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Why You Should Learn the Playbook: Know the Game Plan for Distressed Acquisitions and Divestitures, Part Four—Regulatory Compliance and Related Issues in Distressed Health Care Transactions

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This article follows a three-part series on distressed acquisitions and divestitures and focuses on health care-specific issues. In prior articles, the authors provided an overview of distressed sales, [1] reported on a sampling of market terms and timelines in court-approved sales, [2] and discussed seller and purchaser considerations in negotiating sale terms related to distressed sales. [3] The regulatory compliance and approval issues that arise in healthy and distressed health care transactions are similar. However, in a distressed transaction, timing and liquidity constraints are at the forefront, necessitating tailored solutions and planning. This article explains considerations unique to distressed health care transactions and describes ways in which transaction counterparties may address them.

Regulatory Compliance and Related Considerations

As health care practitioners know, health care transaction notice and review laws have been on the rise. In general, bankruptcy and receivership proceedings do not circumvent or even shortcut state or federal regulatory requirements for health care transactions, including with respect to

licensure and change of ownership. Insolvency practitioners typically work with their health care counterparts to understand the applicable regulatory notice and approval requirements, processes, and timelines. However, there are certain unique considerations underlying the regulatory approval process in a distressed health care transaction.

A buyer's timeline for obtaining regulatory approvals is vitally important in a distressed situation because the seller typically has limited liquidity. In most distressed situations, the seller is relying upon the use of its lender's cash collateral or financing obtained in its bankruptcy case or receivership proceeding (known as debtor-in-possession or DIP financing) to maintain operations during the sale process. Most lenders and financers are unwilling to write a blank check while the regulatory approval process runs its course. For this reason, in a distressed transaction an asset purchase agreement will contain more stringent and detailed requirements related to the timeline for submission of notices and applications (including licensure, Certificate of Need (CON), or any nonprofit or charities law notice or filings) that may be required for ownership changes involving licensed facilities or services, responding to follow-up requests in timely manner, cooperation of the parties with respect to the application and approval process, regular reporting to the seller and its lenders as to status and progress of the approval process, and an absolute end date by which such approvals must be obtained. If approvals are not obtained by the agreed-upon end date and the buyer is unable or unwilling to close, the seller typically has a right to terminate the purchase agreement and may be entitled to retain the deposit as compensation for the delay. Alternatively, some buyers negotiate for this right and may have their deposit returned. Parties should consult with regulators and those with experience in the jurisdiction to ensure the timeline is realistic so that plans can be made to ensure adequate operating capital and because other parties, such as lenders and back-up bidders, may be relying on the schedule laid out in the asset purchase agreement.

Because distressed sale processes in bankruptcy or receivership proceedings typically involve auctions, the second-highest bidder at the auction may be standing by as the back-up bidder in the event the winning bidder is unable to meet the regulatory timeline set forth in the asset purchase agreement or the sale to the winning bidder does not close. In a situation where a winning bidder has failed to timely obtain regulatory approvals, a seller may face a difficult choice in deciding whether to allow the winning bidder additional time or switch to the back-up bidder and re-start the regulatory process. The seller may also face pressure from a back-up bidder to terminate the contract of the original successful bidder. The deposit may or may not be sufficient to compensate the seller for the additional losses sustained because of the delay. It is common for disputes to ensue over which party was at fault for the inability to timely obtain the regulatory approvals and, therefore, should be entitled to the deposit. Factual disputes may arise as to whether both sides diligently made necessary information available and diligently pursued the necessary approvals.

