Health Care Accounts Receivable Financing

Contributed by ***James J. Mazza, Jr.***, ***Justin M. Winerman***, and ***Rebecca L. Ritchie***—Skadden, Arps, Slate, Meagher & Flom LLP. The opinions expressed are those of the authors and do not necessarily reflect the views of their employer, its clients, or any of its or their respective affiliates. This article is for general information purposes and is not intended to be, and should not be taken as, legal advice.

Health care accounts receivable often comprise a significant source of revenue for health care providers, and they are also an asset that lenders may seek as part of their collateral package for a loan to such health care providers. Because a substantial portion of the accounts receivable typically come from government payors,[1] both borrowers and lenders should be aware of particular concerns that apply in structuring financings that rely on these accounts receivable as collateral. This overview describes how health care accounts receivable financing works, beginning with a brief discussion of Medicare/Medicaid reimbursement and applicable statutes, and closing with other aspects of such financing that bankruptcy attorneys should consider.

Introduction

The federal and state governments play a prominent role as payors in the health care system. Generally, there are three sources of accounts receivable for a health care provider: government collections (reimbursements from the government for Medicare, Medicaid, and other governmental health care programs); commercial collections (payments from commercial insurers); and self-pay collections (payments from individuals who received services). A lender is less likely to lend against self-pay accounts receivable, which may be more difficult to collect. This overview discusses both governmental and commercial accounts receivable as collateral, but pays particular attention to government accounts receivable given that they are highly regulated.

Government collections arise as a result of agreements between health care providers and institutions who participate in Medicare or Medicaid and the relevant federal and, in the case of Medicaid, state government agency. Pursuant to provider agreements, the government, either directly or through an intermediary, will periodically reimburse health care providers for the estimated cost of services provided to Medicare or Medicaid patients. Such reimbursement payments are the accounts receivable. The government, or the intermediary, will also conduct a periodic audit to evaluate whether the government has overpaid or underpaid the provider for the services, and the government may subsequently adjust future payments in response to such audit. **42 U.S.C. § 1395g(a)**; **Smart Code®**.

Perfecting a Security Interest in Health Care Accounts Receivable

Under the Uniform Commercial Code, for a lender's interest in the accounts receivable to be fully secured, the interest must attach to the collateral, and the lender must properly perfect the interest. As an initial matter, a security interest in accounts receivable attaches when the health care provider receives the government or commercial collections. See **U.C.C. § 9-203**. With respect to perfection, a lender will want a perfected security interest in both the accounts receivable as well as the deposit account into which the accounts receivable will be deposited. Doing so ensures that in addition to having a lien on the accounts receivable, the lender can also direct the disposition of the funds in the deposit account to exercise the lender's rights pursuant to the lien.

Accounts receivable fall within the definition of "accounts." **U.C.C. § 9-102(a)(2)**. A lender perfects a security interest in accounts by filing a financing statement with the state in which the health care provider is located (which for most corporations, limited liability companies, and limited partnerships organized under the laws of a state of the United States is the jurisdiction of organization of such entity). See **U.C.C.§ 9-307(b)**, **(e)**; **U.C.C. § 9-310(a)**. At that point, the lender has a valid and enforceable lien with respect to the accounts receivable.

After payments of the accounts receivable are placed into a deposit account, they are considered proceeds of the accounts receivable. The lender is still perfected in the proceeds, as long as the proceeds are traceable; however, lenders typically will want the additional security of being perfected in the deposit account itself. In order to perfect a security interest in a deposit account, a lender must establish control over the deposit account. See **U.C.C. § 9-312(a)**. Typically, a lender will do so by executing a control agreement, which provides that the bank overseeing the deposit account will comply with the lender's instructions regarding disposition of the funds in the deposit account and will not require further consent by the health care provider. See **U.C.C. § 9-104(a)(2)**.

