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Documenting Health Care Finance Transactions and Perfecting Security Interests in Commercial and Governmental Receivables

By N. Paul Coyle and Tracy L. Schovain
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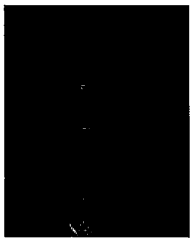

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It is common for lenders to collateralize asset-based, cash flow and real estate loans with, among other items of collateral, commercial and governmental receivables. There are distinct variations of, and risks to the lenders in connection with perfecting liens on such receivables and the various accounts into which each such receivable is deposited. This article summarizes certain issues with respect to perfecting a security interest in both commercial receivables and governmental receivables (*i.e.*, health care accounts receivable), provides an overview of the related "bifurcated" lockbox structure and identifies issues in connection with structuring and documenting such health care finance transactions.

Subsets of Health Care Accounts Receivable

Health care accounts receivable are usually classified in one of three categories: governmental collections, commercial collections and self-pay collections. Governmental collections include payments from Medicare, Medicaid, TRICARE and any other governmental health care program (each, a "Governmental Payor"). Commercial collections include payments from commercial health care insurers (*i.e.*, Blue Cross/Blue Shield, etc.) (each, a "Commercial Payor"). Self-pay collections include payments from individual patients. A lender may have a perfected security interest in health care accounts receivable regardless of whether the payments are received from Governmental Payors, Commercial Payors or individuals.

Specific Types of Collateral under the Uniform Commercial Code and Related Perfection Issues

Under the Uniform Commercial Code ("UCC"), payments from Governmental Payors are considered "payment intangibles" [which is a subset of the term "general intangible" under Revised Article 9 of the UCC ("Revised Article 9")] because such payments are disbursed from federal or state trust accounts and are not paid from insurance policies. Accordingly, lenders obtain a perfected security interest in such receivables the same way as such lenders would by perfecting a security interest in other payment intangibles. This is accomplished by filing a financing statement with the office of the Secretary of State from the state of the borrower's jurisdiction of organization.

Revised Article 9 introduced "health care insurance receivables" as a new type of collateral—a subset of "accounts." The term "health care insurance receivables" is defined in Revised Article 9 as "an interest in or claim under a policy of insurance which is a right to payment of a monetary obligation for health care goods or services provided." The defined term "accounts" in Revised Article 9 specifically includes health care insurance receivables. The term "health care insurance receivables" includes payments from Commercial Payors and individuals, but not payments from any Governmental Payor. As with perfection of liens on accounts and general intangibles, a lender may perfect a lien on health care insurance receivables (a subset of accounts) by filing a financing statement with the office of the Secretary of State from the state of the borrower's jurisdiction of organization.

A lender's security interest attaches to the cash proceeds of the health care insurance receivables and payment intangibles when the borrower receives payment. A borrower is deemed to have received payment from a Governmental Payor when such payment is deposited in a deposit account in the name, and under the control, of the borrower (*i.e.*, any health care provider) (a "Governmental Deposit Account") and a Commercial Payor when such payment is deposited in a deposit account that may be in either the name of the borrower or in the name of the lender (a "Commercial Deposit Account").

Although a lender will have a perfected security interest in collections from the Governmental Payors, the

Medicare anti-assignment rules—and related federal and state rules affecting Medicaid and other governmental health care programs (collectively, the "Anti- Assignment Rules")—prohibit such lender from having control over the deposit account (and control over the disposition of funds on deposit in the Governmental Deposit Account) thereby preventing such lender from having a perfected security interest in a Governmental Deposit Account. Under Revised Article 9, a secured party must have "control" over a deposit account to be perfected in such account. Therefore, a lender cannot be perfected in any Governmental Deposit Account [recall, the lender is still perfected in the cash proceeds (payment intangibles) deposited into such account].

A lender is able to mitigate any risk from not having a perfected security interest on the Governmental Deposit Account by complying with the Anti-Assignment Rules and implementing a sweep mechanism (*i.e.*, daily). At or shortly after closing of a financing transaction, a borrower will direct certain Governmental Payors to forward payments due to such borrower to a deposit account, which is subject to terms and provisions of a depository agreement by and among the borrower, the lender and the depository bank (the "Governmental Depository Agreement"). The Governmental Depository Agreement should specifically state that: the Governmental Deposit Account shall be subject only to the signing authority of the borrower, the borrower shall have exclusive control of the funds deposited in the Governmental Deposit Account and the depository bank shall be subject only to the borrower's instructions regarding disposition of the funds in the Governmental Deposit Account. These minimum provisions will satisfy compliance with the Anti-Assignment Rules.

The Governmental Depository Agreement should also contain provisions directing the depository bank to sweep on a periodic basis (*i.e.*, daily) the proceeds on deposit in the Governmental Deposit Account to another account over which the lender has control (*i.e.*, lender's account). Because the borrower remains in control of the Governmental Deposit Account, the borrower can rescind any sweep order at any time, and the depository bank must comply with any such order. By reducing the balance in the Governmental Deposit Account to zero each day, any risk of the borrower's redirecting or diverting funds is minimized. Typically, depository banks have their forms of Governmental Depository Agreements, which include most of the foregoing provisions. In the case of a Commercial Deposit Account, control may be achieved through the execution of a traditional deposit account control agreement (the "Commercial Depository Agreement") by and among the borrower, the lender and the depository bank. Because these payments are from health care insurance receivables and not payments from Governmental Payors, the borrower and the lender are not subject to the Anti-Assignment Rules, and the lender may have control over the Commercial Deposit Account. As a result of not having to comply with the Anti-Assignment Rules, the Commercial Depository Agreement should provide that: payments from the health care insurance receivables are deposited into the Commercial Deposit Account, which may be in the name of the borrower or the lender; and the lender is in control of the Commercial Deposit Account. As stated above, the lender has a perfected security interest in all funds deposited into the Commercial Deposit Account. In addition, the key element of control exists (even though the borrower may have access to the funds in the Commercial Deposit Account); thus, the lender also has a perfected security interest in the Commercial Deposit Account. Having the Commercial Deposit Account in the name of the lender may also mitigate any risk in any bankruptcy proceeding of any borrower as the account is not property of the borrower—thus, not subject to any stay order of the bankruptcy court.

Regulatory Issues with Various Providers and Related Structuring Issues

In connection with structuring health care finance transactions, particular focus should be on the type of health care provider (*i.e.*, the borrower). With asset-based loans, a lender's focus is with respect to the ownership of the receivable because that receivable will be included in the borrowing base pursuant to which lender will provide loans. These issues arise when considering financing to management services organizations and health care providers subject to the corporate practices of medicine rules in effect in various states. For example, with management services organizations, it is vital to understand whether the receivable included in the borrowing base is the management fee or the underlying receivable from a Governmental Payor. Confirming whether the

health care provider actually owns the receivable can be accomplished by reviewing such health care provider's provider agreement. If the health care provider is a professional corporation owned by physicians and that provider generates the receivable, as long as such physicians assigned all of their rights to such payments and the health care provider generated those receivables using such provider's provider number, those receivables are considered owned by such provider. Thus, to the extent a lender has a security interest in such receivables, such lender has the right to step into the borrower's shoes and realize the full value of the receivable, as opposed to a receivable that constitutes a management fee where the lender is only able to realize the value of such management fee.

Similar issues arise in connection with operations transfer agreements and whether the new operator (*i.e.*, the borrower) is using such new operator's provider number to bill and collect the receivables generated at such facility, or whether such new operator is using the old operator's (the seller's) provider number to bill and collect such receivables. If the new operator is using the old operator's provider number, any and all receivables generated using such old operator's provider number are the property of the old operator. As stated above, in compliance with the Anti-Assignment Rules, Governmental Payors make payments only into accounts in the name of and under the control of the health care provider (here, the old operator). While there may be provisions in an operations transfer agreement to require the old operator to forward such payments to the new operator (the borrower), there are ways to potentially mitigate risks to the new operator.

In order to protect the lender and the new operator in a downside scenario, the operations transfer agreement should provide that in order to secure the old operator's obligation to forward such payments from Governmental Payors to the new operator (*i.e.*, daily), the old operator grants a security interest to the new operator in such receivables generated using the old operator's provider number. The new operator perfects this security interest by filing a financing statement with the office of the Secretary of State from the state of the old operator's jurisdiction of organization. The lender, in turn, has this financing statement assigned to the lender. Thus, the lender has an indirect security interest in the receivables generated at the facility using the old operator's provider number and, to the extent necessary (*i.e.*, court order), can direct payment to the lender.

When structuring health care finance transactions, it is essential for the lender to understand the regulatory issues specific to the health care provider, the facts surrounding ownership of certain receivables and how to perfect such lender's security interest in the various buckets of collateral. As stated above, while lenders may be restricted with respect to certain types of collateral, there are ways to potentially mitigate lender's risks and avoid being "naked" with respect to certain collateral.

About Duane Morris

Duane Morris has one of the most experienced and respected health law practices in the United States. Our lawyers counsel leading organizations in every major sector of the industry on the business and regulatory aspects of transactions involving healthcare companies, including M&A; connect clients with sources of capital and potential buyers and sellers of businesses; and provide full- service portfolio company representation, including employment and labor, litigation and other areas. As today's healthcare providers focus on cost-effective ways to deliver healthcare services, Duane Morris develops innovative and creative ways to help healthcare clients increase their profitability and protect their assets. We tailor our services to specific segments of the industry, including hospitals; physicians; post-acute care, long-term care and senior services; information technology; and mHealth, telemedicine and health information technology.

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Five Hot Topics in Middle-Market Acquisition Financing

By: Brian P. Kerwin, Partner and Chairman of the Corporate Practice Group, and David B. Shafer, Associate, Duane Morris LLP

Out of the depths of the financial recession of the late 2000s, private equity buyout deal-flow has returned record highs. According to the Bain & Company, Inc. Global Private Equity Report 2015, the year 2014 marked an extraordinary volume of buy-out exits, and for the fourth consecutive year in a row, distributions outpaced capital calls for limited partners. While investors certainly enjoy returns that meet or exceed projections, expectations are pushed even higher. For every deal that successfully exits, appetite for new deals grows with corresponding boosts in investible dry powder.

