COVENANT DRIFT:
What Healthcare Lenders & Borrowers Are Missing Between Closing & Default

Designing Healthcare Loan Documents that Serve the Whole Financing Relationship

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Private credit is now a core financing source for mid-market healthcare platforms, alongside the broadly syndicated leveraged loan market, and healthcare has recently ranked among the leading sectors for new leveraged loan issuance in both the United States and Europe. In 2024, healthcare represented approximately 20% of all direct-lending deals, according to PitchBook, underscoring how central the sector has become to private-credit portfolios. That concentration spans a wide range of sub-sectors, from behavioral and addiction treatment to home health, applied behavior analysis, dental-services group practices, and more, each carrying its own version of the same underlying exposure: reimbursement rates set by third parties, labor costs that are difficult to flex down, and integration risk from serial acquisitions and roll-ups. By itself, concentration on this scale is not a warning sign. That concentration means more lenders, sponsors, and borrowers now have capital or equity riding on the same structural vulnerabilities at the same time, which is precisely why the documentation and monitoring



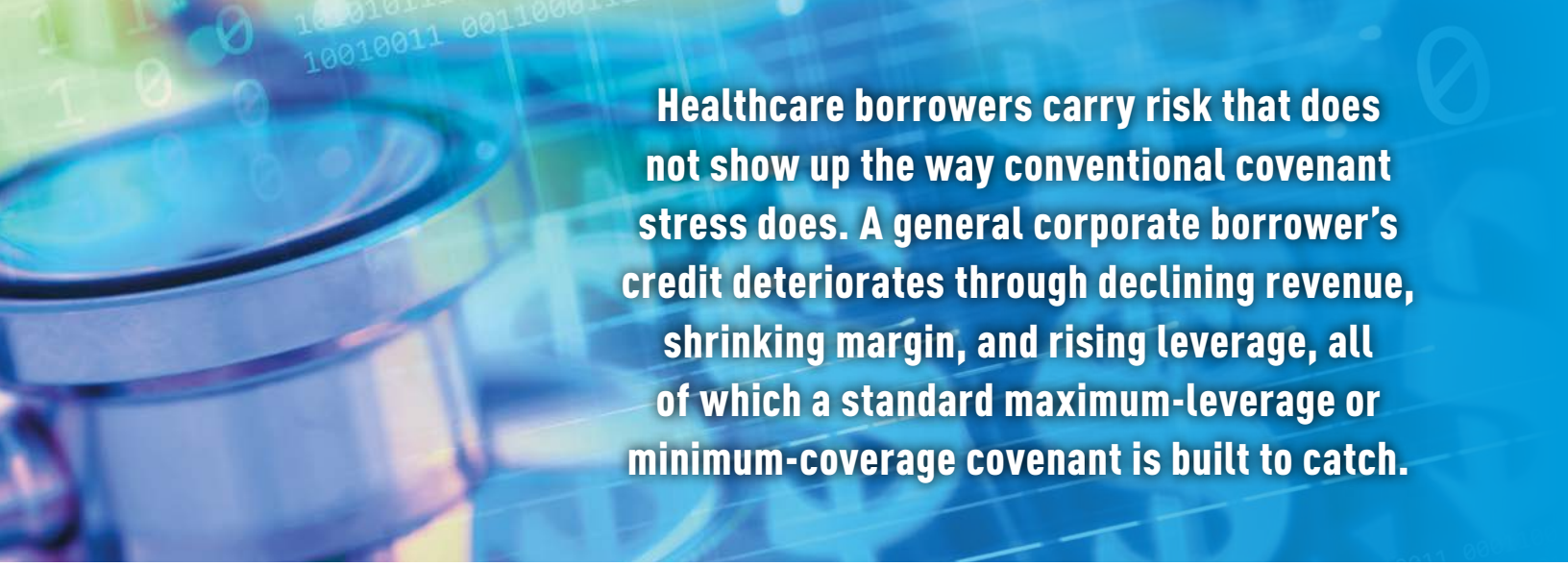
discipline matters more now than it did when healthcare lending was a smaller, more dispersed market.

