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When a Provider Needs Capital

Financing patient accounts receivables can be the way to go.

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BOTH INSTITUTIONAL and individual healthcare providers may find themselves with a need for capital due to a variety of factors, such as delays in receipt of reimbursement from payors, the need to pay vendor debt, or the desire to refinance an existing credit facility. Financing the provider's patient accounts receivable is one way to generate needed capital.

Instead of waiting to receive reimbursement from third party payors for healthcare services or goods provided, receivables financing allows providers to get a portion of that money sooner, thus accelerating cash flow.

Providers considering receivables financing should become familiar with the overall structure and how the financing might impact their cash flow. This article will provide a general overview of healthcare receivables financing for attorneys who advise healthcare providers.

How Financings Work

Accounts receivable financings are secured by patient accounts receivable of the provider and related assets (such as general intangibles and instruments).

In a loan secured by equipment or real property, with which providers may be more familiar, the provider usually borrows a set amount of money in one lump sum. So long as the provider repays the loan as required, the lender takes a relatively hands-off approach and does not closely monitor the provider's business. Accounts receivable financings generally function differently.

Since the lender's collateral is constantly evolving as receivables are collected and new receivables are generated, the borrowing availability adjusts accordingly. For this reason, these financings are generally structured as lines of credit, where the provider can borrow under the facility, repay the loan, and re-borrow as new receivables are generated. In order for the lender to determine the borrowing availability continually, the lender must have access to up-to-date information regarding collections and new receivables generated.

Sometimes an accounts receivable financing is structured as a "two tier transaction," in which a new bankruptcy remote special purpose vehicle (SPV) is formed to give the lender added bankruptcy protection. Under this structure, the receivables are sold by the provider to the SPV, and the SPV borrows money from the lender. The loan is secured by the accounts receivable of the provider and the proceeds of the loan are used to fund the purchases of the receivables. Other than the introduction of the SPV into the process, the mechanics of the transaction are largely the same as a direct loan to the healthcare provider.

As a general matter, providers are able to borrow up to the lesser of the maximum amount of the facility and the "borrowing base."

Calculating the Borrowing

The borrowing base is the lender's calculation of the provider's borrowing ability based on the amount the provider is expected to collect (based on historical collection data) on its eligible receivables outstanding at the time, which amount is discounted to provide a cushion for the lender.

For example, a lender may consider all patient receivables that are less than 90 days old and that are owed by third party payors (i.e., managed care organizations, Medicare and Medicaid, but not amounts owed by the patients themselves) to be eligible for purposes of the borrowing base calculation.

The provider would be able to borrow a percentage of the amount it is expected to collect on these receivables. Thus, if $800,000 of a provider's total of $1 million outstanding patient receivables are deemed to be eligible, and of that amount the provider is expected to collect $700,000, the provider may borrow 80 percent of such amount, or $560,000, regardless of the maximum amount of the loan facility.

The lender may also impose reserves against the provider's availability. For example, if the provider has a potential liability to Medicare in the amount of $50,000, the lender may subtract this amount from the provider's availability, reducing it to $510,000, to increase the likelihood that the provider will have sufficient capital to pay the liability.

Understanding how the borrowing base is calculated and the interplay of the maximum facility amount and the borrowing base is important for several reasons.

First, the provider that is offered a facility with a certain maximum amount should be aware that it will only be allowed to borrow up to its borrowing base.

Second, lenders commonly charge a fee for the "unused" portion of the facility, or the difference between the maximum amount and the borrowing base. Ideally, a provider should negotiate a maximum facility amount that does not exceed its projected borrowing base significantly.

Third, since the borrowing base is a percentage of eligible receivables, the provider should focus on the criteria for eligibility and the lender's ability to change the criteria in the loan documents. While it is expected that lenders will reserve some discretion in loan documents, wide discretion in this area could result in the provider's borrowing availability being substantially lower than the provider expected.