While demand for buyouts continues to grow year-on-year, the number of attractive targets has failed to keep pace. The combination of abundant private equity funds and readily-available debt financing has pushed multiples to near pre-recession levels. As a result, sellers have regained bargaining power lost during the most recent recession, and enjoy valuation and pricing reflective of such shift. In response, sponsors have turned the pressure on lenders to be ever-increasingly accommodating in definitive loan documentation.

This article highlights five current trends in middle-market acquisition finance. Each of the concepts described below had their origins in large-market transactions. As competitive pressures have caused financing terms to become more sponsor-friendly, concepts that were once almost exclusively in the realm of large deals are being introduced by lower and middle-market transactions with greater regularity.

Available Amount/Builder Baskets. One of the increasingly common accommodations often reluctantly being made by lenders in acquisition financings is an available amount basket (also known as a builder basket) insisted upon by certain sponsors. This concept is used as a conduit through which built-up cash or equity contributions can be used by the borrower to make payments or investments that would otherwise often be restricted by the terms of the loan agreement.

The available amount basket concept has its roots in term loan transactions and typically includes a portion of unswept excess cash flow. If the applicable credit agreement requires an excess cash flow payment equal to 50 percent of excess cash flow from the previous fiscal year, the other 50 percent of excess cash flow is "added" to the available amount. Most credit agreements with this concept also permit cash equity contributions from sponsors to increase the available amount.

Uses of the available amount typically include investments, restricted payments and prepayments of subordinated debt—in each case often without giving effect to other limitations in the applicable acquisition financing documents.

Sponsors relish the available amount. If the portfolio company is performing well and enjoying positive cash flow, sponsors argue that it provides well-deserved flexibility to de-lever the company, increase its assets or reward investors. Lenders should take care, however, to ensure that the available amount is limited in its scope and application such that the company remains adequately capitalized to conduct its business.

Incurrence Tests. Originating in high-yield bond indentures, incurrence tests govern lien or debt restrictions and permit borrowers to incur debt or liens so long as they remain in compliance with applicable financial covenants on a pro forma basis after incurring debt or granting a lien. These financial ratios are typically leverage covenants, which, for purposes of an incurrence test, are often set at slightly tighter levels than

Healthcare Buyers Beware: Current Issues in Healthcare M&A

By Neville M. Bilimoria, Esq.[1], and Brian P. Kerwin, Esq.[2], Duane Morris

Whether it be buying medical devices or healthcare facilities or operations, consolidation of dental or dermatology practices, or hospital acquisitions, healthcare M&A today has unquestionably become more complicated. Purchasers engaged in such transactions must take heed of the myriad of unique legal issues surrounding these healthcare deals. Below are some important topical issues that acquirers sometimes overlook in healthcare M&A transactions.

1. Healthcare Regulatory:
The amount of federal and state laws effecting healthcare companies is ever increasing. Purchasers of a healthcare related target need to wade through the mire of healthcare regulatory issues. The breadth of these items can range from FDA oversight for medical devices, to dealing with government licensure and certification for healthcare facilities, to survey and certification histories. Meaningful due diligence is critical in identifying and assessing regulatory enforcement of a healthcare related target.

2. Unclaimed Property (Escheat):
In an acquisition of a healthcare entity, exposure for failing to remit unclaimed property of the target to the state is often overlooked. With unclaimed property laws existing in all 50 states, such exposure could be an unexpected buyer nightmare. Under these laws, unclaimed property, such as uncashed checks, credit balances, unused deposits and overpayments, must be disgorged to the state if not returned to the rightful owner within a designated abandonment period. In the health care industry reportable unclaimed property can include funds such as overlapping payments by insurers and patients to the health care company where the excess is not returned. Since unclaimed property audits can reach back in some instances up to 20 years, it is vital that this potential exposure be identified.

3. Representation/Warranty Insurance:
Representation and warranty insurance (R&W Insurance) is increasingly commonplace in M&A healthcare transactions. It is often proposed by buyers in an auction process in an effort to differentiate a bidder from other suitors by offering lower indemnification caps. Since insurance brokers generally are not able to go to market until the purchase agreement is in substantially final form, it is important to consider the timing sequence and to understand that a buyer will likely not have full visibility into the terms of the R&W Insurance (including scope, amount of coverage and any exclusions) until fairly late in the process, leaving little time to address any gaps in coverage under the policy. Further, any material changes to the purchase agreement that would affect an insurer's scope of coverage that are negotiated after the insurer's due diligence period has begun may introduce delay. Be sure to reserve comment on all applicable sections of the purchase agreement if the final R&W Insurance does not cover certain matters.

If R&W Insurance is utilized, a buyer will typically propose more aggressive reps and warranties to maximize its chances of recovery under the policy, and a seller is often more accommodating because of the lower cap and escrow amount. However, any excluded matters under the policy will need to be clearly understood so they can be properly addressed in the purchase agreement. For example, some insurers are

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willing to provide insurance on a guarantee of collectability rep with respect to accounts receivable, while others are not. It is not market for an insurance company to insure flat reps (i.e., insurers expect sellers to negotiate them); however, insurers can accept a materiality scrape. A retention of 1.0% – 1.5% under an R&W Insurance policy is becoming relatively standard, with the buyer and the seller regularly splitting responsibility equally for the retention. The cap under the purchase agreement will typically match the retention under the R&W Insurance, with exceptions for fundamental representations or matters excluded from coverage under the policy.

4. Independent Contractor vs. Employee Classification:
The proper classification of a person providing healthcare services as either an employee or an independent contractor has many potential implications on business operations, as the classification will determine whether there is a requirement to withhold income taxes, withhold and pay Social Security and Medicare taxes, or pay unemployment taxes. Recently both the IRS and the Department of Labor, as well as various state agencies, have placed increasing emphasis on the correct classification of service providers. Correspondingly, this area has become an increasing concern of buyers seeking to avoid inadvertently acquiring a potentially large liability relating to misclassification. If due diligence uncovers any potential classification concern, many buyers will include specifically tailored reps and warranties or add line-item indemnification. Because of the uncertainty involved, many R&W Insurance providers will exclude classification issues from the scope of coverage.

5. Stark/Anti-Kickback:
A buyer of a healthcare company must also increasingly consider various healthcare fraud and abuse issues. Government health care fraud and abuse scrutiny is at its highest level. Of the $3.5 billion recovered last year for federal prosecution by the Health Care Fraud and Abuse Control Program, more than half was attributable to unnecessary or inadequate care, paying kickbacks to health care providers to induce the use of certain goods and services, or overcharging for goods and services paid by Medicare and Medicaid. The government is now using state-of-the-art fraud detection technology to better analyze and target its oversight.

Due diligence in a healthcare purchase should consider the billing, coding and operation of the target. Stark (physician self-referral) and anti-kickback laws (payments for referrals) can be complicated and therefore analysis of these laws is critical. State law fraud and abuse counterparts can also apply. If adequate due diligence is not performed for healthcare fraud and abuse analysis, a meaningful indemnity escrow is essential. A possible enforcement action post-closing is often difficult to detect during a shortened due diligence as the government spends years investigating providers before cracking down.

6. Tax Bulk Sales/Clearance:
In any healthcare acquisition, a buyer must seek information on potential successor, back-tax liability of the seller. While buyers generally understand that in equity sales and mergers they acquire the target's past tax liabilities, buyers should know that even in an asset purchase they may become liable for those same seller tax liabilities notwithstanding the wording of the purchase agreement.

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The vast majority of states have tax bulk sales or tax clearance requirements. These laws require a notification to the state so it can notify the buyer of any taxes owed. Failure to so notify (and escrow outstanding taxes) will cause the buyer to be liable for such taxes. These taxes can include past sales, unpaid payroll, income, franchise and local taxes. While an indemnity provision can ultimately provide some buyer protection, the state may more promptly commence collection actions against the buyer as well as suspend or revoke the buyer's licenses putting its business in jeopardy. With the prevalence of state and local taxes in the healthcare industry, it is important for buyers of assets to ensure it is not acquiring unknown past seller tax liability.

7. Data Security:
The private healthcare data of a company is often more valuable on the black market than credit card information. Medical identity theft is often not immediately discovered, giving criminals years to milk this data. Currently, privacy and security compliance is at the forefront of federal government enforcement under HIPAA. In just the first four months of 2016, $8.6 million in penalties have been imposed, eclipsing the penalties for all of 2015. In addition, hackers are getting more sophisticated and using malware to halt operations of healthcare providers and force the payment of a ransom to restore connectivity and system adroitness. Recent ransomware attacks in California and Indiana hospitals in April of 2016 highlight the new frontier of cybersecurity crimes in the healthcare market place. These cyber-attacks beg for protection in healthcare M&A transactions. Buyers are wise to ensure that data is locked down and that acquired businesses are not susceptible to costly data breaches. With the increases in penalties and enforcement for cybersecurity, obtaining cybersecurity insurance should be considered.

8. Intellectual Property:
Recent pharmaceutical company M&A activity raises a host of concerns, including ownership of intellectual property (IP) rights (such as valuable patient data from clinical studies used to obtain approval for new drugs) and who will bear the cost and potential liability with respect to enforcing IP or defending against IP suits. These issues pervade research centers and hospitals, and the increase in branding by payers and insurers. While these items can be dealt with contractually, due diligence is particularly important where IP rights have changed hands several times.

Failure to give proper consideration to the eight topics identified above can be detrimental to the long term success of the acquisition of a healthcare business.

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Healthcare Buyers Beware: Current Issues in Healthcare M&A

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Five Hot Topics in Middle-Market Acquisition Financing

By: Brian P. Kerwin and David B. Shafer, Duane Morris LLP

those contained in a credit agreement, leaving some cushion between incurrence test leverage ratios and covenant leverage ratios. These structures often include no hard dollar cap, or do include high dollar caps or a percentage of EBITDA with a "lesser of" concept. The concept is increasingly common in upper middle-market acquisition financing transactions, but remains somewhat rare in all but the best lower and middle-market credits.