This article argues that the loan terms that parties should focus on in healthcare financing are not the ones that give one side leverage over the other following a default. Instead, they are the terms that facilitate all parties—lenders, sponsors, and borrowers—reading the signals early enough for the parties to be constructive, before the relationship hardens into a dispute. The most useful diagnostic language for this is not "covenant compliance" but covenant drift—a private-credit risk management concept from a recent paper by Matchpoint Partners describing the progressive loss of financial, informational, or behavioral protection in a lending relationship before there is ever a formal breach or waiver request. Reading loan documents through that lens—and staying engaged with them for the life of the facility rather than only at closing or default—is what allows healthcare-specific risk to surface while there is flexibility to fix it, for the benefit of the lender's capital, the sponsor's investment, the borrower's business, and, indirectly, the patients the platform serves.

Why Healthcare Financing Now Runs on Private Credit

The center of gravity in mid-market corporate lending has moved from banks and syndicated markets toward private credit. Private credit and broadly syndicated leveraged-loan markets are now roughly comparable in size, at approximately $1.4 trillion each as of December 31, 2025, and

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together they account for around 45% of total lending to private nonfinancial corporations in the U.S., according to Federal Reserve data. Within that private credit market, financing is overwhelmingly originated and held by private debt funds and business-development companies, which together account for about 90% of the market, rather than distributed across a broad syndicate of investors, according to the Association for Financial Markets in Europe (AFME).

Healthcare has been a primary beneficiary and driver of that shift. Healthcare represented approximately 20% of all direct-lending (deal) activity in 2024, according to Prospect Capital Management. In Europe, AFME found the healthcare sector was the leading sector by leveraged loan origination in both the first and second quarters of 2025, and again led all sectors in new leveraged loan issuances in the third quarter of 2025. In the U.S., according to Morningstar, healthcare has consistently ranked among the most active sectors for new institutional loan issuances through 2025, together with software, services, and capital goods. None of this is confined to hospital systems or large multi-site platforms: The same financing dynamics reach addiction treatment providers, home health and hospice operators, applied behavior-analysis platforms, dental service organizations, and a wide range of other roll-up-driven healthcare services businesses, each exposed to reimbursement-rate risk, inflexible labor costs, and integration risk from serial acquisitions and roll-ups in its own way.

That volume of financing concentrated in one sector—on terms increasingly set bilaterally between a fund and a sponsor rather than through a syndicated, publicly disclosed process—changes what a loan document needs to do. A direct lender is a repeat counterparty for the life of the loan, not one of many lenders in a syndicate or one of many holders in a dispersed bondholder group who trade in and out of the position. That gives both sides of a private-credit healthcare financing a genuine, shared interest in documents that support ongoing monitoring and early intervention, not just documents that define what happens after something has already gone wrong.

Why Healthcare Risk Is Different & Why It Moves Quietly

Healthcare borrowers carry risk that does not show up the way conventional covenant stress does. A general corporate borrower's credit deteriorates through declining revenue, shrinking margin, and rising leverage, all of which a standard maximum-leverage or minimum-coverage covenant is built to catch. A healthcare borrower can carry that same deterioration, plus an entirely separate track of risk running through reimbursement dependency on government and private payors, licensure and certificate-of-need status, survey and certification outcomes, and exposure under fraud and abuse regimes, none of which a generic financial-covenant package is designed to see until it has already become a balance-sheet problem.

That second track of risk tends to move quietly. A survey deficiency, a payor audit, or a licensure inquiry can sit unresolved for months while the borrower's reported financials still look unremarkable, because reimbursement often lags the underlying regulatory event and because the borrower has genuine incentive to characterize the issue as routine for as long as possible. By the time it is clear that it could be a problem in the cashflow projections—as delayed reimbursement, a (payor) recoupment demand, a license suspension, or a corporate-integrity agreement—it has already hardened into a crisis rather than a manageable hiccup. This dynamic is precisely what covenant drift is meant to describe—it can be quantitative, such as shrinking headroom under a financial covenant; informational, such as delayed or degraded reporting; structural, such as debt (quietly) accumulating across permitted baskets; or behavioral, such as unexplained changes in forecasts, advisers, or payment priorities, and in each form the borrower is not yet in default, but the lender's protection is already eroding. Undiagnosed regulatory noncompliance in a healthcare borrower is a leading example of behavioral and informational drift. Left undetected, it can delay or kill a closing outright during diligence or resurface later to undermine a lender's collateral and enterprise-value assumptions after the loan has funded.

