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When Your Hospital Becomes The Patient

By

*Brian Browder and John Tishler**

Overcoming financial distress is a challenge for any organization. When a hospital is on financial life support, that challenge is magnified due not only to the complexities associated with operating a hospital, but also because of the vital role a hospital plays in its community. Rural hospitals have been particularly hard hit by financial distress. According to the National Rural Health Association, 55 rural hospitals have closed since 2010 and another 283 are on the brink of closure.¹ This, of course, does not include the numerous hospitals that were financially challenged and sold during that period.

Triage: Sources of Distress

While the Affordable Care Act was initially lauded for attempting to reduce the uninsured population through the expansion of Medicaid, the Supreme Court altered the dynamic when it essentially held in *King vs. Burwell* that each state had the right to opt in or opt out of the expansion.² In those states where Medicaid has not been expanded, the status quo of a large population of uninsured patients receiving care for which the hospital is not reimbursed remains. In states that chose to expand Medicaid, hospitals have received a potentially illusory lifeline of receiving at least some reimbursement for the care provided to these formerly uninsured patients. The resulting increase in top line revenue may in fact obscure the reality that the care being provided costs more than the reimbursement received. The economics, unfortunately, will likely not work over the long term for hospitals in those states that expanded Medicaid.

In this era of declining reimbursements, hospitals are faced with increasing pressure to assume financial

risk, whether through accountable care organizations, bundled payment initiatives or other new approaches to paying for the provision of healthcare goods and services. Often times, the hospital does not have the experience to adequately assess the financial risk of these arrangements. What looks like a good decision now may have unforeseeable negative financial consequences in the future.

Similarly, decisions concerning how best to spend limited capital may have negative financial consequences. For example, building a new multi-million dollar patient tower may temporarily appease stakeholders clamoring for new and better facilities. Hindsight, however, may reveal that the better decision would have been to spend that money on ways to move patients out of the hospital to sites where the cost of care is lower. The lack of a meaningful return on this type of investment not only has opportunity costs (i.e., the money could have been spent on other opportunities) but also may increase the fixed costs of operating the facility without the expected increase in revenue to pay for it.

One of the largest buckets of expenses for a hospital relates to personnel. A hospital's C-Suite is often loathe to cut expenses by shrinking its workforce, in part because the hospital is frequently among the largest employers in the community it serves. Often the reduction in force (RIF) is made too late to materially alter the hospital's declining financial situation. Compounding that problem is the fact that RIFs often lead community members, understandably, to question whether the hospital is in trouble and, as a result, withhold financial support. Furthermore, the most valuable employees that were not subject to the RIF often seek other jobs so as to be in a position to continue to provide for their families. The lack of quality employees remaining at the hospital may accelerate the downward financial spiral.

The relationship between the hospital and its physicians may also contribute to the facility's financial troubles. In the event that the hospital is unable to attract the right type of physicians, whether due to

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¹ See <https://www.ivantagehealth.com/the-rallying-cry-for-rural-hospitals/>.

² 135 S. Ct. 475 (2014).

financial constraints or the location of the facility, the chances of reversing the trend of declining admissions (and resulting financial performance) are diminished. Relocation offers made to the hospital's physicians by financially stable facilities become much more enticing.

Developing a Plan of Care

Upon becoming aware of potential financial difficulties, the hospital's Board of Directors/Trustees and C-Suite executives need to act. Continuing to maintain the status quo is not a viable option for the hospital as a practical matter but often the directors/trustees and executives do not have the experience necessary to lead the hospital out of financial distress. In fact, the failure to act may expose the directors/trustees to liability for failing to fulfill their fiduciary duties.

The constituencies to which a director/trustee owes a fiduciary duty can also be expanded beyond the hospital in certain situations. For example, when financial distress reaches the zone of insolvency, a director/trustee's duty of care may extend to the hospital's creditors. Although the "zone of insolvency" does not have a bright line test, it typically includes situations when the hospital's assets are less than its liabilities or when the hospital cannot pay its debts as they become due. In today's environment of shrinking profit margins, many hospitals that are not part of a multi-hospital system are likely in the zone of insolvency.

