statutory entitlements, not contracts that can be assumed and assigned, because the rights and duties of a health care provider and the Department of Health and Human Services are set forth in Medicare statutes and regulations).

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can be a lengthy and burdensome process.[30] Accordingly, a health care provider debtor and a potential purchaser must pay close attention to cure costs during negotiations.

4. Regulatory Approval Process May Impose Additional Risk

Health care providers are highly regulated entities subject to federal and state regulations and licensure rules. As a result, acquiring the assets of a health care debtor is often more complicated and time-consuming than acquiring the assets of a debtor operating in another industry. Federal law establishes change-of-ownership requirements for Medicare provider agreements.[31] In addition, transfers of government contracts, licenses, permits and certificates of need are subject to various state statutes and regulations, and such transfers typically require notice to and approval by the relevant agency.

The same requirements apply in Chapter 11. Bankruptcy Code Sections 363(d) and 1129(a)(16) require compliance with any applicable nonbankruptcy law in the event of a sale of a nonprofit corporation. In addition, Section 541(f) of the Bankruptcy Code specifically governs a sale of a nonprofit corporation to a for-profit entity and provides that such a sale may only take place under the same conditions that would be applicable outside of Chapter 11. With respect to sales of for-profit hospitals, the Bankruptcy Code does not contain a specific provision that requires compliance with applicable nonbankruptcy law. However, noncompliance with state statutes and regulations could result in the lack of appropriate licensure and the inability of a purchaser to operate the business. Effectively, therefore, compliance with state statutes and regulations governing health care businesses is required where the debtor is a for-profit entity.

The need for regulatory approvals can also provide the debtor's creditors and other constituencies with an alternative way to challenge a disfavored transaction. For example, in 2014, Prime Healthcare Services Inc. agreed to acquire six troubled nonprofit hospitals from the Daughters of Charity Health System and committed to keep all of them open and operating — and providing essential services for their communities — for a period of five years. The Service Employees International Union (SEIU), expressing concern based upon Prime Healthcare's previous hospital acquisitions that services would be cut, prices would be raised, and caregivers would be laid off, opposed the takeover. The sale of a health care business in California requires the approval of the state's attorney general. The SEIU reportedly recruited state lawmakers and community groups to oppose the transaction and took out television ads urging the attorney general to reject it. The attorney general ultimately approved the sale to Prime Healthcare on February 20, 2015, subject to certain conditions (including the requirement that Prime keep the hospitals open for 10 years, not five).[32] Highlighting the importance of securing regulatory approvals to health care acquisitions, Prime Healthcare walked away from the deal in early March 2015 after reportedly requesting and failing to obtain a modification of some of the conditions imposed by the attorney general.[33] Although the Daughters of Charity Health System saga has not thus far played out in Chapter 11, the same regulatory approval process would be required and SEIU and other creditors could continue to challenge the transaction in a Chapter 11 context.

5. Purchaser Must Still Comply With Antitrust Laws

The Bankruptcy Code does not exempt Chapter 11 health care acquisitions or combinations from compliance with federal and state antitrust statutes. In 1994, the Department of Justice (DOJ) and the Federal Trade

[30] Obtaining a new provider agreement requires a survey of the purchaser by a designated state agency that may take months or even years to complete, and a purchaser cannot seek Medicare reimbursement until the effective date of its new provider agreement, which is typically after the survey is completed. Ari J. Markenson and Kelly J. Skeat, *New CMS Guidelines for Acquiring a Medicare Provider: Buyer Beware*, Compliance Today, September 2014, at 55, http://www.duanemorris.com/articles/static/markenson_compliancetoday_090914.pdf.

[31] Prior to a merger of a health care provider into another corporation or the consolidation a health care provider into another corporation, in order to transfer the Medicare billing number or privileges of the seller, Medicare regulations require the current owner and the prospective new owner to submit enrollment applications. Prohibitions on the Sale or Transfer of Billing Privileges, 42 C.F.R. § 424.550 (2015). Failure to properly do so could result in sanctions to the current owner or deactivation of the Medicare billing number. *Id*. Approval of such an application may take several months; however, upon approval, the authorization is generally retroactive to the closing date of the sale. Markenson and Skeat at 54. While the application is pending, the purchaser can use the seller's provider number, though reimbursement on some amounts may be placed under temporary holds during that time. *Id*. Upon approval of the application, the buyer will usually be able to recover such amounts. *Id*.