Regulatory approval in distressed transactions may be denied for the same reasons as in non-distressed transactions. Health care lawyers are well-aware of the increased scrutiny over transactions involving sales of not-for-profit entities to for-profit entities and/or private equity groups. However, in a distressed situation the seller typically has limited options in the event such approval is denied. The buyer may have negotiated for termination of the purchase agreement and return of the deposit in the event required approvals are not obtained. The seller may require

additional or alternative financing to enable it to continue operating and pursue an alternative sale, which financing may not be forthcoming. Even if a back-up bidder was selected and is arguably required to move forward as purchaser, the back-up bidder may no longer stand ready, willing, and able to proceed. Changed circumstances may result in the back-up bidder seeking to renegotiate its price. Or there may be no readily available alternative purchaser.

A recent example is Amsterdam House Continuing Care Retirement Community, a not-for-profit continuing care retirement facility that filed chapter 11 bankruptcy in the United States Bankruptcy Court for the Eastern District of New York on March 22, 2023. After a lengthy, contested sale process, a for-profit buyer was selected as the highest and best bidder and was approved by the bankruptcy court on December 27, 2023. The buyer submitted its change of ownership applications to the New York Department of Health shortly thereafter. The buyer's obligation to close was contingent upon its applications being approved by an outside date. Eventually on October 3, 2024, after the parties had agreed to multiple extensions of the closing date, the Department of Health notified the buyer of certain alleged deficiencies in its applications and deemed them abandoned and withdrawn.

The denial left the debtor and other parties in interest, including employees and residents, scrambling to find a solution with only enough liquidity to maintain operations for a couple of months. The debtor was required to return the buyer's deposit, and the backup bidder was no longer obligated to close given the length of time that had passed. The debtor was able to renew its sale process and locate an alternative purchaser, but at a significant cost to its estate and creditors who will recover substantially less under the alternative proposal. And the debtor required additional financing to operate until the sale was approved and closes. On February 20, 2025, the bankruptcy court approved the alternative sale. The parties estimate that regulatory approvals could take one to two years.

New State Laws Impact Distressed Health Care Transactions

New state laws[4] modeled after the federal Hart-Scott-Rodino (HSR) Act now require or will soon require parties to provide notice of certain health care transactions to state regulators.[5] The HSR Act provides for the U.S. Federal Trade Commission to review transactions that meet a size-of-transaction threshold (currently $126.4 million) to determine if the transaction at issue will adversely impact competition. The size-of-transaction threshold set by certain states is much smaller than the HSR Act size-of-transaction threshold and will therefore capture a larger number of transactions. For example, in Indiana the size-of-transaction threshold is $10 million and in New Mexico there is no size threshold. In addition, the initial review period set by certain states for state regulators to examine a transaction is longer than the HSR Act's 30-day period. In Oregon, the initial review period is 180 days and in Indiana the initial review period is 90 days. Certain state laws also specifically speak to the involvement of private equity partnerships in the transactions. The new state law notice and review requirements will impact distressed health care transactions that were formerly "small" enough to proceed without HSR Act review in several ways, including increasing the cost, time, and risk of obtaining necessary regulatory approvals.

To streamline the process, as soon as possible, parties to a distressed transaction should advise the

state agency reviewing the transaction of its distressed nature and prepare notice material that will assist the state agency in its review. To the extent the state agency permits it, parties should engage in information sharing with the individuals responsible for approving the transaction. Parties should also determine whether the state regulators have provisions for expedited review of distressed transactions. Oregon, for example, has a provision permitting emergency exemptions where the financial forecast demonstrates a need to preserve the solvency of an entity.[6] Parties should be prepared to share bank statements, payroll information, financial statements, budgets and forecasts with regulators to explain any need for expedited review given the financial condition of the enterprise. Finally, buyers and sellers should familiarize themselves with the elements of transactions that have required further state regulatory review or have caused previous proposed transactions to be barred from proceeding to help their clients assess transaction risk and formulate notices to the state regulators that address applicable concerns. For example, parties should be prepared to communicate how a transaction impacts the market share, patients' access to care, and cost of care in a service area.