Courts generally apply the "business judgment" rule to determine whether directors/trustees have satisfied their fiduciary duties to the hospital and other potential third party constituencies. Essentially, this means that a court will not substitute its judgment for that of the directors/trustees based on a presumption that the directors/trustees acted on an informed basis, in good faith and with the best interests of the hospital. Receiving the benefit of this presumption requires that the directors/trustees take an active role in obtaining the information necessary to satisfy their duties of care and loyalty. To do so, the directors/trustees must be knowledgeable about the financial and business affairs of the hospital. Courts generally find that when directors/trustees are exercising their business judgment in distressed situations, they are entitled to rely on information, opinions, reports

and statements prepared by professionals that have the requisite expertise and experience. Generally, this group of advisors would include accountants and attorneys. Once armed with this knowledge, the directors/trustees should provide strategic input to the hospital's affairs, including possible means and methods to reverse the hospital's financial decline.

In addition, the advice of public relations professionals and turnaround managers is often critical to successfully managing a hospital's recovery from financial distress. The reverse also may be true: by not retaining experts to advise management or the Board, officers and directors may be found not to have exercised their duties sufficiently.

Public relations professionals play a critical role in managing the recovery process by delivering a consistent message to the hospital's stakeholders. Absent a uniform and continuous message about the hospital's plan for recovery, rumors and misinformation run rampant. Without a clear message, lenders and vendors are unlikely to be willing to grant the hospital flexibility in terms of satisfying existing or future financial obligations. Furthermore, uncertainty of the hospital's future may create a sense of unease among the hospital's existing or potential employees, patients and donors.

Turnaround managers are consultants with expertise in examining the operation of an organization in financial distress. Their recommendations to management or the directors/trustees are aimed at improving the hospital's operations and finances, both from a near term standpoint and frequently a long term view. They can also play the "bad guy" role by delivering the difficult restructuring messages to the applicable stakeholders. Due to the complexities associated with operating a hospital, engaging turnaround managers with healthcare experience is critical.

Recovery Pathways for the Distressed Hospital - Short Term

In consultation with experienced professional advisors, directors/trustees of financially distressed hospitals should consider both short term tactics to raise capital and to reduce costs (thus averting the immediate cash crunch) while considering the strategic options for the continued delivery of quality

healthcare services in their community over the long term. A few of those tactics are discussed below.

- **Cash Generation**

A careful review of the hospital's assets and their present uses may reveal a ready source of cash, in particular with respect to non-core assets. For example, a hospital could unlock the value of its medical office buildings by selling them to a real estate investment trust while entering into a long-term lease of the buildings. This allows a quick infusion of cash while maintaining the hospital's ability to control its campus.

Another source for generating cash may be the sale of a hospital's ancillary service lines. Waller was recently involved with a distressed hospital that had a home health agency in a Certificate of Need state. After running an auction during a very compressed time frame, Waller was able to increase the purchase price for an ancillary business ultimately received by the hospital by more than three times the initial price offered. The sale also ensured that the home health service would continue to be available in the community, albeit through a new, better capitalized operator.

- **Expense Reduction**

Reducing the number of employees at the hospital is another way to lower expenses. Management and directors/trustees considering an RIF should bear in mind that the financial benefits will not be instantaneous. Whether due to the WARN Act (which requires employers with 100 or more employees to provide 60 days' advanced notification of mass layoffs) or otherwise, many hospitals will provide their employees with advance notice of the RIF. During the period of time between the announcement and the effective date of the RIF, the soon-to-be-terminated employees will understandably be distracted and thus may not deliver the same level of service or patient care as previously provided. Moreover, the soon-to-be-terminated employees may raise issues of patient safety. In addition, emotionally charged stories about the departing employees will appear in the media.