Anti-assignment provisions in the laws governing Medicare and Medicaid complicate this process with respect to government collections. These provisions generally prohibit government payments under Medicare and Medicaid from being made to anyone other than health care providers, who must thus have full control over the disposition of such payments on deposit in a deposit account. See **42 U.S.C. § 1395u(b)(6)**; **42 U.S.C. § 1395g(c)**; **42 U.S.C. § 1396a(a)(32)**; **42 C.F.R. § 424.73**. Put another way, unlike other ordinary accounts receivable, governmental health care accounts receivable cannot be directly assigned to a lender as collateral. Directly assigning health care accounts receivable to a lender or granting a lender control over a deposit account containing payments of health care accounts receivable, such that the lender can direct the ultimate disposition of such funds, would violate the anti-assignment provisions.[2]

But the anti-assignment provisions do not prevent a health care provider from granting a security interest in Medicare and Medicaid receivables. To address this complication, a lender will often require a so-called "double lockbox" arrangement. Under this structure, pursuant to a depository agreement, the health care provider agrees to direct the deposit of government collections into a designated governmental deposit account. The health care provider has exclusive control of the funds deposited therein, and such account is subject to the exclusive signing authority of the health care provider. The health care provider is deemed to have received the payment when the funds are deposited into the governmental deposit account, satisfying the anti-assignment provisions. The depository agreement,

however, also provides that such funds are subsequently swept on a periodic basis (generally, daily) into a different account controlled by the lender, which allows the lender to control the ultimate disposition of the funds. Still, this arrangement is not without risk, as the health care provider must at all times have the right to rescind the order directing the sweep of its deposit account. If the health care provider files for bankruptcy, the secured lender may request a bankruptcy court order authorizing the assignment of the health care debtor's Medicare and Medicaid receivables.

Issues That May Arise Upon a Health Care Provider's Entry Into Bankruptcy

Lending against health care accounts receivable presents a variety of other issues for lenders, borrowers, and other parties to consider once the health care provider files for bankruptcy. Several of these issues are discussed briefly below.

Automatic Stay . The automatic stay is a fundamental protection for all debtors, including health care debtors. It aims to give distressed companies who file for bankruptcy a "breathing spell" from their creditors, including health care lenders and the government, unless the government is excepted from the stay because it is deemed to be exercising its governmental "police powers." For more, see **Overview – Automatic Stay**; **Overview – Police Power Exception to the Automatic Stay**.

Recoupment and Setoff . As noted above, the federal or state government, generally through a fiscal intermediary or state agency, respectively, reimburses a Medicare or Medicaid provider on a periodic basis. Reimbursement payments are estimates of actual expenditures and are subsequently audited annually to determine if the government has overpaid or underpaid the health care provider across the year. The government can then adjust subsequent reimbursement payments to account for any prior overpayment or underpayment.

Upon learning of a health care provider's bankruptcy filing, the government may decide to suspend Medicare and Medicaid reimbursements while it determines whether it is owed any overpayments under the applicable provider agreements. As such, a secured lender's right to health care accounts receivable may be affected.[3]

Some courts have held that withholding post-petition Medicare and Medicaid reimbursements is a violation of the automatic stay. See **Smart Code**. This may turn in part on whether a court views the government's actions as recoupment or setoff.

Recoupment is an equitable defense that permits the reconciliation of claims arising out of the same transaction, without regard to whether both claims arose prepetition. See **Court Opinions**; see also **Overview – Recoupment**. Recoupment is distinct from setoff, which is governed by the Bankruptcy Code and requires that the claim and the debt are mutual, valid, and enforceable obligations that arose prepetition, but does not require that the claims be part of the same transaction. **11 U.S.C. § 553(a)**; see also **Overview - Setoff**; **Comparison Table - Setoff & Recoupment**. Importantly, setoff is subject to the automatic stay, but recoupment is not. **11 U.S.C. § 362(a)(7)**; **Smart Code**. Therefore, whether the claims arise from the same transaction is critical. If so, the claims are thus subject to recoupment, and the government could try to recoup overpayments without needing bankruptcy court relief.

