April 08, 2026

Advising Health Care Providers in Financial Distress

This Briefing is brought to you by AHLA's Physician Organizations Practice Group.

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Even in the best of times, health care providers can fall into financial distress. Unfortunately, for many providers, we do not live in the best of times. Increasing compliance costs, tightening in the labor market for trained and licensed providers, declining reimbursements, funding cuts, changing insurance status for patients, and growing scrutiny from both private and public payers, has created the "perfect storm" resulting in increased risk of financial distress for health care providers.[1] While broader macroeconomic trends affect businesses in all industries, and certain indicators like the U.S. stock market suggest continued financial health into 2026, more specific and meaningful factors point to 2026 and beyond as an era in which many health care providers will struggle to survive and thrive. For purposes of this Briefing, "financial distress" does not have a technical definition but rather refers to the state of affairs of a provider whose viability as an independent stand-alone business, for financial reasons, is perceived (by insiders) to be threatened, whether or not the provider is currently insolvent.

This Briefing aims to assist attorneys in advising health care providers who may be in, or may be entering, an episode of financial distress, or who are looking for strategies to avoid or resolve such financial distress. First, this article discusses methods attorneys can use to detect signs of financial distress and identify providers who are undergoing financial distress. Second, this article addresses several issues particular to the health care industry when dealing with financial distress scenarios. Finally, this article describes several strategies that attorneys and other advisors can work through with their clients to help them resolve episodes of financial distress.

Identifying Providers in Financial Distress

There is as great a variety of relationships between health care providers and their counsel as there are types and sources of financial distress for providers. Some counsel may be in-house with access to governing board or executive and managerial meetings where financial results are directly addressed. Some counsel may have long-term relationships with their clients characterized by deep trust, such that providers share business struggles with their counsel (hopefully, before they turn into a crisis or litigation). Nevertheless, some counsel may need methods and strategies to identify when a client is in financial distress when they do not have these relationships or insights into a health care provider's financial condition.

CPAs/Advisors

As one mentor was fond of telling the authors, the three best friends of young physicians just going into practice are their attorney, their banker, and their accountant. Many attorneys may also be familiar with the joke that an attorney's proficiency in math only extends as far as their rate multiplied by number of hours. Ideally, counsel will have consistent and strong relationships with their clients' accountants and bankers. These accountants and bankers can assist in detecting impending financial distress. Financial advisors can be an important source not only to alert counsel when problems arise but also to interpret financial records and data. These same advisors can be an important sounding board for solutions when determining how to resolve episodes of financial distress.

Vendor/Landlord Disputes

Another warning signal of financial distress for counsel includes an uptick in unpaid rent or unpaid vendor bills, or simply an increase over baseline in disputes with vendors or landlords. This signal can be particularly acute when a client does not have a significant history of litigation (or even demand letters). An important indicator that a client may be undergoing financial distress is if the client was historically non-litigious but then finds themselves with a stack of complaints or demand letters. Such disputes with vendors are not only a signal of financial distress but also its cause, and vendors and landlords are among parties that counsel may have to interact with to pursue strategies to resolve a client's financial problems.

Employee Issues

Lastly, another indicator of potential financial distress is a high level of employee turnover in a client's office. This is particularly true if a high level of turnover is an aberration from the client's past patterns. [2] Employees may be leaving for a variety of reasons, including missed payroll, delayed bonuses, employee benefits that are less than promised, or simply overwork due to the provider being financially unable to hire sufficient staff. Special attention should be given when the employees leaving are long-term staff, which indicates the presence of issues that were not previously present, or those in a financial role. Additionally, if staff in a revenue cycle management or financial management role are departing, counsel should consider addressing potential whistleblower risk for the client.

Relatedly, another concern regarding employees and staff includes frequent and disruptive changes to employment agreements or compensation systems. Providers may change compensation methodologies in response to changes in reimbursement or because of other changes within the practice, such as transactions with other providers. Agreements may change to deal with new compliance issues (i.e. newly promulgated regulations or guidance from federal health care programs), or to take advantage of new sources of payment. However, when none of these causes or factors are present, and the changes cause, as a material result, a decrease or delay in compensating providers or staff, counsel should be wary that financial issues may go deeper and should be inquired after promptly.

Maintaining Relationships

Above all, whether clients are known to be suffering from financial hardship or distress, it is imperative that legal counsel maintain efficient communication and frequent contact with health care providers so problems can be detected early. For example, one strategy could be reaching out to clients that have been dormant or quiet for six months or more to schedule an annual "check-up" to stay abreast not only of the status of the provider's business but also of plans the provider has for the coming year. On occasion, this "check-up" (since it is counsel-initiated rather than requested by the client) may be done free of charge. While this approach may be effective in generating additional work, its primary value is in maintaining active communication with clients to make them feel comfortable reaching out when more serious (or negative) circumstances are at hand.