Transfer of Provider Agreements

Another issue that frequently arises in distressed health care transactions is with respect to transfer of a seller's Medicare and Medicaid provider agreements. A buyer may want to take assignment or transfer of such agreements to ensure continuity in billings and collections, yet will of course not want to be responsible for pre-transfer liabilities of the seller for recoupment of prior overpayments, civil monetary penalties, or False Claims Act liability. In the case of a solvent seller, the buyer may receive an indemnity and have recourse against the seller for such pre-closing liabilities. In the case of a distressed seller, however, an indemnity will have little to no value as the seller typically has no remaining unencumbered assets and dissolves post-closing.

In some cases, bankruptcy courts have permitted the transfer of provider agreements to a purchaser "free and clear" of any liabilities of the seller. However, it is not settled that every court would permit such a result. This issue was litigated in 2019 in the context of the transfer of a Medicaid provider agreement in the chapter 11 case of *In re Verity Health System of California, Inc.* (*Verity*). In *Verity,* the bankruptcy court held, in a comprehensive opinion, that the Medicaid provider agreement at issue (i) was in the nature of a statutory entitlement, and not a contract, and did not need to be assumed to be transferred; (ii) could be sold, outside the ordinary course of debtors' business, in the same fashion as other estate assets; and (iii) could be transferred to the purchaser of debtors' assets free and clear of all liabilities that the state alleged had attached thereto.[7] Although this opinion was vacated when the parties settled, it is well reasoned and persuasive.

In light of the uncertainty as to how a provider agreement will be treated, purchasers wanting to take assignment or transfer of a distressed seller's provider agreements will likely want to protect themselves against potential successor liability. This may include conducting enhanced diligence including reviewing the seller's prior cost reports, audits, billing, and coding processes and examining seller's historic overpayment liability. To provide for a source of recovery in the event of such liability, a purchaser may request that a portion of the purchase price be held back in escrow for a period of time post-closing.

Medicare and Medicaid Program Disputes

Distressed transactions may also involve health care entities in a current dispute with Medicare. Whether that dispute can be resolved by a bankruptcy court may depend on where the case is pending. The United States can be expected to argue that bankruptcy courts do not have jurisdiction over any dispute regarding Medicare payments or decisions unless and until the debtor exhausts its administrative remedies under the Medicare rules. Ordinarily, this means that a debtor must exhaust the Medicare program's multi-level review process, which can take years.[8] To support its position, the federal government relies on 42 U.S.C. § 405(h) (Section 405(h)), which states that federal courts may take jurisdiction over Medicare disputes only after a party exhausts applicable appeal processes within the Medicare system. A complete discussion of this issue would be too lengthy to include here. It should be noted, however, that there is currently a split among the federal circuits regarding whether bankruptcy courts are barred by this provision from adjudicating disputes with the Centers for Medicare & Medicaid Services.[9] For this reason, parties should examine the holdings of courts with jurisdiction over the enterprise before making general assumptions.

Conclusion

As described herein, healthcare transactions, whether distressed or not, typically involve a unique set of legal, regulatory, and practical complexities that differentiate them from transactions in other industries. These complexities require careful consideration and planning, regardless of the financial condition of the seller. From navigating evolving state regulatory approval processes to determining the treatment of Medicare and Medicaid provider agreements, each decision should be carefully evaluated against the inherent liquidity constraints and urgency that are common to distressed transactions. Both seller and buyers can mitigate risks by proactively engaging with regulators, undertaking enhanced due diligence, and structuring agreements to address the practical realities of distressed conditions. A partnership between insolvency practitioners and their healthcare counterparts is essential to maximize the likelihood of a successful outcome for all parties while maintaining continuity of care for patients.

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[1] https://www.americanhealthlaw.org/content-library/publications/briefings/a4094e97-3c39-485e-b559-fcae40926315/why-you-should-learn-the-playbook-know-the-game-pl.

[2] https://www.americanhealthlaw.org/content-library/publications/briefings/196b4fda-a874-42f0-b98b-be9d267d3e47/why-you-should-learn-the-playbook-know-the-gam-1.