Some courts, including those in the Third Circuit, apply a narrow "single integrated transaction" test to the analysis of whether claims arise from the same transaction. Under this test, in order for recoupment to apply, "both debts must arise out of a single integrated transaction so that it would be inequitable for the debtor to enjoy the benefits of that transaction without also meeting its obligations."[4] **Court Opinions**. Other courts, however, take a broader approach, often referred to as the "logical relationship" test, which contemplates that a "[t]ransaction" may include "a series of many occurrences, depending not so much upon the immediateness of their connection as upon their logical relationship."[5] **Court Opinions**. The difference between the two approaches is the extent to which the respective obligations are interconnected. **Court Opinions**.

Often, the health care provider and the government may agree to enter into stipulations or settlements (at times, after litigation) that preserve the health care provider's access to these accounts receivable, and thus the provider's access to liquidity, during the bankruptcy case while also preserving the government's rights and defenses with respect to those amounts.

Treatment of Provider Agreements . A related issue in health care provider bankruptcies is whether Medicare and Medicaid provider agreements are treated as executory contracts. If they are considered executory contracts, any defaults under such provider agreements must be cured to assume and/or assign such agreements. This perspective allows the government to assert potentially significant cure amounts and otherwise permits the government to elevate its claim because health care providers in bankruptcy will not want to lose access to Medicare or Medicaid revenues. Notably, unlike other contract counterparties, the government argues that it need not meet its burden to establish a certain cure amount. If, on the other hand, the agreements are statutory entitlements, they may be sold free and clear of successor liability under **11 U.S.C. § 363(f)** without any requirement to cure defaults. For more, see **Overview – Provider Agreements in Bankruptcy**.

DIP Financing . A lender considering providing **debtor-in-possession (DIP) financing** to a health care provider can negotiate terms that protect the lender against some of the above-described risks associated with lending against health care accounts receivable. For example, working capital lenders may be willing to extend current financing packages to a DIP loan if they have continued access to these accounts receivable as collateral. A lender may also agree to provide DIP financing subject to a priming lien over existing lenders including, potentially, the right of governmental or commercial payors to assert recoupment or setoff rights against the accounts receivable. Nevertheless, DIP financing packages from incumbent lenders willing to prime themselves in exchange for a **roll-up** and other protections are more typical than priming DIP loans. In addition, as noted above, another possibility is that a lender might request that the DIP order provide for the assignment of Medicare and Medicaid receivables, which would qualify as a court-ordered exception to the anti-assignment provisions. Ultimately, a close inspection of the borrowing base is important to understand options for DIP financing packages with these accounts receivable as a centerpiece to financing.

Endnotes

[1] According to the Centers for Medicare & Medicaid Services, in 2021, Medicare and Medicaid spending accounted for 21% and 17%, respectively, of total national health expenditure. CMS.gov, “NHE Fact Sheet,” **https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet**.

[2] Assignment of payments on governmental accounts receivable is possible if made pursuant to court order. As discussed further below, lenders should consider requesting such assignment as adequate protection or as part of an order approving DIP financing.

[3] In the process of auditing prior reimbursement payments, the government may discover grounds to assert a variety of claims in the bankruptcy. Such claims include, for example, claims for uncapped cure amounts regarding provider agreements, as discussed below, or claims under the False Claims Act (which might be substantial given that statute's provision for treble damages). With respect in particular to claims under the False Claims Act, the government may also assert that such claims are not dischargeable, raising considerations for structuring transactions in the chapter 11 context. See **Overview – Fraud & Abuse Litigation and Health Care Chapter 11 Cases**.

[4] In re Univ. Med. Ctr., **973 F.2d 1065**, **1081** (3d Cir. 1992), superseded by statute on other grounds as stated in In re Mu'min, **374 B.R. 149**, **168**–69 (Bankr. E.D. Pa. 2007) (concluding that the Department of Health and Human Services was not entitled to recoup overpayments in 1985 through 1987 against amounts due to a bankrupt provider in 1988 under a Medicare provider agreement).

[5] Newbery Corp. v. Fireman's Fund Ins. Co., **95 F.3d 1392**, **1402** (9th Cir. 1996) (alteration in original) (quoting Moore v. N.Y. Cotton Exch., **270 U.S. 593**, **610** (1926)).