Special Issues in the Health Care Industry

Whether providers are entering into or finding themselves in the midst of financial distress, counsel should be aware of special considerations or situations unique to health care providers or similarly distressed businesses.

Fraud and Abuse

When approaching a state of financial distress, some providers may feel increased pressure to enter into risky ventures or otherwise push legal boundaries to enhance revenue. Some providers pursue such options out of a sense of obligation to employees and colleagues to keep the business afloat. In other circumstances (especially where a provider formerly experienced financial prosperity), these efforts may simply be an attempt to maintain a lifestyle. When providers feel that running their "normal" business is no longer profitable, the temptation to enter into questionable "side hustles" may be irresistible.

The kinds of arrangements that may be problematic are too numerous to list here[3] but frequently feature the following: arrangements involving efforts to profit from referrals (often paired with contracts that include excessive reimbursement in exchange for little or no labor), aggressive or predatory billing practices (e.g. routine upcoding), and providing experimental or uncovered procedures (and particularly trying to shoehorn them into existing coverage guidelines). Counsel should be aware of the various fraud and abuse authorities that may apply to these arrangements, not only the Stark Law, Anti-Kickback Statute, and accompanying regulations but also other Medicare reimbursement regulations, state fraud and abuse laws, and private payer reimbursement guidelines.

Unscrupulous operators (consultants, sales representatives, and others) may particularly target those providers that are otherwise struggling to maintain financial stability and health, which underscores the importance of (i) maintaining good relationships and open communication with clients, and (ii) attempting to identify early situations where financial distress may be a factor. It is important for counsel to distinguish between arrangements that may have a legitimate clinical purpose and benefit and those that principally or exclusively serve the provider's bottom line. Knowing when and to what degree a provider is experiencing or perceiving financial distress can be an extremely helpful tool in aiding counsel in differentiating between the two.

Fiduciary Duties of Health Care Providers in Insolvent Situations

Delaware law is the leading governing framework for fiduciary obligations for boards as financial stress deepens. When a company nears insolvency, directors owe duties to the corporation and its residual claimants as a whole, not to creditors directly.[4] If the company becomes insolvent, creditors may gain standing to bring derivative claims, yet the duties themselves do not shift to creditors but instead remain duties to act for the enterprise.[5] Insolvency may be assessed using balance-sheet and cash-flow tests, so contemporaneous financial analyses and outside advisor input should be reflected in the record. This foundation matters in health care, where volatile reimbursement and regulatory headwinds can push otherwise viable platforms into temporary distress without mandating liquidation or a creditor-preferred strategy.

The exercise of corporate formalities and diligence in corporate decision-making becomes more important as distress accelerates. The fiduciary duty of care requires boards to inform themselves, deliberate on alternatives, and weigh regulatory consequences, including the impact on Medicare and Medicaid participation and licensure. For providers with sponsor affiliations (i.e., hospitals or clinics), physician-owner interests, or management services arrangements, conflict management is essential. Independent committees, separate counsel and bankers, and careful assessment of director independence help address duty-of-loyalty risks. In nonprofit settings, directors must also consider the charitable mission and state approval regimes for major transactions. Many states require attorney general notice, and sometimes court approval, for nonprofit hospital sales, closures, or governance changes, so early engagement and a record linking the transaction to the organization's mission can be a decisive factor.

Health care's federal regulatory overlay heightens oversight duties. Decisions that implicate the Centers for Medicare & Medicaid Services (CMS), civil monetary penalties, corporate integrity agreements, or essential licensure have consequences beyond ordinary commercial risk. Corporations that ignore foreseeable noncompliance or the loss of critical licensure may face claims that the board failed to exercise good-faith oversight. Closure plans lacking adequate patient transitions or sale structures that disregard change-of-ownership rules can harm both patients and value. Directors should therefore make compliance a primary boardroom consideration and work with counsel to map the regulatory impact of every path under consideration. As insolvency deepens, fiduciary litigation risk increases, particularly around selective transfers, insider transactions, and sale processes. Courts examine whether the board's process was reasonable under the circumstances, whether conflicts were managed,

and whether the path chosen was rationally related to maximizing enterprise value. While boards do not owe duties to preserve specific service lines or facilities, ignoring patient-care obligations or predictable regulatory issues can signal an uninformed process and heighten litigation exposure.