[32] Notwithstanding the ultimate approval of the transaction, the impact of the SEIU objections to Prime Healthcare's acquisition of the hospitals was significant. Just after the sale was approved by the California attorney general, the Daughters of Charity Health System sued the SEIU, alleging that the union's interference caused other potential bidders to drop out and significant delays in obtaining the requisite approvals, costing the system tens of millions of dollars. Chris Rauber, *Daughters of Charity system sues SEIU, Blue Wolf Capital for 'interfering' with sale*, Feb. 25, 2015, http://www.bizjournals.com/sanfrancisco/blog/2015/02/daughters-of-charity-system-sues-seiu-blue-wolf.html

[33] *See* Jon Healy, *Prime Healthcare: villain or victim in Daughters of Charity story?*, Mar. 10, 2015, http://www.latimes.com/opinion/opinion-la/la-ol-prime-daughters-of-charity-kamala-harris-20150310-story.html#page=1 (quoting a Prime Healthcare spokesperson: ''[c]onditions [imposed by the California attorney general] dictate operations far beyond the scope of what is typical, including service offerings, financial reporting, governance, staffing levels, on-call coverage, seismic compliance and insurance contracts. . . . Maintaining all services for 10 years regardless of whether the services are needed or 'essential' for the communities served is unprecedented and untenable''). Similarly, Tenet Healthcare Corp.'s effort to acquire several nonprofit hospitals in Connecticut was derailed by an inability to obtain governmental approvals. Connecticut's governor reportedly imposed 47 conditions on Tenet's acquisition. Among other conditions, Tenet would have been prohibited from reducing the hospitals' workforce or cutting services for a period of five years. Tenet withdrew its offer. *See* Matthew Sturdevant and Christopher Keating, *Tenet's Plan To Buy Connecticut Hospitals Is Dead*, Feb. 5, 2015, http://www.courant.com/business/hc-tenet-hospital-deal-dead-20150204-story.html#page=1.

Commission (FTC) established an ''antitrust safe zone'' for certain types of transactions, including the merger of two general acute care hospitals where one of the hospitals has been in existence for more than five years, has fewer than 100 licensed beds, and has an average daily census of 40 patients or less. Transactions outside of the safe zone that lead to industry consolidation may be scrutinized and barred if it is determined that they would substantially lessen competition.[34]

Recently, the FTC has made controlling medical costs a ''top priorit[y].''[35] In remarks made at a February 2015 conference, FTC chairwoman Edith Ramirez conveyed that in adapting to changes in market forces and the regulatory scheme by merging various healthcare businesses, the health care industry was neglecting to resolve antitrust problems.[36] The FTC is particularly concerned with two recent trends in healthcare mergers – mergers involving urban hospitals purchasing suburban hospitals and hospitals purchasing different types of providers, including imaging companies or diagnostic centers.[37] Ramirez remarked that the FTC will pursue hospitals and other groups that violate antitrust laws.[38] Accordingly, strategic purchasers should be prepared to engage with the DOJ and FTC to address antitrust concerns, particularly in larger transactions.[39]

Conclusion

For many distressed providers and strategic purchasers, the Chapter 11 sale process and the unique issues it presents can seem foreign and daunting. With the assistance of experienced advisors, however, many of the potential risks and pitfalls can be mitigated or avoided completely. A Chapter 11 sale can provide significant advantages for all parties involved in a sale of health care assets and should be considered as a potential option for distressed providers.

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[34] The Sherman Act prohibits contracts, combinations and conspiracies that unreasonably restrain trade, as well as attempts to monopolize. *See* 15 U.S.C. § 1, 2. The Clayton Act prohibits combinations of entities that substantially lessen competition or tend to create a monopoly. *See* 15 U.S.C. § 18.

[35] Diane Bartz, *FTC prioritizing competition in healthcare market*, Feb. 25, 2015, http://www.reuters.com/article/2015/02/25/healthcare-ftc-idUSL1N0VZ0RH20150225.

[36] Michael Macagnone, *Antitrust Concerns Abound in Hospital Mergers, Ramirez Says*, Feb 24, 2015, http://www.law360.com/articles/624722/antitrust-concerns-abound-in-hospital-mergers-ramirez-says.

[37] *Id.*

[38] *Id.*

[39] The Hart-Scott-Rodino Antitrust Improvement Act of 1976 (the HSR Act) requires that certain acquisitions of assets or voting securities between parties exceeding size-of-person thresholds be reported in advance to the DOJ and FTC. *See* 15 U.S.C. § 18a. Outside of bankruptcy, this reporting triggers a 30-day waiting period during which the DOJ or FTC may decide to investigate further and issue a second request for information about the parties or the transaction. The waiting period is reduced to 15 days for transactions consummated in Chapter 11 under Section 363(b) of the Bankruptcy Code. 11 U.S.C. § 363(b)(2)(B). If the agency issuing the second request determines that the proposed acquisition would violate federal antitrust law, it may seek an injunction. Alternatively, it may negotiate a consent order with the parties to allow the transaction to proceed, subject to certain divestiture or other conditions. In the absence of agency action, the parties are free to complete the proposed transaction.

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