Blessings in Disguise: Hidden Opportunities in Health Care Bankruptcies

BY PETER DOMAS & CAROLYN J. JOHNSEN

In 2016 alone, 21 hospitals were closed across the United States because of unsustainable financial performance, and the trend has continued with 7 additional hospitals and 18 other hospital departments closing in just the first half of 2017. Financial challenges facing many entities in the health care industry are not limited to hospitals, or even a particular geographic region. From surgery centers to family practice groups, behavioral health providers to nursing homes, rural, urban, for-profit and non-profit alike, numerous health care organizations are struggling to survive as the health care industry undergoes a metamorphic shift in economics and operations.

The financial struggles of these health care organizations have continued despite a long history of industry growth far in excess of the broader rate of national economic growth. For example in 2016, spending on health care increased 6.2 percent, while the rate of growth across all industries increased by only 1.5 percent. While the myriad of changes to the health care industry over the past 10 years, in the form of a regulatory, financial reimbursement, technology, and patient demographics, have no doubt contributed to the challenges facing the health care industry, they do not in and of themselves, explain why, in an industry that is still growing four times faster than the rest of the economy, so may health care organizations are facing such daunting financial distress.

The answer most likely lies with the fact that for so long, the health care industry enjoyed rates of growth in excess of almost six times the rate of inflation, and since the 2007, growth rates have steadily declined. As a result, an industry that became structurally dependent upon unsustainable growth rates must realign its operations and business strategies to survive as reimbursement and growth inevitably return to more sustainable levels. With the changes in the health care reimbursement and regulatory environment, it is all but certain we will see an increase in the number of distressed health care entities over the next few years.

Far from doom and gloom, the realignment of the health care industry that is already underway, and is almost certainly to escalate, combined with unending need for health care, generates an outstanding opportunity for both financially stable organizations as well as those distressed entities that identify the need to reform before it is too late. With industry growth still at four times the national GDP, financially stable organizations will have the opportunity to acquire providers, networks, and assets that can facilitate continued growth, and distressed entities can take advantage of resources, such as bankruptcy, to restructure, reposition, and reinvent their operations for long-term viability.

In years past, the bankruptcy option was tagged as the remedy of last resort. But, in today' world, bankruptcy means opportunity. Today's health care playing field consists of a myriad of scenarios and combinations: for example: i) small hospitals are capital constrained; ii) big hospitals want to become small; iii) physicians want to be employees; iv) physician groups want to grow in specialty spaces. A bankruptcy can provide the necessary forum and mechanisms to resolve structure legacy issues, solve capital requirements, enhance financial stability and maximize value.

From any perspective, bankruptcy is not a badge of financial distress, but rather a business tool to use in revitalizing, restructuring, and accomplishing the goals management foresees or needs to anticipate. This may include effectuating a merger, a sale/purchase of assets or equity, a way to deal with regulatory issues and cumbersome leases or contracts, or what might be a straight-up restructure of debt and equity with new capital. In any case, the bankruptcy process can provide a safe haven from which a company can emerge with a clean balance sheet – the proverbial clean bill of health.

While financially distressed hospitals, physician practices, and other healthcare entities, present opportunities for financially stable organizations to expand their services and compete more effectively, distressed acquisitions in particular also generate risks unique to health care, which must be identified, understood and managed. These challenges include

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Why Screen for Depression?

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Although many national guidelines support screening for depression in adolescents and adults, it is often forgotten during a busy primary care visit. Evidence has shown that early identification of depression and initiation of treatment improves outcomes and reduces the morbidity and mortality associated with depression as well as other co-existing chronic illnesses.

The World Health Organization (WHO) lists depression as the leading cause of disability worldwide. This disability not only effects the individual, it has an impact on the family and society as a whole. In the United States, the financial burden of depression continues to climb with costs that are associated with absenteeism, presenteeism, suicide, medication therapy, outpatient visits and the cost of inpatient care. In 2016, it was estimated that for every $1 invested in appropriate care for depression and/or anxiety, the return on investment is $4 in the form of improved work productivity, improved health life years and the ability to function in society. In addition, there is a decreased cost related to medical care.

Health care providers know that patients present differently when depressed. Many patients will not initiate a discussion regarding mood. Routine screening can help identify these depressed symptoms providing an opportunity for further assessment.

Patients with multiple chronic illnesses and older adults have the highest risk of depression, though they have the lowest rates of depression screening. Time gets away from providers when trying to address multiple issues in a short amount of time, but evidence has shown that improved outcomes and reduced morbidity of many chronic illnesses can occur with early detection and treatment of co-existing depression.

Medical and nursing journals as well as public news sources are full of discussions about the "opioid crisis". Numerous studies have shown that persons with chronic pain and co-existing depression have higher tolerance to opioids and increased risk of opioid abuse. Screening and adequate treatment for depression or other mental health conditions is a vital part of chronic pain management.