Remedies

Bankruptcy Tools and Limits for Health Care Providers

Chapter 11 offers stabilizing tools for distressed providers. The automatic stay, debtor-in-possession (DIP) financing, the rejection of burdensome executory contracts and leases, and the ability to consummate going-concern sales or confirm a plan all help preserve value. Smaller practices may benefit from Subchapter V if debt limits are met, though hospitals and larger providers typically exceed those thresholds. Chapter 7 liquidation usually does not fit active providers due to patient care, medical records, and licensure consequences. When a wind-down is unavoidable, planning for compliant medical-record custodianship and safe patient transitions is critical, and state-court receiverships can provide a more tailored path for certain assets.

Provider agreements and government reimbursement complicate any health care Chapter 11 case. Courts diverge on whether Medicare provider agreements are executory contracts that must be assumed and cured or statutory entitlements that can transfer free and clear.[6] The more common view treats these agreements as executory, which permits broader recoupment on the theory that they constitute a single, integrated transaction over time. Bankruptcy also does not eliminate regulatory oversight. CMS and state agencies can invoke the police and regulatory power exception to the stay for genuine regulatory actions.[7] Asset sales under Section 363 of the Bankruptcy Code typically cannot eliminate successor obligations imposed by federal health care law. A buyer that takes assignment of a Medicare agreement in a change of ownership (CHOW) generally inherits associated liabilities, including overpayments. Courts will enforce free and clear sale provisions, but they do not displace federal statutes and regulations that condition participation in Medicare and Medicaid.

Health care debtors should anticipate the appointment of a patient care ombudsman and related reporting and hearing obligations and should budget accordingly. Aligning any sale timeline with CHOW processing, licensure updates, and certificate-of-need (CON) requirements is vital to avoid value-destructive operating interruptions. Practically, Chapter 11 can improve access to liquidity, facilitate contract rationalization, pause most litigation, and maximize value through a court-supervised sale. Chapter 11, however, cannot stop bona fide regulatory actions, eliminate recoupment and setoff rights, or circumvent regulatory approvals for licensure and transfers.

Financing and Liquidity in Health Care Restructurings

Liquidity is both an early warning sign and the main lever in health care restructurings. Heavy concentrations of government receivables may present significant risk because Medicare and Medicaid payments are subject to setoff, recoupment, suspension, and anti-assignment rules. Lenders often require robust cash reporting, proven revenue-cycle performance, and clear modeling of audit and appeal pipelines. When recoupment risk is material, DIP budgets should include buffers for payment holds and realistic realization rates, particularly for providers with high denials or pending cost report reconciliations.

Prepetition lenders often provide DIP financing with roll-ups and milestones. In a health care case, milestones must align with regulatory timelines for CHOW approvals, CON modifications, and licensure updates to avoid liquidity cliffs triggered by regulatory delay. Intercreditor dynamics can be acute where accounts receivable financiers, equipment lessors, and real estate lenders intersect. Perfecting liens in provider receivables, addressing vendor setoffs, and navigating cure costs for mission-critical contracts require close coordination. Courts may approve priming liens where adequate protection exists, but adequate protection analyses must account for government recoupment rights that can erode collateral value in ways not seen in commercial receivable pools. Boards should test whether new-money financing addresses root-cause issues, such as adverse payer mix, unsustainable leases, or compliance risks, rather than merely delaying necessary operational change.

Operational Rightsizing

Rightsizing can be effective, but in health care it cannot be driven by commercial calculus alone. The Bankruptcy Code's rejection power is a valuable tool for shedding unprofitable medical office leases, underutilized service lines, and outdated technology arrangements. Closure or consolidation plans must be sequenced with patient transition obligations to ensure continuity and minimize risk. Workforce and medical staff implications should be planned in parallel, including collective bargaining issues, medical staff bylaw processes, and credentialing transitions for physicians affected by service-line changes. Revenue-cycle continuity, preservation of referral patterns, and payer-contract amendments should be built into the implementation plan to stabilize reimbursement after changes.

Courts and regulators will focus on whether patient transitions are safe and adequately resourced. Plans should identify receiving providers with capacity, address transportation and continuity of specialty care, and include coordinated communications with payers and regulators. Documented execution on these elements promotes operational stability and strengthens the case for necessary changes in Chapter 11. Boards that tie right-sizing to a credible patient-care plan, and that sequence actions to match regulatory timing, reduce risk and preserve value.