As with the available amount, incurrence tests provide sponsors with the ability to manage a portfolio company without directly involving the lender. If the company can "handle" the additional debt and remain within financial covenant compliance, sponsors argue that they should be permitted to flexibly manage their acquired portfolio company.

Net Debt leverage calculation. Leverage ratios are typically calculated as the ratio of debt to EBITDA. Net debt is an accommodation made by lenders to permit borrowers to reduce the debt portion of the ratio by the amount of cash on the company's balance sheet as of the date of such calculation. Variations on the theme include netting cash, cash equivalents, liquid assets, netting cash maintained in a deposit account subject to a control agreement in favor of the lender and capping the amount of cash that reduces debt. Whether leverage ratios will be calculated based on net debt is often negotiated at the commitment letter or term sheet stage. Variations and limitations are typically not fully vetted until credit agreement negotiations are well underway.

As with other identified concepts, net debt leverage calculations are rather common in upper-middle-market transactions and have worked their way into lower and middle-market deals. If acceptable to a lender, careful consideration should be given to limiting the amount of cash or other assets that offset debt. Sponsors posit that unrestricted cash or cash equivalents could be used to immediately reduce debt. However, other assets may be more illiquid, making their application more dubious.

Diligence Information Risk and "Knowledge." One of the classic struggles in any sophisticated acquisition or acquisition financing transaction is whether representations and warranties and closing conditions should be qualified with "knowledge" and, if so, whose knowledge. Often categorized as a legal comment, at their core, knowledge qualifiers are used as a risk-shifting tool. Clean representations and warranties, without knowledge qualifications, place the risk on the sponsor and borrower to diligence each representation to ensure its accuracy. For a sponsor, that additional time and effort increases transaction cost and adds some element of execution risk while it conducts the necessary diligence on an unfamiliar target. As a result, sponsors are increasingly insisting on knowledge qualifiers as a way to minimize diligence information risk.

Sponsors' argument has some logical attraction—the sponsor can only represent as to what it actually has knowledge. But doing so shifts information risk on a lender, a party that is no closer to the target than the sponsor itself. Nevertheless, many lenders have agreed to include knowledge qualifiers, often with limitations including "best of" knowledge, or including knowledge of key members of the target's existing management team. Lenders should take care to manage diligence information risk to strike the appropriate balance to consummate the particular acquisition financing transaction.

Application of Prepayments. For middle-market acquisition financing transactions with amortizing term loans, application of voluntary and mandatory prepayments carries heightened importance, particularly for regulated banks. Most lenders will, at least initially, require application of all prepayments (voluntary or mandatory) in either inverse scheduled

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order (i.e., applying to the last payment first, working backwards) or pro rata among the remaining scheduled installments reducing each installment by some amount. With greater frequency sponsors are requesting that prepayments, voluntary and/or mandatory, reduce scheduled amortization payments in direct order of maturity, or however the sponsor may elect.

Whether a lender is willing to accommodate the sponsor's request varies from deal to deal. Mandatory prepayments are often treated differently than voluntary prepayments on the theory that mandatory prepayments are often independently driven events. In either case, lenders and sponsors must consider the impact on fixed charge calculations to ensure that the calculation of fixed charge coverage ratios retain their teeth if payments are applied in direct order.

As a cross-section, the concepts highlighted above represent only a handful of the ways that financing terms have become generally more pro-sponsor since the end of the last recession. With demand at an all-time high, and worthy targets not matching pace, competition among lenders financing acquisitions in the middle market is not likely to yield more restrictive terms. For every inch one lender is willing to cede, another may be willing to give two. Given the very frothy environment, it is critical that important concepts are addressed in the commitment letter or term sheet stage. Doing so will almost certainly lead to smoother negotiation and more rapid deal execution.

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American Bankruptcy Institute, ABI Health Care Insolvency Manual, 2012 Edition, Chapter 11: Health Care Receivables Financing

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Chapter 11: Health Care Receivables Financing

Health care financing can take many forms (i.e., real estate financing, leveraged loans, asset-based loans), but health care receivables financing is a common method used by health care providers to meet their working-capital needs. Typically, this financing takes the form of revolving loans extended from time to time to such providers based on the value of their accounts receivable. Although health care lenders often obtain other forms of collateral, such as inventory, general intangibles (such as contract rights) and fixed assets, most health care lenders base borrowing levels upon the estimated collectible value of certain receivables generated by the health care provider. The different categories of payors, together with the regulatory restrictions by which many health care providers are bound, can present risks for lenders that are not knowledgeable or experienced with the unique aspects of health care financing.

This chapter addresses issues relating to extensions of credit secured by a lien on a health care provider's accounts receivable (including health care insurance receivables and amounts owed by governmental payors), enforcing a lender's lien on such collateral and collecting its collateral following a borrower's bankruptcy filing, and providing debtor-in-possession financing (DIP financing) to a health care provider. While this chapter is not intended to address all issues relating to health care financing, where applicable, related topics are cross-referenced to other chapters of this Manual.

1. Health Care Accounts Receivable

a. Health Care Accounts Receivable Generally

The largest and generally the most significant asset of a health care provider is its accounts receivable, making it an important form of collateral for lenders. Health care accounts receivable are typically categorized by lenders into one of three categories: (1) governmental collections; (2) commercial collections; and (3) self-pay collections. Governmental collections include payments from Medicare, Medicaid, TRICARE and any other governmental health care programs (each a "governmental payor"). Commercial collections primarily include payments from commercial health care insurers (e.g., Blue Cross/Blue Shield, etc.) (each a "commercial payor"). Self-pay collections include payments from individuals who received health care goods and services from the health care provider (each an "individual payor").

Most health care providers' receivables are properly classified as "accounts" under Revised Article 9 of the Uniform Commercial Code [600] ("Revised Article 9"), and certain of those receivables may be further classified as "health care insurance receivables." These are a subset of "accounts" and are defined in Revised Article 9 as "an interest in or claim under a policy of insurance which is a right to payment of a monetary obligation for health care goods or services provided." [601] The term "health care insurance receivable" includes health care accounts receivable from commercial payors, but not from individual payors or governmental payors.

Depending on the source of funding for payments from governmental payors, such payments may be classified under Revised Article 9 as an "account" while others may be classified as a "payment intangible." This is because certain payments made by governmental payors (i.e., those made under the Medicare program) technically may not be made for services rendered by the health care provider but rather are assignments of payments made to patients who are entitled to receive disbursements from federal or state trust accounts established to provide coverage for medical care. As a result, certain payments from governmental payors are treated as "payment intangibles" under Revised Article 9, which defines a "payment intangible" as "a general intangible under which the account debtor's principal obligation is a monetary obligation." [602]

b. Assessing the Net Collectible Value of Receivables: Collectibility, Recoupment and Setoff Issues

Although a health care lender often receives a lien on all health care receivables to secure the loans made to the health care provider, certain receivables are excluded from a health care lender's credit determination. Typically, a health care receivables loan will include a "borrowing base," which is made up of certain categories of receivables and certain sublimits within those categories that relate to the anticipated collectability of such receivables. For example, a health care lender may not extend credit on receivables that have been

outstanding for a long period of time, because the likelihood of collecting those receivables has been diminished. Similarly, many health care lenders will not lend against accounts receivable owed by individual payors because of the difficulty in collecting from individuals, as opposed to government agencies or commercial insurers. Once the categories are established (often called "eligible accounts"), the health care lender hedges against collectability risks by advancing against only a percentage of what it determines to be the collectible amount of eligible accounts.

A fundamental risk in health care receivables financing is the possibility that offsets, recoupment and other contractual or program-based reductions in the amount of receivables will occur after the health care lender has determined the borrowing base, thereby reducing the anticipated amount of collections. As discussed in Chapter 9 of this Manual, receivables from governmental payors arise under programs that permit some form of withholdings, offsets, recoupments or other reductions in the amounts of receivables paid to the health care provider in respect of amounts owed by such health care provider to the governmental payors. When an overpayment is discovered (whether by the health care lender or the health care provider) it is often necessary to establish a "reserve" against the borrowing base to ensure that the total value of eligible accounts as calculated by the health care provider is adjusted downward to take into account the possibility that such accounts may not be collected in full. Certain commercial receivables also carry setoff and recoupment risks. For example, many forms of managed care are set up with a capitation-payment model in which the health care provider receives a monthly fee per managed care member in exchange for agreeing to treat the members as the need arises. However, in many situations, those capitation payments are subject to offsets or recoupments against future payments if a higher-than-expected number of members seeks treatment elsewhere. Because of the inability on the part of the health care provider to control the risk of offset or recoupment, many health care lenders either will not lend against capitation payments or will establish very large reserves that reduce availability for such types of accounts receivable.

To address these issues, it is imperative for both the health care provider (borrower) and the health care lender to be familiar with the types of health care receivables that make up the borrowing base and the collection history with respect to those receivables. To properly manage its risks, a potential lender should review the rights of governmental payors and commercial payors to effect such reductions and the historical track record between the health care provider and these third-party payors. It is equally important that the health care lender closely monitor the health care provider's collection history during the course of the loan so that adjustments may be made to the borrowing base as necessary.

c. Perfection

A health care lender perfects its liens on accounts (including health care insurance receivables) and general intangibles (including payment intangibles) by filing a financing statement with the office of the Secretary of State in the state where the health care provider is organized. The lender's security interest attaches to the cash proceeds of such collateral when the health care provider receives payment.