Crucial Cash Management

Another crucial aspect of an accounts receivable financing is cash management.

Since the lender's main collateral is cash collections, which are fungible and easily disposable, the lender may want to monitor its collateral. As a condition of this type of financing, lenders will often require that the provider's collections on accounts receivable pass through the lender's control.

The provider usually is required to inform its third party payors to send payments on receivables directly to the lender. The lender then automatically retains monies owed to it, and returns any excess cash to the provider. As the provider needs additional cash, which need could arise as often as daily, it re-borrows and the cycle continues.

Implementing this cash management system allows the lender to exercise control over its collateral. If the provider defaults under the loan documents and a balance is outstanding under the loan facility, this system permits the lender to repay itself without the provider's cooperation. As a result, if a provider has insufficient cash to fund its operations, the provider cannot choose to pay another creditor, such as a vendor, before the accounts receivable lender.

There is one important limitation, however, on the lender's ability to exercise control over the provider's cash collections. Under federal and New York state law, payments from the Medicare and Medicaid programs must be

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made directly to the provider of services, except in limited circumstances (such as when there is an assignment of payment pursuant to a court order).[1] These limitations are commonly referred to as “anti-assignment rules.”

Similar restrictions exist for the CHAMPUS and CHAMPVA programs.[2] Thus, a healthcare provider may not direct such governmental agencies to send payments directly to a lender or to a bank account that is owned or controlled by the lender.

These provisions are designed to prevent fraudulent billing practices. A provider may, however, grant a security interest in accounts receivable to a lender, including collections of governmental receivables, in connection with a financing.

The Centers for Medicare & Medicaid Services (CMS), the agency that administers the Medicare program, has announced a policy that accounts receivable financing arrangements are consistent with the Medicare and Medicaid statutes and regulations, so long as payments are sent to the healthcare provider at its own address and the healthcare provider continues to have the right to direct the payments.[3]

As a result of the anti-assignment rules, lenders will generally require that payments from governmental entities be sent to a lockbox (in the case of checks), which is linked to a lockbox account, or to the lockbox account directly (in the case of electronic funds transfers (EFTS) or direct deposit), which account is under the exclusive dominion and control of the healthcare provider. The provider then instructs the bank to send all of the funds in the lockbox account to an account that is controlled by the lender.

These instructions must be revocable, so that the provider retains the right to direct the funds as required by the anti-assignment rules; however, the provider agrees in the loan document not to change or revoke the instruction. If the provider does redirect the funds, it is an event of default under the loan agreement.

A cash management system of this type gives the lender the maximum permissible control over the provider’s cash collections while remaining compliant with the anti-assignment rules.

Patient Information

Another issue that both providers and lenders need to focus on when healthcare receivables are involved is the confidentiality of patient information.

In the course of reviewing information about the healthcare provider’s accounts receivable, both in the due diligence process and in the monitoring of the collateral, a lender will necessarily have access to patient health information. For example, the lender may have access to patient names on a report of outstanding receivables and billing information that may include diagnosis codes.

Both providers and lenders have an interest in taking the necessary steps to comply with applicable law relating to patient confidentiality.

New York state law and federal law contain restrictions on the use and disclosure of patient information. Under New York Public Health Law §18(6), a healthcare provider needs to obtain patient authorization in order to release the patients’ information to the lender.

Accordingly, the provider should review its general consent form (e.g., an admissions consent, in the case of an inpatient facility) to see if the language is broad enough to permit disclosure to the lender. If the disclosure is not permitted, the provider should revise its patient consent form to allow the disclosure by the provider to the lender, or have the patients sign an additional consent form that contains appropriate language.

The applicable federal law dealing with patient confidentiality is the Health Insurance Portability and Accountability Act of 1996, commonly referred to as “HIPAA.” The administrative simplification provisions of HIPAA limit uses and disclosures of patient information by the provider.