Another way to reduce expenses is through outsourcing one or more clinical services. For example, rather than continuing to run a service line that loses money, the hospital could engage a third party to provide that service and bear the financial risks and rewards relating to it. It would not be unusual for the

third-party provider to hire, at least initially, the hospital's employees in the service line who might otherwise lose their jobs.

Recovery Pathways for the Distressed Hospital - Long Term

While examining the short term strategies to generate cash and to reduce expenses, directors/trustees, in consultation with experienced professional advisors, should also consider how to achieve the organization's goals with respect to sustaining the availability of quality healthcare services in their community on a long term basis. A few of those strategies are discussed below.

- **Sell the Hospital**

Although it is often an emotionally difficult decision to accept, many communities have determined that the best way to sustain quality healthcare services in their community is by selling the hospital to a better capitalized operator. A sale of the hospital does not mean that the community loses its voice in how the hospital operates. In fact, it is very common for the purchase and sale agreement to contain covenants concerning how the buyer will operate the hospital going forward. Common covenants include commitments to continue to operate the hospital for a period of time; to continue to operate certain core services for a specified period of time; to honor the charity care policies of the hospital; to make a specified amount of capital expenditures; and to hire substantially all of the hospital's existing employees. It is not uncommon for the community to have the benefit of monetizing the hospital assets with the net proceeds being held in a foundation that benefits the community in other ways.

- **Create a Free-standing Emergency Department**

The directors/trustees may determine that the local community does not have the necessary characteristics to support a medical surgical hospital that is consistently able to deliver a full range of quality healthcare services. In such circumstances, the directors/trustees may consider shuttering the hospital and replacing it with a free standing emergency department. Free-standing emergency departments operate 24 hours a day and typically provide pharmacy, laboratory and radiology services. Patients with

more serious health conditions would be stabilized at the free standing emergency department prior to being transferred to hospitals a short distance away that are more equipped to care for them. Free-standing emergency departments can also be paired with clinics to provide the community with both emergency and non-emergency services.

- **Transform into an Ambulatory Care Delivery Model**

Critical access hospitals (CAHs) could be transformed into Federally Qualified Health Centers (FQHC) or Rural Health Clinics (RHC), which have much more favorable reimbursement structures than traditional physician offices without the high fixed cost associated with the operation of an acute care hospital.

- **Rural Health Centers:** RHCs use mid-level providers, such as nurse practitioners (NP), physician assistants (PA), or certified nurse midwives (CNM) with physician supervision to provide primary care.
- **Federally Qualified Health Centers:** FQHCs are community-based, safety net providers. In addition to enhanced reimbursement, some of the primary advantages of FQHCs include participating in the 340B Drug Discount Pricing Program for purchasing prescription drugs at steep discounts, granting access to National Health Service Corps providers and resources, the right to have out-stationed Medicaid eligibility workers on-site, and access to the Federal Vaccine for Children program. FQHCs may be available to receive free medical malpractice insurance under the Federal Tort Claims Act program and may be eligible for a myriad of grant and loan opportunities for both service and capital expansions.

- **Affiliations and Non-Control Transactions**

As an intermediate step between selling the hospital and shuttering it in favor of a free standing emergency department, RHC, or FQHC, directors/trustees may determine that an affiliation is the best means by which to ensure the continued delivery of quality healthcare in the community. A non-control transaction is a hospital affiliation that does not involve the sale of substantially all of the assets of the hospital or the transfer of a majority of governance control over the hospital. While many names and

variations exist, some of the more common non-control transactions include:

- **Special member models**, in which a larger hospital or system takes a minority interest in a smaller one in exchange for financial and programmatic investments.
- **Branding arrangements**, which are designed to leverage the name, clinical expertise, or physician platform of a system or academic medical center on behalf of an unaffiliated hospital or system.
- **Management and Joint Operating Arrangements (JOAs)**, either for discrete service lines or whole hospitals. These “virtual mergers” conceptually allow hospitals to pool resources and expertise and benefit from joint purchasing power. The hallmark of the JOA type of affiliation is that participating hospitals retain their separate identities, Boards of Directors/Trustees, and a certain amount of autonomy even though considerable management and financial authority is shifted to the governing body of the JOA.