Although a health care lender will have a perfected security interest in accounts and general intangibles by filing a financing statement, a lien on deposit accounts is not perfected by filing. Instead, a health care lender must obtain "control" over the deposit account in order to be perfected. Under Revised Article 9, control exists if, among other things, (a) the lender is the depository bank at which the health care provider maintains the deposit account or (b) the lender enters into an agreement with the depository bank at which the health care provider maintains the deposit account whereby the depository bank agrees to follow the instructions of the lender with respect to the disposition of funds in the deposit account, without further consent of the borrower. [603] The Medicare anti-assignment rules (and related federal and state rules affecting Medicaid and other governmental health care programs) (collectively, the "Anti-Assignment Rules") prohibit any Medicare or Medicaid payments to be made directly to a deposit account if the health care provider does not have full control over the disposition of funds on deposit in such account. [604] Moreover, if the health care lender is also the depository bank, the health care lender must expressly waive its rights to set off any amounts due to it any funds on deposit in an account into which Medicare or Medicaid make direct payments. Such a waiver must be included in the loan documentation. Since the lender cannot have "control" over the borrower's governmental deposit account under the Anti-Assignment Rules, the lender cannot be perfected in the account itself. However, it should be noted that though the Anti-Assignment Rules prohibit any person (including the health care provider's lender) other than the health care provider from having "control" over the disposition of funds already in deposit in such account, they do not prohibit or in any way restrict a health care provider from granting a lien on receivables owed by a governmental payor. [605]

Not having a perfected lien on a governmental deposit account does not leave a health care lender "naked" from a collateral standpoint. The lender does not need control of the health care provider's deposit account in order to have a perfected security interest in cash proceeds of "accounts" or "payment intangibles" (i.e., payments from governmental payors). For the lender's security interest to remain perfected in such cash proceeds, the proceeds must remain identifiable. [606] This is accomplished through a bifurcated lockbox structure (as described more fully below). Thus, once a governmental payor makes a payment to a health care provider and that payment is

deposited into the designated governmental deposit account (which is the deposit account subject to the terms and provisions of a governmental depository agreement, as described more fully below), the lender's security interest is perfected in the cash proceeds, so long as such proceeds remain identifiable.

d. Enforcement and Collection: The Bifurcated Lockbox Structure

To best address the control restrictions discussed above and to mitigate the lender's risk of a health care provider redirecting payments received in any governmental deposit account, most health care lenders will implement the following structure for cash management.

To begin with, at or shortly after the closing of the financing transaction, the health care provider should direct the governmental payors to forward payments due to such health care provider into a deposit account established solely for such purpose and that is subject to terms of a depository agreement (a "governmental depository agreement") by and among the health care provider, the lender and the depository institution (in some cases, the lender may also be the depository institution). To comply with the Anti-Assignment Rules, this governmental depository agreement should specifically state: (1) The governmental deposit account shall only be subject to the signing authority of the health care provider; (2) the health care provider shall have exclusive control of the funds deposited in the governmental deposit account; and (3) the depository bank shall be subject only to a health care provider's instructions regarding the governmental deposit account. If structured in this way, the health care provider is deemed to have received the payment when the funds are deposited by the governmental payors into the governmental deposit account. It is at this moment that the lender's security interest attaches to the cash proceeds of the payment intangibles.

The governmental depository agreement should also contain provisions directing the lender to sweep on a periodic basis (e.g., daily) the funds in the governmental deposit account to the lender's collection account or to an account over which the lender has control. By reducing the balance in the governmental deposit account to zero each day, the risk that the health care provider may redirect or divert funds is minimized, thus reducing the lender's economic exposure. This is because the health care provider remains in control of the governmental deposit account (due to the anti-assignment laws) and can rescind any sweep order at any time, with which the lender must comply. Because of the remittance into one deposit account and the standing sweep instructions into another controlled deposit account, the arrangement is also sometimes known as a "double lockbox." Technically, however, this is not correct, as there is only one lockbox associated with the health care provider's deposit account. These days, the lockbox itself serves only a limited function, as most payments are made via ACH wire transfer and not by check.

Commercial payors and individual payors similarly should be directed to make payments into a deposit account established solely for such purpose (a "commercial deposit account"). Control over the commercial deposit account can be achieved through the execution of a traditional deposit account control agreement (a "commercial depository agreement") by and between the health care provider and the lender. [607] Because this deposit account will not receive collections from government payors, the health care provider and the lender are not subject to the Anti-Assignment Rules and the lender can have control over such deposit account. Contrary to the provisions of the governmental depository agreement, the commercial depository agreement should provide that (1) the collections are deposited into the commercial deposit account, which may be in the name of the health care provider or the lender, and (2) the bank will honor the lender's instructions with respect to the funds on deposit in the commercial deposit account without the further consent of the borrower.

As discussed above, the lender has a perfected security interest in all funds deposited into the commercial deposit account, and most importantly, in the deposit account (even though in some instances the health care provider may have access to the funds in the commercial deposit account). Thus, the lender can enforce its security interest against the collateral in the commercial deposit account.

The last step in the typical cash-management structure is to have the funds on deposit in the governmental deposit account and the commercial deposit account swept to the lender's collection account on a daily basis to repay a portion of the outstanding revolving loan balance or other obligations due on such loan. Once the loan balance is reduced, the health care provider may be able to borrow additional funds in accordance with the borrowing-base-availability determinations under the loan documentation.

2. Impact Of Health Care Business Bankruptcy On A Health Care Receivables Lender

The rights of a health care receivables lender are affected by the commencement of a case under the Bankruptcy Code by a health care provider.

a. General Impact of Bankruptcy on a Health Care Receivable Lender

The principal benefit a health care provider-debtor receives from filing for chapter 11 relief is the automatic stay. [608] When a chapter 11 petition is filed, creditors including health care lenders are automatically prohibited from taking action against the debtor (including a health care provider) or its property, among other things, to collect debts arising before the filing of the chapter 11 petition. The automatic stay has the effect of a court-ordered injunction. Actions that violate the automatic stay may result in sanctions imposed by further court order; therefore, it is necessary to carefully consider the automatic-stay provision before taking any action that may affect the debtor health care provider or its property.

Included in the types of actions prohibited by the automatic stay are: (1) commencing lawsuits against the debtor health care provider with respect to debts arising before the filing of the chapter 11 petition; (2) taking action to seize or attach the debtor's property by legal process or private action; and (3) taking actions to foreclose or otherwise enforce liens or mortgages on the debtor's property. The automatic stay does not prohibit certain actions, including any act to perfect an interest to the extent that perfection is permitted under other applicable law to relate back to the time of transfer of the interest (e.g., purchase-money security interests under U.C.C. Section 9-317(e) or under the 30-day perfection defense provided by the preference statute, § 547(e)(2)(A) of the Bankruptcy Code) or to maintain the perfection of a security interest. [609]

A lender can apply to the bankruptcy court for an order modifying or vacating the automatic stay with respect to specific property of the debtor health care provider, or with respect to pending or proposed litigation. [610] Bankruptcy courts have considerable discretion in determining whether the stay should be modified or vacated. During the early stages of a chapter 11 case, the bankruptcy court is generally reluctant to grant such relief. If such property of the debtor is needed for an effective and successful reorganization, the bankruptcy court will not permit a health care receivables lender to take control of the collateral.

b. Treatment of Health Care Receivable Lenders in Bankruptcy

What happens to the lender's security interest and collateral when the health care provider becomes the subject of a bankruptcy case? [611] In addition to the impact of the automatic stay described above, the following provides a brief review of the additional substantial impact that a bankruptcy case for a health care provider will have on its health care receivable lender. [612]

i. Delay in Receiving Amortization Payments

Like other debtors, a health care provider debtor that is the subject of a bankruptcy case under the Bankruptcy Code is generally not permitted to make payments on account of its prepetition obligations prior to making a general distribution to its creditors — which, in a chapter 11 case, occurs upon the effective date of a confirmed chapter 11 plan of reorganization. For most such health care providers' chapter 11 cases, the typical time between the date that a petition for chapter 11 relief is filed and the effective date of a chapter 11 plan ranges between one and two years. Accordingly, absent court approval (including, without limitation, in connection with the provision of consensual or court-ordered adequate protection), [613] the prepetition obligations owed to a health care lender will remain outstanding without repayment during the pendency of the case.

ii. Right to Post-Petition Interest and Expenses

Although unsecured and undersecured creditors generally are not entitled to file a claim for interest accruing after the commencement of a bankruptcy, oversecured creditors are entitled to receive post-petition interest from a debtor; a secured lender against a debtor is entitled to such interest to the extent that it can be paid from the value of its collateral in excess of its secured claim. To the extent provided for in its transaction documents, a secured lender can also recover post-petition fees, costs and charges to the extent of its equity cushion. [614] Accordingly, to ensure entitlement to receive post-petition interest, a health care receivables lender should make sure that it is protected by an equity cushion — i.e., where the value of the collateral exceeds the value of the liens held against such property — sufficient to provide for interest over the course of a bankruptcy case by its borrower, the health care provider. As discussed previously, given that most health care lenders do not lend against 100 percent of the value of the health care accounts receivables, it is common for health care lenders to be oversecured. Entitlement to post-petition interest and expenses, however, does not necessarily mean that such interest will be paid as it accrues. In the absence of an order granting adequate protection (as discussed below), a debtor is mandated to pay post-petition interest

only upon exiting bankruptcy. Typically, the right to receive post-petition interest is determined in connection with the plan of reorganization process or an adequate-protection hearing.

iii. Limitations on Floating Liens

The Bankruptcy Code recognizes the rights of secured lenders whose liens exist as of the filing date of a bankruptcy case. Although "proceeds" of collateral existing before bankruptcy are covered by liens, the scope of a "floating lien" on after-acquired property is cut off as of the time of commencement of the bankruptcy case. [615] This is because § 552(a) of the Bankruptcy Code provides:

Except as provided in subsection (b) of this section, property acquired by the estate or by the debtor after the commencement of the case is not subject to any lien resulting from any security agreement entered into by the debtor before the commencement of the case.

Section 552(b) of the Bankruptcy Code, in turn, permits the lender's pre-petition lien to continue to attach to post-petition property of the estate where the "security interest created by such security agreement extends to property of the debtor acquired before the commencement of the case and to proceeds, products, offspring, or profits of such property...." [616] Thus, a lender's pre-petition security interest may extend to post-petition assets that otherwise replace the lender's pre-petition collateral to the extent provided under the lender's security agreement and applicable nonbankruptcy law.