Transactions and Regulatory Approvals

Sales under Section 363 of the Bankruptcy Code can deliver speed and a market-tested process with stalking-horse protections, but buyers should plan for health care-specific successor exposure, including overpayments tied to assigned provider agreements. For nonprofits, member substitutions, affiliations, or asset transfers may require attorney general notice and, in some jurisdictions, court approval. Parties should reflect these contingencies in timelines and closing conditions. Corporate practice of medicine and fee-splitting rules complicate acquisitions of physician practices and management services organizations and often require alternative structures, such as friendly professional corporation or foundation models. Antitrust review can be intense in concentrated markets; while a failing-company narrative can be compelling, parties should develop a robust evidentiary record and anticipate coordination with state health agencies and CON authorities.

Deal covenants should allocate responsibilities for CHOW filings, licensure, HIPAA-compliant data transitions, and medical-record custodianship. Post-closing integration plans should address quality metrics, compliance-program continuity, and cultural integration of clinical and administrative teams.

Where transactions are unavoidably conflicted, sellers should build a record demonstrating a fair process and a well-supported view of value, including outreach to logical bidders and sensitivity analyses for reimbursement, recoupment, and timing risks. Aligning milestones with regulatory lead times helps avoid liquidity pressure and value leakage if approvals take longer than expected.

Planning and Decision Drivers

Decision-making in distressed health care should be grounded in realistic liquidity, regulatory timing, and stakeholder cohesion. Cash forecasting should distinguish among net payable claims, expected denials, pending appeals, cost report true-ups, and any accelerated or advance payments subject to recoupment. Modeling should include sensitivity cases for claim suspensions and elevated withholdings and should map the impact of regulatory timing on the liquidity runway. Counsel should assess whether provider agreements will be assumed and cured or addressed via sale and assignment, recognizing that most courts permit recoupment against assigned agreements. Early coordination among restructuring counsel, health care regulatory counsel, investment bankers, and operational leadership is essential so that deal structure, financing, and regulatory sequencing align with patient-care imperatives.

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[1] Hannah Albarazi, *Hospitals Face 'Perfect Storm' of Fed. Cuts, Revenue Strains*, Law360 (Feb. 10, 2026), https://www.law360.com/healthcare-authority/articles/2437462?nl_pk=fe6d9b78-735d-4b81-a6ac-e34dab07a0a4&ab_exp_id=nl_subject&ab_exp_var=b&utm_source=newsletter&utm_medium=email&utm authority&utm_content=2026-02-11&read_main=1&nlsidx=0&nlaidx=0.

[2] Nevertheless, if a client has persistently high turnover rates, this may be an indicator of personality issues or simply poor management skills.

[3] In addition, we do not list specific suspect ventures to avoid casting unnecessary aspersions on some legitimate arrangements, or distracting counsel with a discrepancy of form over substance.

[4] *See N. Am. Catholic Educ. Programming Found. v. Gheewalla*, 930 A.2d 92, 101 (Del. 2007)("When a solvent corporation is navigating in the zone of insolvency, the focus for Delaware directors does not change: directors must continue to discharge their fiduciary duties to the corporation and its shareholders by exercising their business judgment in the best interests of the corporation for the benefit of its shareholder owners.").

[5] *Id.* at 103 (holding creditors of insolvent corporations have no right to bring direct claims for breach of fiduciary duties against corporate directors but creditors may bring derivative claims on behalf of the insolvent corporation or any other direct nonfiduciary claim).

[6] *Compare Univ. Med. Ctr. v. Sullivan (In re Univ. Med. Ctr.)*, 973 F.2d 1065, 1077 (3d Cir. 1992) ("Congress' failure to legislate special treatment for the assumption or rejection of Medicare provider agreements indicates that assumption of these agreements, like that of other executory contracts, should be deemed subject to the requirements of section 365, unless and until Congress decides otherwise."), *with In re Vitalsigns Homecare, Inc.*, 396 B.R. 232, 236 (Bankr. D. Mass. 2008)("The

parties have framed the issue as whether the Bankruptcy Code permits the sale of a Medicare provider number free of any claims for recoupment against the successor and agree that this is a case of first impression in this circuit. In fact, the case law addressing this issue is scant and contradictory. Some courts hold that the provider number arises under an executory contract while others conclude that reimbursement is a statutory entitlement.").

[7] 11 U.S.C. § 362(b)(4)("The filing of a petition . . . does not operate as a stay . . . to enforce such governmental unit's or organization's police and regulatory power, including the enforcement of a judgment other than a money judgment, obtained in an action or proceeding by the governmental unit to enforce such governmental unit's or organization's police or regulatory power.").

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