Reading Covenant Drift in Three Dimensions

Rather than treating healthcare-specific loan terms as a checklist of features, it is more useful to organize them around the three ways covenant drift shows up in a healthcare credit: quantitatively, informationally, and structurally. Two

further categories of drift—cybersecurity incidents and borrowers whose operations increasingly depend on artificial intelligence—deserve separate consideration because the market has not yet fully adapted standard covenant packages to address these concerns.

Quantitative drift, in Matchpoint Partners' framework, is the compression of headroom under a financial covenant before the covenant is breached. In a healthcare credit, headroom can shrink for healthcare-specific reasons that a lender monitoring only the headline leverage or coverage ratio will not see until it is too late. These explanations can include a payor-mix shift toward slower-paying government programs, a change in days-in-accounts-receivable by payor category, or a drop in occupancy or census tied to a licensure or survey issue. A covenant package that pairs the financial test itself with borrower reporting broken out by payor category, rather than aggregated revenue and EBITDA alone, lets both sides see the same early movement in headroom and understand what is actually driving it, rather than discovering the cause only once the covenant is breached.

The Matchpoint Partners paper describes informational drift as the progressive loss of reliable visibility into the borrower's condition, most often through late, incomplete, or repeatedly corrected reporting. Generic information covenants are built around monthly or quarterly financials and an annual compliance certificate, a cadence calibrated to catch financial deterioration. But regulatory and reimbursement problems often take shape on a different timeline than financial statements reveal, so a borrower's numbers can still look unremarkable for months while a licensure or payor issue is actually developing underneath them. Healthcare-specific information covenants close that gap not by requiring more frequent financial reporting, but by requiring different reporting. The value of this reporting is not adversarial. It gives the borrower's own management the same early view of a developing problem that the lender has so that both sides are working from the same facts before positions harden.

Structural drift, according to Matchpoint Partners, is the accumulation of permitted debt, liens, or other exceptions across baskets in ways that are individually compliant but collectively erode the lender's position, along with default architecture that does not distinguish a temporary, curable regulatory issue from a fundamental one. A binary default trigger tied to a licensure survey deficiency or a routine payor audit can convert a manageable, fixable issue into an immediate default under the credit facility, which helps no one—it does not get the borrower's regulatory issue resolved any faster, and it forces the lender into a workout posture prematurely, before it has enough information to know whether workout is actually warranted. Graduated mechanics, cure periods sized to how healthcare regulatory processes actually move, springing covenants, and notice-and-cooperation provisions that treat engagement of qualified healthcare regulatory counsel as a compliance step rather than a distress signal give the borrower room to fix a problem while still giving the lender a clear, contractually defined event of default.

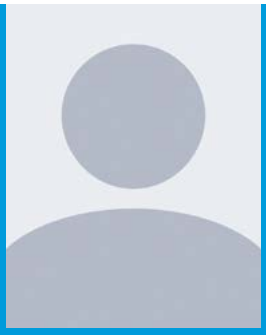
Cybersecurity provisions in healthcare loan documents have typically been treated as a data-security representation and an insurance requirement, addressed once at closing and revisited only if litigation arises. Healthcare providers have particular exposure to ransomware: Hospitals and other providers were the subject of 133 publicly reported ransomware attacks between 2016 and the end of 2019 alone, with 47 of those occurring in 2019, and providers are frequently targeted precisely because a disrupted system creates urgent pressure to pay, according to research from Carrier Management. A documented instance of a ransomware attack directly caused a covenant breach in a healthcare credit. A 2019 attack on Pleasant Valley Hospital in West Virginia forced the hospital to spend roughly $1 million on new computer equipment and infrastructure, and that cost, combined with declining patient volume during remediation, caused the hospital's debt-service coverage ratio to fall to 78% against a 120% requirement in its loan agreement, triggering a covenant violation reported to its bondholders. This incident is an early and significant instance of a cyberattack triggering a declared covenant violation in this sector. The lesson for healthcare loan documents is to treat a material cybersecurity incident as its own discrete, defined trigger for enhanced reporting and lender engagement rather than waiting for it to eventually surface as a missed financial covenant months later, once remediation costs and disrupted revenue have already done the damage.