While preserving a lender's lien, § 552(b)(1) of the Bankruptcy Code also grants a bankruptcy court the authority to limit the scope of such a lien based on the "equities of the case." [617] Courts, however, are reluctant to apply such a remedy outside of situations where the facts truly warrant equitable intervention.

In a health care lending context, this typically means that a lender has a lien on collections of accounts receivable generated prior to the filing date, even if they are collected after such date, but the lender's lien does not extend to accounts receivable or other collections related to services rendered and/or goods sold after the chapter 11 case is filed, absent a cash-collateral agreement, adequate-protection stipulation, or a DIP financing arrangement that provides for such liens.

iv. Setoff/Recoupment Rights

A health care lender's right of setoff, if existing at the time of commencement of the bankruptcy case, is protected to the same extent as a lien (but is subject to the automatic stay and other restrictions). [618] Therefore, a health care receivables lender that also is the debtor's depository bank will retain its banker's setoff rights (to the extent such right is not waived or is not restricted by court order) but may not be able to exercise them. To exercise a right of setoff, a party must obtain authorization from the bankruptcy court. In contrast, unless a bankruptcy court order provides otherwise, a party may exercise recoupment rights to reduce amounts owed to a debtor without need of a court order. See Chapter 10 of this Manual for a more detailed discussion on setoff vs. recoupment.

v. Adequate Protection

The Bankruptcy Code gives a secured lender the right to "adequate protection" of its interest in property that secures its claim against a debtor in bankruptcy. At any time, at the secured lender's request, the bankruptcy court must prohibit or condition the health care debtor's use, sale or lease of collateral as is necessary to adequately protect the lender's interests. The purpose of adequate protection is to protect the lender against a decline in the value of its collateral resulting from (a) the automatic stay of actions against the debtor and the collateral, and (b) the debtor's use, sale or lease of the collateral during the bankruptcy case. [619] The debtor has the burden of proposing and providing adequate protection to the secured lender. [620] The health care provider debtor may meet its burden by making periodic cash payments to the lender, granting the lender an additional or replacement lien on the debtor's other assets or providing the lender other relief that will result in the lender realizing the "indubitable equivalent" of its interest in the collateral. Which form of adequate protection will be provided will depend greatly on the facts and circumstances facing the parties and will be impacted, in part, by the condition of the lender's collateral. If a lender's collateral is declining in value, the lender may be entitled to receive periodic cash payments to compensate it for its collateral depreciation (either in the form of periodic interest payments or payments offsetting any decrease in collateral value). If, however, the health care receivables lender possesses a sufficiently large equity cushion, the existence of such equity cushion in and of itself can be deemed to provide adequate protection to such lender. [621]

Health care lenders often receive as adequate protection replacement liens in the post-petition accounts receivable of the debtor, given that such collateral generally is the largest and most significant asset of the health care provider and in light of the impact of § 552 of the Bankruptcy Code on the lender's pre-petition lien. Sometimes, in addition or in the alternative (i.e., where another lender is providing DIP financing and the replacement lien does not adequately protect the original health care lender), a health care lender may receive interest or other periodic payments as adequate protection.

vi. Cash Collateral

If the lender's collateral is comprised, in whole or in part, of cash collateral, a debtor in a case under the Bankruptcy Code may not use such cash collateral unless either (a) such lender consents to the debtor using the cash collateral or (b) the bankruptcy court authorizes the debtor to use such cash collateral after determining that the lender's interest in the cash collateral is adequately protected. [622] If the debtor and lender are able to reach terms for the consensual use of cash collateral, these parties will often enter into a detailed stipulation establishing the terms for the use of cash collateral. Such a stipulation usually contains many of the same terms and protections provided under a DIP financing agreement. If, on the other hand, the parties cannot reach a consensual agreement as to the use of cash collateral, the debtor can obtain authority to utilize the cash collateral by an order of the bankruptcy court. When a debtor seeks to utilize cash collateral without the consent of the secured creditor with the interest in the cash collateral, the debtor bears the burden of demonstrating that the secured creditor's interests are adequately protected. In such a situation, unless the use of cash collateral creates a benefit for the lender, any use of the lender's cash collateral decreases the value of the lender's collateral, and the lender will need to receive additional consideration or benefits to be adequately protected (such as payments or replacement liens, unless there is an adequate equity cushion in other collateral that provides adequate protection).

vii. Treatment under a Chapter 11 Reorganization Plan

A plan establishes classes of creditors and interest-holders. [623] Creditors secured by different properties must be separately classified. Accordingly, a lender who is secured by health care receivables (and other assets) will be separately classified in any plan of reorganization. A plan also may provide that a class of creditors or interest-holders is "unimpaired," retaining all of their rights under applicable nonbankruptcy law. [624] A plan also provides the means for its implementation, including any corporate combinations, sales of property or issuance of securities. [625] Each creditor that does not accept the plan must receive at least as much as the creditor would receive if the debtor were liquidated under chapter 7 on that date (the "best interests" test). [626]

A secured creditor must receive (a) distributions on account of its claim to the extent of the value of its collateral and (b) to the extent that it is undersecured, distributions on account of such deficiency pro rata with the debtor's general unsecured creditors. If a class of creditors or interest-holders rejects the plan, the plan can still be confirmed provided the plan meets more stringent requirements that are intended to preserve strict priority in right of payment; this procedure is called "cram-down." In cram-downs, secured lenders (such as health care receivables lenders) must retain their liens on the pledged property (or the proceeds of the sale if sold under § 363 of the Bankruptcy Code) and must receive deferred cash payments totaling the allowed amount of the secured claim and valued as of the effective date of the plan at not less than the value of the creditor's lien; alternatively, a secured lender also may be provided with the "indubitable equivalent" of its secured claim. [627] The appropriate interest rate paid on such deferred-cash payments under a plan of reorganization, however, may be a source of dispute and litigation before the bankruptcy court.

viii. Other Relief

The Bankruptcy Code also offers a secured lender other, more involved forms of relief that usually take more time and effort to pursue, including (a) dismissal of a debtor's bankruptcy case, [628] (b) conversion of the chapter 11 case to a liquidation under chapter 7 of the Bankruptcy Code, [629] (c) appointment of a chapter 11 trustee or examiner, [630] and (d) termination of the debtor's exclusive period for filing and soliciting acceptances of a reorganization plan. [631] The health care receivables lender may also object to the proposed sale or other disposition of the collateral, and object to and vote on a reorganization plan.

ix. Position of Health Care Lenders vis-à-vis Government Payors

The risk of recoupment and setoff is significant from a health care lender's perspective. Where a health care lender has a lien in the health care provider's accounts receivable, it is likely that the health care lender's position with respect to the receivables is subject to the

government's right of recoupment or setoff. Where the government's right to recover overpayments is characterized as a recoupment, courts have found that the health care lender's right in the receivables is subject to the government's right of recoupment on the ground that the government "never owed the [health care entity] the full amount of the accounts receivables because it had overpaid, and so the full amount was not the [health care entity's] to assign to [the secured creditor]. Recoupment of that amount merely confirmed the assignee's debt to the express terms of the contract between the account debtor and the assignor." [632]

Where the government's right to recover overpayments is characterized as a setoff, courts have found that a health care lender's rights in the health care accounts receivable is junior to the government's right of setoff pursuant to UCC § 9-318, which provides that a right of setoff may be asserted if it arises before notification of the account assignment. [633] At least one court has held that, after finding that the government's right to recover Medicare overpayments was a setoff right, the government's setoff right was senior to the interests of bondholders who claimed perfected security interests in the debtor's Medicare receivables. [634] Specifically, the court found that since the Medicare statutes (which were in existence at the time the bondholders' security interest in the receivables were perfected) clearly provided notice of the government's rights to offset overpayments, the bondholders could only have taken an interest in the health care provider's receivables subject to the government's right to seek overpayments. [635]

In addition, Congress enacted the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 (BAPCPA), which amended the Bankruptcy Code. As part of those amendments, the Secretary of Health and Human Services was granted the ability to "exclude" a debtor health care provider from "the [M]edicare program or any other Federal healthcare program" without being in violation of the automatic stay. [636] Given the importance of Medicare to many health care providers, this statutory exclusion from the automatic stay poses a further potential material risk for health care lenders. While this is likely just the codification of earlier practice, at a minimum, this exception to the stay adds clarity and will add to the negotiating leverage that the U.S. government possesses vis-à-vis the debtor health care providers, pre-petition health care lenders and DIP financing lenders, with respect to the treatment of claims under Medicare and other federal health care programs.

x. Certain Additional Costs in Health Care Business Bankruptcy Cases

BAPCPA also provided that in all "health care business" bankruptcy cases, the bankruptcy court is required to appoint a patient care ombudsman unless the court determines that no such ombudsman is needed. [637] This requirement for the appointment of such a patient care ombudsman could add material costs to a health care providers' bankruptcy case. Similarly, the 2005 amendments also provided that the actual and necessary costs incurred by a debtor health care provider, a federal agency or a state of local governmental entity for closing a health care business, including, without limitation, the costs associated in complying with the patient record retention requirements under § 351 of the Bankruptcy Code [638] and for transferring patients, are accorded administrative expense priority status. [639] Accordingly, a lender must be cognizant of the potential for these types of additional costs to be imposed upon a health care provider in the event that the health care provider becomes the debtor in a bankruptcy case. To protect itself, a lender should make adequate reserves against such potential costs that may arise in a bankruptcy case.