Affiliation agreements can be successful if the community hospital is receiving or will receive substantial and immediate financial benefits that will assist it to meet its strategic goals. Affiliation agreements that are easily canceled, not legally binding on both parties or do not have well-defined measurable objectives and exit strategies, run the risk of doing little more than documenting an agreement to work together in the future.

Bankruptcy

Unfortunately, the reality is that despite the best efforts of management, the directors/trustees and the employees of the hospital, some hospitals will need to avail themselves of the protections offered by the bankruptcy code. Although a comprehensive analysis of the intricacies of a hospital bankruptcy proceeding are beyond the scope of this article, a few considerations for management and directors/trustees to bear in mind follow:

- **Bankruptcy Does Not Create Cash**

As a general matter, the filing of a bankruptcy petition prevents a hospital’s creditors or potential creditors from initiating or continuing to pursue

efforts to collect monies owed by the hospital to its creditors or potential creditors (including persons who have filed medical malpractice claims against the hospital) for pre-petition obligations. The hospital will need to have enough cash, whether through a debtor in possession loan or cash on hand, in order to continue to satisfy its going-forward financial obligations during the pendency of the bankruptcy case in addition to the fees and expenses of its professional advisors.

- **Obligations to the Government Are Not Dischargeable**

The obligations to repay the government for “overpayments” received by the hospital prior to filing for bankruptcy, whether they arose in the ordinary course of business or are the result of violations of applicable law, are not dischargeable. Absent highly unusual circumstances, if the hospital is sold in the bankruptcy proceeding, those liabilities follow the provider number that the buyer would assume.

- **Change of Ownership Rules Remain**

The filing of a bankruptcy petition does not alter the change of ownership requirements that would apply outside of bankruptcy. For example, many states have a process that must be followed when a tax exempt hospital transfers its assets. These same procedures must be followed just as the filings under the Hart-Scott-Rodino Antitrust Improvements Act and Medicare change of ownership filings must be made.

- **Additional Considerations in a Liquidation**

In the event that, despite the best efforts of all of the stakeholders to save the hospital, there is not enough cash to sustain the operations of the hospital through a bankruptcy process, the process of winding up the affairs of the hospital needs to include considerations of the well-being of its patients and members of the community. While the successful transfer of patients from a hospital that is closing to facilities that are

able to provide a quality level of care is of utmost importance, there are other facets that should not be overlooked. Among other matters, management and directors/trustees should ensure that the patient records are transferred to a custodian that will make them available to the appropriate parties as necessary, and that the inventory of pharmaceuticals is secured and disposed of appropriately.

- **Special Considerations for Government-owned Hospitals**

If a hospital or its assets are owned by a government or a governmental subdivision (such as a hospital district), approval may have to be obtained before a bankruptcy can be filed. Management and directors/trustees can obtain the advice of counsel, but this could slow down the process and put additional pressure on dwindling financial resources.

Conclusion

With regulatory changes at the federal and state levels and shifts in how and where care is delivered, an increasing number of hospitals are nearing or already experiencing financial distress. Hospitals looking to position themselves for the future must evaluate their current situation—their financials, market demographics, physician retention, etc.—and where things are headed. Based on this assessment and in consultation with experienced advisors, hospital directors/trustees and management should consider both short term tactics to raise capital and to reduce costs as well as the longer term, strategic options for the continued delivery of quality health-care services in their community. Boards of directors/trustees and management have a particular responsibility to lead their facilities in the right direction.

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