Under HIPAA, a provider may disclose patient information for “health care operations” of the provider. Among the activities covered under this definition are quality assurance, credentialing, arranging for legal services and auditing functions and general administrative activities. An accounts receivable financing would appear to fit into this definition.[4]

Even if this activity falls under a provider’s “healthcare operations,” the provider is still bringing in an unrelated entity, namely, the lender, to provide financing to the provider and, the lender must access patient information in the process. Under HIPAA,[5] the lender is likely to be viewed as a “business associate” of the provider.

A business associate, as defined under HIPAA,[6] includes a person who provides financial services to the provider, where the provision of services involves the disclosure of patient information. Providers may disclose patient information to business associates so long as a HIPAA-compliant business associate agreement exists between the provider and the business associate.

It has become standard industry practice for the documentation of an accounts receivable financing to include a business associate agreement with the lender. Business associate agreements must comply with the HIPAA privacy and security regulations and contain certain provisions designed to ensure that business associates maintain the confidentiality and security of the patient information disclosed to them by the provider.

Exit Strategy

In addition to the foregoing transactional issues, as well as other issues common to financings in general (e.g., confirming that there are no conflicting liens and negotiating representations and covenants), providers should be aware that it may be difficult to exit an accounts receivable financing.

By its nature, the financing is structured so that the provider is continuously dependent upon the lender for capital, as the provider borrows and its cash flow is applied to pay down the existing loan. Thus, if a provider consistently borrows the full availability under its loan facility and spends substantially all of the proceeds, the provider may not have sufficient funds to satisfy all outstanding obligations, either at the maturity of the loan or earlier, without a new infusion of capital.

If feasible, the provider could try to wean itself off the facility by gradually decreasing its borrowings. By doing so, cash collections may accumulate to fund all or a portion of a payoff.

While accounts receivable financings are a viable alternative for healthcare providers to raise capital, it is essential for a provider to understand how these financings function in order to evaluate both the financial benefits and the impact on the provider’s cash flow. If the provider chooses to pursue this source of financing, the limitations of the federal and state anti-assignment rules and confidentiality laws should be heeded in order to lawfully extract liquidity from patient receivables.

1. 42 U.S.C. §§1395g(c) (Medicare) and 1396a(a)(32) (Medicaid) and 18 N.Y.C.R.R. §515.2(b)(14)
2. 32 C.F.R. §199.7(j) and 38 U.S.C. §1781. CHAMPUS is the Department of Defense’s health insurance program that is similar to private insurance, and provides certain medical benefits to, among others, retired military personnel and certain of their dependents. CHAMPVA is a similar program for veterans.
3. Note that there is some inconsistency in the positions of Medicare and Medicaid with respect to whether payments may be sent directly to a bank account under the provider’s control. The Director of CMS’ (then the Health Care Financing Administration, or “HCFA”) Medicaid Bureau issued a letter to Medicaid administrators dated Dec. 11, 1990 that specifies that payments cannot be sent to a bank. However, the current Medicare Intermediary Manual (§3488.2) and the Medicare Carrier’s Manual ((§3060.11) explicitly permit payments to be made to a bank account under the provider’s sole control. We assume that the later statements in these manuals reflect the current position of the U.S. Government.
4. 45 C.F.R. Part 164.501.
5. 45 C.F.R. Part 164.508(a)(1) (stating that a provider may not disclose patient information without a valid HIPAA authorization unless the disclosure is otherwise permitted or required under HIPAA. Thus, a provider could theoretically seek a HIPAA authorization from patients for disclosures necessitated by an accounts receivable financing. This approach is impractical, however, as a HIPAA compliant authorization needs to be a separate document, specifically describe the purpose of the disclosure, have an expiration date, and be revocable. As it would be impractical to seek such a document from all former patients for which receivables are outstanding and all new patients, most providers do not consider this to be a practical solution to this issue.)
6. 45 C.F.R. Part 160.103(1).

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