3. Debtor-In-Possession Financing To Health Care Providers

DIP financing under the Bankruptcy Code offers a well-developed legal structure for secured lending that is unsurpassed for mitigation of recovery and litigation risk. While most DIP credit facilities are substantially similar to traditional asset-based financings, DIP financing is unique in that bankruptcy court approval of the facility, the granting of a security interest in collateral and the enforcement of remedies are obtained in advance of the credit being extended and from the same bankruptcy court in which judicial remedies would later be sought. If properly structured, DIP financing can be more profitable to a health care receivables lender than secured credit outside of bankruptcy and more certain of repayment (because of the inducement and protections given to the lender under the Bankruptcy Code). In addition, by providing DIP financing, a pre-petition secured creditor can protect itself from becoming subjected to a priming lien from a third-party DIP lender. As discussed more fully herein, certain rights available to Medicare and Medicaid, however, can make lending on certain post-petition health care receivables riskier than lending on the same class of pre-petition receivables.

a. Overview

Under the Bankruptcy Code, a company filing a bankruptcy petition for reorganization under chapter 11 has the ability to obtain credit after the bankruptcy petition date. To induce the provision of such post-petition credit, § 364 of the Bankruptcy Code grants post-petition lenders bankruptcy court-approved protections, including (a) secured status, potentially priming [640] existing secured creditors, and (b) priority

status for their unsecured claims, with right to payment ahead of other priority and nonpriority unsecured claims. The bankruptcy courts generally recognize that post-petition lenders should be paid commercially competitive interest rates, front-end fees and attorney's fees in connection with loan transactions under § 364 of the Bankruptcy Code. This can greatly reduce or offset the administrative costs often associated with putting together complex loan packages such as are common in health care receivable financings.

In general, health care receivable lenders are motivated to extend such credit for several reasons. Such lenders holding pre-petition claims against a chapter 11 debtor can obtain certain distinct advantages by providing new, post-petition financing, including:

• enhancing their review, supervision and control of the debtor's assets;

• conditioning the financing upon the debtor's waiver or curtailment of actions to contest the lender's pre-petition claims and/or security interests;

• obtaining judicial approval of (a) the lender's remedies and enforcement mechanisms, (b) the terms of financing, (c) the DIP lender's collateral and (d) the priority of the security interest held by such lenders;

• maintaining some control over the reorganization process;

• priming or limiting the setoff or recoupment rights of account-debtors (i.e., the parties who owe payables to the health care provider debtor which are pledged to the lender) that may otherwise negatively affect the health care receivables granted as collateral to such lender; and

• securing the pre-bankruptcy debt with new collateral ("cross-collateralization").

By extending post-petition DIP financing, the DIP lender becomes an integral part of the chapter 11 process and maintains a seat at the negotiating table regarding the terms and form of any potential restructuring proposal or an eventual decision to sell the DIP's business or liquidate such business.

Like other lenders, there are also several disadvantages that pre-petition health care financing lenders may suffer if they decide not to provide DIP financing, including:

• Other lenders may "prime" or dilute the collateral and assets that secure the obligations owed to the pre-petition lenders by being granted liens equal or senior to existing liens of non-DIP pre-petition lenders; and

• The pre-petition lender surrenders significant control over the reorganization process to other lenders that do not necessarily have the same agenda, viewpoint or interests.

Lenders also extend post-petition credit because of the favorable terms of the loan. Lenders have viewed such financings as introducing or supporting relationships with a potential long-term customer (presuming the health care provider debtor will successfully reorganize and require credit post-reorganization).

b. Types of Post-petition Credit

Section 364 of the Bankruptcy Code gives lenders wide latitude in the types of post-petition credit that they can offer to health care providers. Section 364 of the Bankruptcy Code in general permits four types of post-petition credit:

1. ordinary-course unsecured credit; [641]

American Bankruptcy Institute, ABI Health Care Insolvency Manual, 2012 Edition, Chapter 11: Health Care Receivables Financing

2. unsecured credit outside the ordinary course; [642]

3. superpriority unsecured or junior secured post-petition credit; [643] and

4. equal or senior "priming" secured post-petition credit. [644]

Outside of ordinary trade debt, loans under § 364(a) of the Bankruptcy Code are not typical in health care provider bankruptcy cases, as usually the DIP lender requires the greater protections of financings approved under § 364(c) and (d) of the Bankruptcy Code.

i. Superpriority Credit and Nonpriming Liens

Most financial institutions extending DIP financing do so on a secured basis, with the collateral tending to be in a form that is liquid, self-liquidating or easily liquidated. In this sense, health care receivables lending falls within the typical types of DIP financing. Thus, lenders who are familiar with asset-based financing, such as health care receivables, generally should be comfortable with secured DIP financing, which often may be viewed as a specialized form of asset-based lending. In fact, DIP asset-based financing is perhaps the most secure form of asset-based lending because a bankruptcy court must have first approved such financing, and such approval (a) may be conditioned on a prohibition of future priming liens and (b) may override negative covenants in existing, pre-petition loan agreements. As an alternative or supplemental inducement for post-petition lenders, the Bankruptcy Code also permits the debtor to grant a lender superpriority status (confirmed by a bankruptcy court order). This option enables the lender to be repaid out of unencumbered assets as well as its collateral, ahead of other creditors, whether they are pre- or post-petition creditors. Of course, the basic risk analysis for such DIP financing is no different when the health care provider is in or out of bankruptcy: Given the collateral package and other rights against the debtor, is there sufficient liquid collateral or unencumbered assets to ensure repayment?

As with unsecured DIP financing under § 364(b) and (c) of the Bankruptcy Code, secured or priority DIP financing must be necessary for the preservation of the debtor's estate and authorized by the bankruptcy court after notice and an opportunity for a hearing. Additionally, the debtor's management or chapter 11 trustee (if one is appointed to replace management) must demonstrate that financing cannot be obtained without the added burden to the estate of the grant of a security interest or a superpriority — in other words, that credit cannot be obtained by offering ordinary administrative expense priority under § 364(a) or (b) of the Bankruptcy Code. This means that the debtor may have to show the bankruptcy court that it has unsuccessfully searched for better terms from other potential lenders before agreeing to a priority or secured claim against its estate under § 364(c) of the Bankruptcy Code. Furthermore, bankruptcy courts will examine the terms of a § 364(c) transaction to ensure that they are fair and reasonable. If the bankruptcy court determines that the terms of a financing agreement are unduly burdensome or that less-onerous financing is available from another lender, the bankruptcy court may reject the proposed DIP financing. [645] This ensures that the debtor is not giving up rights in property without a beneficial return.

Section 364(c) of the Bankruptcy Code enables post-petition lenders to obtain either an extraordinary administrative expense priority (a superpriority) or a nonpriming lien. This section can be used by a lender to obtain a superpriority, which gives such lender's claim priority over all other unsecured claims, including ordinary administrative expenses (such as the fees of debtor's counsel), although frequently a carve-out from the superpriority is negotiated for a specific amount of post-petition professional fees. As a practical matter, such a loan would be paid from the debtor's unencumbered assets before any money is distributed to other unsecured creditors. Under § 1129 of the Bankruptcy Code, a chapter 11 plan cannot be confirmed over the objection of a creditor holding such a priority claim unless the creditor is paid in cash as soon as practicable after the effective date of the plan. If the chapter 11 case is unsuccessful and it is converted to chapter 7, the claim is paid ahead of all unsecured claims arising prior to conversion, including any unsecured deficiency claims by secured creditors. Section 364(c) of the Bankruptcy Code also authorizes a lender to obtain a security interest in unencumbered property of the debtor's estate or a junior security interest in already-encumbered property. A post-petition lender also can receive both (1) superpriority status and (2) security interests (pursuant to either § 364(c) or (d) of the Bankruptcy Code). The loan agreement, however, must specify the lender's level of priority; a lender may not later safely claim a status that was not included in its negotiated credit agreement with the debtor. Where DIP financing is sought in a health care provider's bankruptcy, usually such financing primarily involves secured DIP financing approved under § 364(2) of the Bankruptcy Code (liens granted on otherwise-unencumbered property) or priming liens under § 364(d) of the Bankruptcy Code.

ii. Priming Liens

In situations where there are few or no unencumbered assets, a DIP financing will most probably be provided under § 364(d) of the Bankruptcy Code (unless the court approves the use of the DIP financing to take out the pre-existing secured debt). Section 364(d) of the Bankruptcy Code permits the lender to bargain with the debtor for the greatest level of protection: a priming lien on property of the estate already subject to an encumbrance. As with § 364(c) financings, for a § 364(d) financing, (1) the debtor must be unable to obtain credit on less-burdensome terms; (2) the credit must be necessary for the preservation of the estate; and (3) bankruptcy court authorization pursuant to notice and an opportunity for a hearing is required. Additionally, however, because such priming liens interfere with the bargained-for rights of the existing, primed secured creditor, the Bankruptcy Code requires the debtor to show that the value of the existing creditor's current interest in the collateral is protected notwithstanding the new loan and security interest. The trustee or the debtor in possession must provide the creditor whose lien is primed "adequate protection" for the value of its secured interest, unless such creditor consents to the priming lien. [646] Because the automatic stay prohibits the exercise of the secured party's state law remedies, the Bankruptcy Code's adequate protection requirement is intended to ensure that collateral held by a secured creditor is not devalued during the case. [647]

Thus, if a DIP financing proposes to prime a creditor's security interest, the debtor must show that its ability to pay the primed creditor from the collateral is not diminished, or the debtor must otherwise compensate the secured creditor for the loss of its collateral's value. If a lender provides DIP financing to a pre-petition debtor, its DIP financing will, in effect, be priming its own pre-petition secured guaranty position. As a condition to providing DIP financing, the lender may require that its pre-petition loan be repaid in full (which may be approved in certain circumstances by the bankruptcy court). If such relief is not sought or obtained, the lender can require periodic interest or other payments on account of the debtor's pre-petition obligations. (As set forth above, to the extent that a lender is oversecured, such payments will be treated as interest payments; if such lender is undersecured with respect to the pre-petition obligations, adequate-protection payments may be recharacterized as prepayments of principal.)