[3] https://www.americanhealthlaw.org/content-library/publications/briefings/6a7f2dfb-5526-4c7a-a74b-535104fe9e04/Why-You-Should-Learn-the-Playbook-Know-the-Game-Pl.

[4] As of the date of publication, the following 15 states have passed laws providing for health care transaction notice requirements: California, Colorado, Connecticut, Hawaii, Illinois, Indiana,

Massachusetts, Minnesota, Nevada, New Mexico, New York, Oregon, Rhode Island, Vermont, and Washington.

[5] A detailed resource for state laws with health care transaction notice requirements can be found at: https://explore.ebglaw.com/state-laws-with-health-care-transaction-notice-requirements-welcome/ (last visited May 19, 2025).

[6] An exemplar of Oregon's review of a request for emergency exemption can be found here: https://www.oregon.gov/oha/HPA/HP/HCMOPageDocs/018-TCC-Optum%20FinalEmergencyExemptLetter.pdf.

[7] *In re Verity Health System of California, Inc.*, 606 B.R. 843 (2019).

[8] C.F.R. § 404.900 (describing the administrative process).

[9] The Third, Sixth, Seventh, Eighth, and Eleventh Circuits have held that Section 405(h) bars bankruptcy courts from exercising jurisdiction over Medicare claims, whereas the Fifth and Ninth Circuits have held the opposite. *Compare Florida Agency For Health Care Admin., et al. v. Bayou Shores, SNF, LLC (In re Bayou Shores, SNF, LLC)*, 828 F.3d 1297, 1331 (11th Cir. 2016) ("The bankruptcy court was without [28 U.S.C.] § 1334 jurisdiction under the § 405(h) bar to issue orders enjoining the termination of the provider agreements and to further order the assumption of the provider agreements."); *with In re Benjamin*, 924 F.3d 180, 184-88 (5th Cir. 2019) (Section 405(h) "strips federal jurisdiction under only the listed statutory provisions—§§ 1331 and 1346—not under unlisted ones, such as bankruptcy jurisdiction under 28 U.S.C. § 1334."); *Do Sung Uhm v. Humana, Inc.*, 620 F.3d 1134, 1140 n.11 (9th Cir. 2010) (noting the "special status" of bankruptcy court jurisdiction over bankruptcy issues); *and Nurse's Registry & Home Health Corp. v. Burwell (In re Nurses' Registry & Home Health Corp.),* 533 B.R. 590, 593 (Bankr. E.D. Ky. 2015) (court holds that "the statutory bar on federal jurisdiction over unexhausted Medicare Act disputes . . . did not apply to bankruptcy jurisdiction."); *see also* Samuel R. Maizel & Michael B. Potere, *Killing the Patient to Cure the Disease: Medicare's Jurisdictional Bar Does Not Apply to Bankruptcy Courts*, 32 EMORY BANKR. DEV. J. 1 (2015). The split is further evidenced by the Eleventh Circuits discussion of holdings in the Third Circuit. In *In re Bayou Shores SNF, LLC,* 828 F.3d, at 1311, the Eleventh Circuit noted distinctions drawn within the Third Circuit, "[a]n earlier Third Circuit case, *In re Univ. Med. Ctr., Inc.*, 973 F.2d 1065, 1073–74 (3d Cir. 1992), appears to suggest (but not hold) that § 405(h) may not apply to bankruptcy courts. However, that case involved a claim that HHS had violated an automatic bankruptcy stay. The court's opinion hinged on its holding that such a claim did not 'arise' under the Medicare act. *Id.* at 1073. In *Nichole Med. Equip.*, the Third Circuit explicitly adopted *Bodimetric*, noting that 'Congress clearly prohibited federal courts from exercising subject matter jurisdiction or diversity jurisdiction over claims arising under the [Medicare] Act.'"

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