The American Diabetes Association recommends screening for depression at the time of diagnosis; annually, and at any time there is a change in diabetes control. Persons with diabetes have higher rates of depression. Often, effective treatment of depression can improve indicators of glucose control. Other common conditions that have shown improvement with co-existing depression include chronic obstructive pulmonary disease, heart failure and hypertension.

Of course, screening for depression cannot occur without a team approach for follow-up and referral if necessary. Creating a workflow within the clinic for screening and follow-up care if needed is essential for effective care. Depression management can include education regarding depression, care management, referral to therapy and medications if depression is moderate to severe. Staff and care managers can assist with clinic workflow to ensure close follow-up. Rooming staff can be educated in administering the Patient Health Questionnaire 2 (PHQ-2) and the PHQ-9 version if the PHQ-2 scores three or higher. Most electronic health record programs have these screeners available for easy documentation and mapping to the quality measure.

As of January 2017, depression screening and appropriate follow-up care are measured and incentivized by the new Merit Based Incentive Payment System (MIPS). MIPS is the new quality measure reporting system that previously was the Physician Quality Reporting System (PQRS). The Centers for Medicare and Medicaid were already tracking depression screening through PQRS, though MIPS has expanded the measures to include closer follow-up of depression and assessment of remission. A few MIPS high priority items are specific to depression care:

1. Coordination of care for persons with major depressive disorder and specific co-morbid conditions

2. Depression assessment of remission within 6 months and at 12 months after diagnosis (remission defined as PHQ-9 less than 5)

3. Suicide risk assessment for adolescents and adults with major depressive disorder

Knowing the area resources is an important part of the care for depression. Behavioral health providers can assist with depression care through a variety of methods. The patient or clinic can initiate a referral with these providers. Collaborative care between primary care and behavioral health is evidence-based to improve symptoms and remission. However, collaboration is often difficult unless the clinic has onsite behavioral health services. Facilitating networking opportunities for primary care and local behavioral health providers can assist with developing professional relationships and improving collaboration.

Screening for depression is an important component of primary care. Clinicians and staff have formed relationships with the patient as well as the family, and clinics are also aware of available community resources. Primary care can address the social determinants that are often associated with poor physical and mental health. Identifying depression early and initiating evidenced-based management guidelines based upon severity, can improve quality of life for the patient and family, as well as the outcomes of coexisting conditions.

Resources:

Guidelines for depression screening and management

Mitchell J, Trangle M, Degnan B, Gabert T, Haight B, Kessler D… Vincent S. (2016). Institute for Clinical Systems Improvement: Adult depression in Primary Care. Retrieved from https://www.icsi.org/_asset/fnhdm3/Depr.pdf

Merit-based Incentive Payment System information

Department of Health and Human Services. (2017). Merit-based Incentive Payment System: Quality measures. Retrieved from https://qpp.cms.gov/mips/quality-measures

USPSTF screening guidelines

United States Preventative Task Force. (2016). Depression in adults: Screening. Retrieved from http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-adults-screening

Blessings

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successor liability for regulatory compliance, fraud and abuse laws, (Anti-kickback statute, False Claims Act, and Stark Law) and Medicare and Medicaid overpayments. Furthermore, state licensing and certificate of need transfers may be complicated when a company being acquired has a track record of economic challenges. Depending on how dire the financial distress has become, the timeframe for conducting due diligence and financial modeling may also be significantly reduced. A skilled team planning for and assessing these transactions are key.

Whether your organization is doing well, or underperforming, there are significant opportunities in this uncertain time. Assembling a team of skilled legal, accounting and operational advisors will be necessary to surviving and thriving in the changing healthcare industry. Whether you are concerned about your organization's financial sustainability, or are seeking opportunities to expand operations through acquisition of distressed entities, now is the time to developed strategies to maximize your organization's goals.

1 Ellison, Ayla, 21 Hospital Closures In 2016, Becker's Hospital CFO Report, (January 6, 2017,).available at : https://www.beckershospitalreview.com/finance/21-hospital-closures-in-2016.html

2 Ellison, Ayla, 7 Hospital Closures So Far in 2017, Becker's Hospital CFO Report, (July 25, 2017,).available at

https://www.beckershospitalreview.com/finance/7-hospital-closures-so-far-in-2017-072517.html See also, Ellison, Ayla, 18 Hospital Department Closures in 2017 so far, Becker's Hospital CFO Report, (June 15, 2017,).available at : https://www.beckershospitalreview.com/patient-flow/18-hospital-department-closures-in-2017-so-far.html

3 See PWC Medical Cost trend: Behind the Numbers 2018 at 4 (June 2017). Available at https://www.pwc.com/us/en/health-industries/health-research-institute/behind-the-numbers/reports/hri-behind-the-numbers-2018.pdf

4 See Bureau of Economic Analysis Gross Domestic Product reports, Available at:

https://www.bea.gov/national/

5 See PWC at 4. and Bureau of Economic Analysis Gross Domestic Product reports for 2007.