A growing number of healthcare platforms, particularly in diagnostics, revenue-cycle management, and care coordination, now depend materially on AI tools for core operations. Automated coding logic, the kind of rules-based or AI-assisted system increasingly used in revenue cycle management, has recently come under governmental scrutiny. In November 2024, University of Colorado Health (UCHealth) paid a $23 million settlement to resolve allegations that it violated the False Claims Act. The U.S. Department of Justice found that UCHealth's automatic coding rule assigned the highest-severity ER billing code based on vital-sign check frequency rather than actual clinical severity, something its own coding staff had flagged internally before enforcement stepped in. A borrower whose billing accuracy, clinical documentation, or utilization management increasingly runs through an AI tool is taking on a new category of operational and regulatory risk that a generic technology representation will not capture, and diligence and covenant design should treat it as its own line of inquiry rather than folding it into standard IP terms.

Why This Serves Everyone at the Table—Including When Things Go Wrong

The healthcare tailored covenant package (in lieu of standard financials covenants for financing deals) is not designed to hand one side leverage over the other. A borrower's board that engages qualified legal and financial advisors early and works through the range of reasonably available strategic alternatives before a covenant issue becomes a full-blown default is acting consistently with well-established Delaware fiduciary principles—directors must act on an informed basis, in good faith, and in the best interests of the corporation, and can rely in good faith on the advice of officers, outside advisors, and board committees in doing so, according to the *ABA's Business Law Today*. Delaware courts have repeatedly scrutinized whether a board's process, including its engagement of financial and legal advisors, was informed and

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disinterested. In 2009's *In re Trados Inc. Shareholder Litigation*, the court denied the defendant's motion to dismiss fiduciary-duty claims based on the board's decision to approve the merger, underscoring that a board's process, not just its ultimate decision, is what courts examine when a transaction is challenged. That same scrutiny of process does not extend automatically to creditors. *In North American Catholic Educational Programming Foundation, Inc. v. Gheewalla* from 2007, the Delaware Supreme Court held that creditors of an insolvent Delaware corporation have no right to assert direct fiduciary-duty claims against the corporation's directors, leaving that duty enforceable derivatively on behalf of the corporation rather than as a direct obligation to creditors.

A private credit lender's own credit- and portfolio-monitoring discipline runs on the same logic from the other side of the table—institutional guidance on credit-risk management calls for continuous, forward-looking monitoring using early-warning indicators tied to deterioration in revenue, margins, liquidity, leverage, and covenant performance, precisely so that a lender can verify, engage, and re-underwrite before a technical breach forces a binary decision. Framed this way, getting ahead of the standard that applies to a distressed board is not a borrower-side obligation that benefits the lender at the borrower's expense; it is the same early-engagement discipline that a well-run private credit fund is already expected to apply to its own monitoring from the opposite direction. When both sides reach that discipline early and together, the relationship—and the continuity of patient care the financed platform provides—is what gets protected.

Conclusion: From Closing Document to Living Instrument

The healthcare-specific covenant terms described here only do their job as an early bellwether if someone is monitoring them throughout the life of the loan. A representation about licensure status, a covenant tied to payor-mix reporting, or a graduated cure mechanism tied to a survey deficiency has no early-warning value if the certificate arrives, gets checked against the numeric threshold, and gets filed away until the next compliance date. The value of these terms is realized through the monitoring habit built around them—a lender that understands the payor-mix trend line quarter over quarter, a borrower that treats a scheduled reporting call as a chance to flag a developing issue before it is required by the contract to do so, and both sides that have agreed in advance on what a given signal means, so that neither side is negotiating the meaning of the covenants for the first time in the middle of a dispute.

That perspective is what distinguishes covenant drift as a frame from a static list of healthcare representations and covenants. A document drafted once at closing is a snapshot of the risks the parties could identify at that moment. A relationship that stays engaged with the document—watching headroom, reporting quality, and basket usage move over the life of the loan—is what actually catches quantitative, informational, and structural drift while there is still room to address it, before it hardens into a waiver negotiation, a workout, or a disruption to the patients the financed platform serves.

Isabelle Breier, an associate with Dechert LLP, contributed to the production of this article.