In health care provider bankruptcy cases, lenders have used priming liens under § 364(d) of the Bankruptcy Code to minimize, eliminate or clarify the amount of potential erosion to health care receivables under the doctrines of setoff or recoupment. By adding express provisions in the order that limit the ability of governmental payors and commercial payors to assert recoupment or setoff rights and expressly stating that the DIP financing lender's rights and liens prime the interests of such governmental payors and commercial payors, a DIP financing lender can seek to limit such attacks against the amount of receivables. [648] Of course, the health care provider debtor must satisfy the requirements for obtaining priming DIP financing under § 364(d) of the Bankruptcy Code that all parties whose liens and interests are primed are adequately protected. As a practical matter, by including such provisions in a proposed order, the lender and the governmental payors and commercial payors reach a consensual resolution whereby the amount of potential recoupments, setoffs or other reductions to receivables is delineated and memorialized, which allows the parties to know the amount of the receivables borrowing base with greater certainty. Moreover, it should be noted that Medicare and Medicaid actively seek to preserve their rights of setoff and recoupment in any order approving DIP financing, particularly in jurisdictions where such rights are consistently preserved by the courts.

c. Protections and Rights of the Post-Petition DIP Financing Lenders

A health care provider debtor may not incur post-petition credit until authorized to do so by the bankruptcy court. Consequently, the lender's rights are defined by court order, and the lender need not extend credit until the order is granted.

i. Finality of Bankruptcy Court's Authorization of Post-Petition Credit

Absent bad faith on the part of the lender in making the loan, if a stay pending an appeal of the order approving a post-petition financing is not obtained, any reversal or modification of such order will not affect the validity of the post-petition debt or the priority of the liens granted to the post-petition lender. [649] The rationale for the finality of post-petition financing orders is to promote the provision of post-petition credit and to overcome lenders' reluctance to take the risk that a loan agreement under which they have provided funds will be overturned or modified on appeal. Additionally, § 364(e) of the Bankruptcy Code may also prevent a bankruptcy court from later modifying a financing agreement if the lender acted in good faith. Even though the terms of § 364(e) of the Bankruptcy Code only cover modifications on appeal, the principles underlying § 364(e) of the Bankruptcy Code illustrate that bankruptcy court orders approving DIP financings constitute binding commitments that can be changed only if it is established that the lender acted in bad faith.

ii. Rights and Protections under the DIP Financing Agreement

Aside from the finality of post-petition financing orders under § 364(e) of the Bankruptcy Code and the security interests and priority status

permitted under § 364(c) and (d) of the Bankruptcy Code, as in traditional lending arrangements DIP lenders are protected by the rights and protections included in the financing documents. As with non-bankruptcy credit agreements, the DIP credit agreement may provide for substantial monitoring and restrictions of the debtor's actions and expenditures. In this regard, it should be noted that (a) the debtor in possession or trustee has additional public disclosure requirements under the Bankruptcy Code and (b) is subject to increased scrutiny by parties in interest, often leading to many parties' closer monitoring of the debtor's financial condition. The DIP lender may also provide for additional events of default under the financing documents, keyed, for example, to the debtor's meeting easily definable goals in the bankruptcy case, e.g., filing a plan of reorganization on or before a set date.

Typically, following negotiations between the prospective lender and the debtor in possession or trustee, the debtor will present the bankruptcy court with a completed agreement and proposed order authorizing that agreement. While the bankruptcy court may refuse to enter the proposed order unless certain provisions are deleted or modified, the lender has a large degree of control over the financing package and, as noted above, if the lender is dissatisfied with the changes proposed by the bankruptcy court, the lender does not have to accept them and can choose not to close or fund.

If the terms of the financing documents unreasonably restrict the debtor's actions or disrupt the bankruptcy case, the bankruptcy court may not approve the financing. For example, bankruptcy courts are wary of terms that (a) seek cross-collateralization of pre- and post-petition debt; [650] (b) excessively restrict the management and control of the debtor's operations, especially when the lender is also a pre-petition creditor or the restrictions harm other creditors; (c) excessively restrict the trustee's or debtor in possession's ability to obtain legal services; (d) overly disrupt the bankruptcy case; (e) waive the debtor's avoiding powers in respect of pre-petition transfers; or (f) waive other causes of action (again to unduly benefit a post-petition lender that also is a pre-petition creditor). These common post-petition reservations, however, relate to the particular circumstances surrounding each post-petition financing and will depend to a large extent upon (a) the availability of alternative sources of less-burdensome financing and (b) whether the post-petition lender also is a pre-petition creditor perceived to be obtaining undue advantage for its pre-petition claims as a consequence of its post-petition loan. DIP loans by lenders who may also be seeking to acquire all or a substantial portion of the debtor's business also will be carefully scrutinized. In any event, such considerations may cause a bankruptcy court to be reluctant when considering whether to authorize such credit to be incurred, but do not affect the rights of good-faith lenders after the bankruptcy court has approved the DIP financing order.

d. Risks Associated with Extending Post-Petition Credit

By far, the biggest risk a post-petition lender to a health care provider faces is the possibility that accounts receivable will not continue to be paid and collected with the same frequency that they were prior to filing the chapter 11 case. It is very possible that a loan balance that typically "turned" (i.e., was paid in full) in 28 days pre-petition may be outstanding for a longer period of time post-petition as payors determine whether any valid setoff or recoupment rights exist. This is a particularly real concern as it relates to government accounts as Medicare intermediaries are instructed to notify the Department of Health and Human Services (HHS) immediately upon learning of a health care provider's bankruptcy or suspected bankruptcy so that HHS may determine whether or not to suspend payments at the outset of a bankruptcy filing, while any overpayments are identified. [651] Even more concerning to a post-petition lender is the very real possibility that, in light of the fact that a majority of courts have characterized the government's post-petition recovery of pre-petition overpayments as a recoupment, [652] if an overpayment is determined to have been made by the government prior to the filing of the chapter 11 case, post-petition receivables against which the post-petition lender advanced revolving loans may be retained by the government and not paid over to the post-petition lender to pay down the post-petition loan balance.

Once bankruptcy court approval has been obtained, few impediments unique to the Bankruptcy Code exist that will interfere with the lender's ability to enforce its remedies, such as by liquidating the collateral. Other than as set forth in the prior paragraph, the primary risks borne by the post-petition lender are the same risks faced by lenders to nonbankrupt entities hinging on the liquidation value of the collateral and the borrower's cash flow. If granted a security interest, the lender will want to ensure that the liquidation value of the collateral will provide sufficient protection if the debtor is unable to repay the loan. Because the typical collateral for post-petition financings is either liquid, self-liquidating or easily liquidated (such as inventory or health care receivables), the ability of the lender to enforce its remedies is made easier. Furthermore, by providing in the financing documentation that the automatic stay under § 362 of the Bankruptcy Code be lifted without notice or on short notice after a major default, the DIP lender can enhance its ability to enforce its remedies rapidly.

Like any financing transaction, a debtor may default under the terms of the DIP financing agreement. As discussed above, however, in the case of a default, the post-petition lender will be able to enforce its rights under the agreement as approved by the bankruptcy court. Bankruptcy courts recognize that reliance upon the order authorizing financing is critical to post-petition lenders. Given the priority status or security interests contained in the financing agreement and order, lenders should be assured of enforcement of those rights upon an event of default.

There are several other risks peculiar to DIP financing [653] that can be minimized or eliminated by (a) ensuring that the DIP financing is adequately secured or that sufficient unencumbered assets exist, (b) acting in good faith in accordance with customary lending practices, (c) providing that proper procedural requirements are followed and (d) providing for adequate protections in the DIP financing order.

4. Conclusion

Health care receivables financing can present a lender with several hurdles if the lender is not knowledgeable about the provider's collateral and the rules and regulations that must be followed to ensure enforcement of the health care lender's lien, especially in the context of dealing with government payors and Anti-Assignment Rules. To properly manage these and related risks, the lender must also be prepared for the impact of a bankruptcy filing by the health care provider on the lender's security interest and collateral and the ability to enforce such security interest against pre-petition and post-petition assets of the debtor health care provider. The automatic stay, the general delay involved in bankruptcy cases and the limitations on floating liens are just a few of the obstacles that health care lenders must face when interacting with a debtor health care provider. The lender is not, however, without rights and protections afforded under the Bankruptcy Code, including, among others, the right to adequate protection, the receipt of replacement liens and/or post-petition interest, the preservation of the lender's existing right of setoff, and protections in connection with treatment of the lender's claims under a health care provider's plan of reorganization.

One of the best methods for mitigating such recovery risks from a health care provider's bankruptcy is the lender's ability to provide DIP financing to the health care provider pursuant to a well-developed set of structures and rules that offer the lender several protections. Section 364 of the Bankruptcy Code gives lenders a wide variety of post-petition financing alternatives, each of which offers levels of protection against other creditors of the debtor and ensures that the health care lender is an integral part of the provider's bankruptcy case. Despite these protections, the lender still has the risk that its collateral (i.e., accounts receivable) will not continue to be paid and collected with the same frequency as pre-petition, especially where government accounts are involved. In such cases, access to the courts and orders thereof can be of value to the health care lender.

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[600] "U.C.C." means the Uniform Commercial Code, as drafted by the National Conference of Commissioners on Uniform State Laws. The U.C.C. has been adopted, with some variations, by all fifty states along with the District of Columbia and the United States Virgin Islands. Although there may be slight differences in the form of the U.C.C. ratified by any particular state, for purposes of this Chapter, unless otherwise specified, we will refer to the form of the U.C.C. as adopted by, and in effect in, the State of New York.

[601] U.C.C. § 9-102(a)(46).

[602] U.C.C. § 9-102(a)(61).

[603] U.C.C. § 9-104.

[604] See 42 U.S.C. §§ 1395g(c), 1395u(b)(6) and 1396a(a)(32). A violation of the Anti-Assignment Rules could result in, among other things, the termination of the health care provider's participation in the governmental health care program, impairing, among other things, the lender's collateral. See Medicare Claims Processing Manual (Pub. 100-4) Ch. 1 § 30.2.15 (Rev. 1, 10-01-03). Of course, non-federal law-based restrictions on health care receivable assignments may be unenforceable as violative under Section 9-408 under the Revised Article 9. That section "makes ineffective any attempt to restrict the assignment of ...a health care insurance receivable...." See U.C.C.§ 9-408, Official Comment 2.

[605] See, e.g.,In re Missionary Baptist Found. of America Inc., 796 F.2d 752 (5th Cir. 1986) (anti-assignment rules were not intended to prohibit the granting of security interests in governmental receivables where health care provider had control over initial payments from the governmental entity); In re East Boston Neighborhood Health Center, 242 B.R 562 (Bankr. D. Mass. 1999) ("The [Anti-Assignment Rules] may impair the [lenders'] ability to seek payment on the receivables from the governmental insurer without the provider's cooperation...[but] the statutes do not impair the [lenders'] ability to enforce their security interests once payment has been issued.").

[606] See U.C.C. § 9-315(d)(2).

[607] Some health care lenders will permit individual payors to make payments directly to the health care provider (borrower) so long as the health care provider covenants in the loan documentation state that it will promptly deposit such payments into the commercial deposit account.

[608] 11 U.S.C. § 362 .

[609] 11 U.S.C. §§ 362(b)(3) (specifying exception to automatic stay for such look-back perfections and to maintain perfections of security interests) and 546(b)(1) (carving out such matters from the Bankruptcy Code's avoidance powers).

[610] 11 U.S.C. § 362(d) .

[611] The term "health care business" is a defined term under § 101(27A) of the Bankruptcy Code and provides both a description of the business (e.g., an entity primarily engaged in the offering of services or facilities to the general public for diagnosis, treatment or related health care services), as well as a nonexclusive list of examples.

[612] In addition to the topics reviewed in this chapter, a bankruptcy case undoubtedly may have other significant impacts on a health care receivables lender. For example, a lender in appropriate circumstances may be subjected to surcharges under 11 U.S.C. § 506(c) . Also, a sale of assets under 11 U.S.C. § 363 or under a chapter 11 plan and, as applicable, the availability of credit-bidding protections under 11 U.S.C. § 363(k) , and selling free and clear of liens under 11 U.S.C. § 363(f) , all may materially impinge upon such lender's rights and interests. Although a health care receivables lender will be affected by such matters, the impact on a health care receivables lender is similar to the impact on other types of secured lenders. Such generic impacts on secured lenders are beyond the scope of this chapter and are not reviewed here.

[613] See Section 2.b(v) of this chapter for a discussion of adequate protection.

[614] See 11 U.S.C. §§ 502(b)(2) (general disallowance of unmatured interest) and 506(b) (oversecured creditor entitled to post-petition interest and out-of-pockets fees/expenses). But see, e.g., Travelers Casualty & Surety Co. of America v. Pacific Gas & Electric Co., 127 S.Ct. 1199 (2007); United Sav. Ass'n v. Timbers of Inwood Forest Assocs. Ltd., 484 U.S. 365 (1988).

[615] See 11 U.S.C. § 552(a) .

[616] For a detailed discussion regarding the scope of "proceeds" captured by § 552(b)(1) of the Bankruptcy Code, see Ray Warner, Article 9's Bankrupt Proceeds Rule: Amending Bankruptcy Code Section 552 Through the UCC "Proceeds" Definition, 46 Gonz. L. Rev. 521 (2011).

[617] 11 U.S.C. § 552(b)(1) .

[618] See, e.g., 11 U.S.C. § 553 . A lender's setoff rights may also be impacted by the ability of a debtor to provide alternative adequate protection or by the terms of the DIP financing with a third-party lender (i.e., setoff rights may be subject to being primed under 11 U.S.C. § 364(d)).

[619] See 11 U.S.C. §§ 361 and 362(d).

[620] See 11 U.S.C. §§ 362(g)(2) and 363(p)(1).

[621] Often, a debtor and a secured lender may agree that interest payments should be made to the secured creditor during the course of a bankruptcy case, while preserving until the plan confirmation process a final determination regarding entitlement to adequate-protection payments or post-petition interest. If the lender is determined not to have been entitled to such payments, the payments made to the secured creditor during the course of the case would be treated as prepayments of principal.

[622] See 11 U.S.C. § 363(c)(2) .

[623] 11 U.S.C. § 1122 .

[624] 11 U.S.C. § 1124 .

[625] 11 U.S.C. § 1123(a)(5) .

[626] 11 U.S.C. § 1129(a)(7)(A) .

[627] See 11 U.S.C. § 1129(b)(2)(A).

[628] See 11 U.S.C. §§ 305 and 1112(b).

[629] See 11 U.S.C. § 1112(b).

[630] See 11 U.S.C. § 1104.

[631] See 11 U.S.C. § 1121(d).

[632] See Inre Doctors Hospital of Hyde Park Inc., 337 F.3d 951, 954 (7th Cir. 2003).

[633] In re Metropolitan Hospital, 131 B.R. 283 (E.D. Pa. 1991).

[634] Id. at 290-91.

[635] Id. at 291 ("Here, the security interests in 'gross revenues' were perfected in 1976 and 1981. The Bondholders Committee and the Indenture Trustee were sophisticated lenders that knew, or should have known, the mechanics of the provider-reimbursement provisions of the medicare statute. Inasmuch as this provision of the medicare statute existed prior to 1976, their security interests would not attach until the provisions of the medicare statute were satisfied" (citations omitted)).

[636] 11 U.S.C. § 362(b)(28).

[637] See 11 U.S.C. § 333(a)(1).

[638] See 11 U.S.C. § 351.

[639] See 11 U.S.C. § 503(b)(8).

[640] A "priming lien" is a lien granted pursuant to § 364(d) of the Bankruptcy Code on previously encumbered property; it is actually senior to all other pre-petition liens.

[641] 11 U.S.C. § 364(a).

[642] 11 U.S.C. § 364(b).

[643] 11 U.S.C. § 364(c).

[644] 11 U.S.C. § 364(d).

[645] This was the basis for the bankruptcy court to reject the DIP financing recently sought by the Los Angeles Dodgers in its bankruptcy case. See In re Los Angeles Dodgers LLC, Case No. 11-12010, Docket No. 285, slip op. at 5 (Bankr. D. Del. July 22, 2011) (where Major League Baseball offered unsecured loan on more favorable terms, court rejected proposed secured DIP financing sought by Los Angeles Dodgers).

[646] See 11 U.S.C. § 361.

[647] As set forth above, § 361 of the Bankruptcy Code lists three nonexclusive methods of adequately protecting a secured creditor: 1.making cash payment(s) to compensate a creditor for the decrease in value of the creditor's interest in the property; 2. providing the creditor an additional or replacement lien to the extent the creditor's interest in the property decreases; or 3. granting such other relief as will result in the realization by the creditor of the indubitable equivalent of its interest of such property. An "equity cushion" (the value of the collateral in excess of the secured debt) may serve as adequate protection. In general, the courts will examine the amount of the equity cushion to determine whether a primed secured creditor is adequately protected. Other courts examine both the existence of an equity cushion and the chances for a successful reorganization when determining whether the primed creditor is adequately protected. Absent an equity cushion, adequate protection requires that the primed creditor receive something to compensate it for the decrease in value of its interest.

[648] See, e.g., In re Sun Healthcare Group Inc., 245 B.R. 779, 782-83, 785 (Bankr. D. Del. 2000) (restrictions imposed upon governmental payors asserting setoff or recoupment rights between transactions unless such transaction occurred both under same provider agreements or statutes and during the same cost-year (citing In re University Medical Center, 973 F.2d 1065, 1081 (3d Cir. 1992)).

American Bankruptcy Institute, ABI Health Care Insolvency Manual, 2012 Edition, Chapter 11: Health Care Receivables Financing

[649] See 11 U.S.C. § 364(e) .

[650] Some courts do not permit cross-collateralization of both pre-petition and post-petition debt. Most courts, however, allow cross-collateralization when: (a) the debtor's business would not survive without the proposed financing; (b) the debtor cannot obtain alternative financing on acceptable terms; (c) the lender will not accede to less burdensome or preferential terms; and (d) the proposed financing is in the best interests of the creditor body.

[651] SeeMedicare Financial Management Manual (Pub. 100-6) Ch. 3 § 140.6.5 (Rev. 12, 10-18-02) ("Bankruptcy law allows a creditor like Medicare to freeze payments if it thinks it has the right to set-off those payments. Generally, in the Part A context, the first 2-3 weeks of Medicare payments after a debtor files for bankruptcy result from prepetition services. Therefore, [HHS] might decide to freeze all payments for prepetition services and then request bankruptcy court permission to set-off those payments against prepetition overpayments. Because there is such a short period during which there might be prepetition payments available to set-off available to freeze for set-off, it is critical to find out about the bankruptcy and the provider's overpayments quickly.... Other prepetition payments, such as underpayments or payments delayed because of medical review, may be available to set-off against prepetition overpayments.").

[652] See, e.g., In re Holyoke Nursing Home Inc., 372 F.3d 1 (1st Cir. 2004); United States v. Consumer Health Services of America Inc., 108 F.3d 390 , 395 (D.C. Cir. 1997); Doctors Hospital of Hyde, 337 F.3d 951 (noting, without discussion, that such application of pre-petition overpayments constitutes equitable recoupment); In re District Memorial Hospital of Southwestern North Carolina Inc., 297 B.R. 451 (Bankr. W.D.N.C. 2002);State of Illinois v. Daiwa Special Asset Corp., 291 B.R. 453 (N.D. Ill. 2002); Ravenwood Healthcare Inc. v. State of Maryland, Department of Health and Mental Hygiene, No. MJG. 06-3059, 2007 WL 1657421 (D. Md. June 4, 2007).

[653] These items include (a) ensuring that the notice and hearing requirements under the Bankruptcy Code are satisfied, (b) acting in "good faith," (c) protecting against other DIP lenders, (d) protecting against the risks associated with conversion of a chapter 11 case to a chapter 7 liquidation case or dismissal of a case, and (e) minimizing the risk that the DIP lender's collateral may be surcharged.
