Lawyer Insights

Coronavirus Q&A: Hunton's Health Practice Leader

By Matthew Jenkins
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In this edition of Coronavirus Q&A, the leader of Hunton Andrews Kurth LLP's health practice discusses a severe financial squeeze on hospital law departments, how the pandemic can help doctors persuade patients to make lifestyle changes, and why COVID-19 relief funds will complicate hospital mergers and acquisitions.

Matthew Jenkins, a partner in the Richmond, Virginia, office, joined predecessor firm Hunton & Williams LLP in 1984 and never left. He counsels hospitals and health systems on transactions, anti-fraud enforcement, workplace safety and contracts with health insurers, among other matters.

Jenkins shared his perspective as part of a series of interviews Law360 is conducting with prominent attorneys regarding the evolving legal and business challenges posed by the coronavirus crisis, which has killed more than 156,000 Americans.

This interview has been edited for length and clarity.

What COVID-19 issues are you working on most?

For our Virginia-based clients, we've been helping them navigate the new emergency temporary standards for COVID that were created by our Occupational Safety and Health Administration. Those are heightened workplace requirements for employees with higher risks of infection.

The requirements are very extensive. And so working in conjunction with our labor and employment law group, we've been advising clients on how to navigate their heightened responsibilities under that regime. And of course that's going to impact hospitals considerably.

Talk more about what that means for hospitals.

As you might expect, hospitals have employees whose tasks absolutely put them at higher risk of COVID infection. And the real challenge for hospitals is they're already dealing with the pandemic and a plethora of federal subregulatory guidance that's coming out with respect to that.

Now we've got a whole new layer of complexity in how they evaluate workplace safety precautions, and whether those precautions are consistent with other federal or locality requirements and the like.

Any other big issues you're handling right now?

For our clients outside Virginia, they've faced almost a one-two punch. On the one hand, they've seen a significant diminution of revenue because they've stopped doing elective cases. That means the outside

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legal spend budgets for most hospital system law departments are very severely constrained. So they're trying to figure out how much of the work that they might have previously sent to outside counsel they can accomplish using their own resources.

At the same time they're doing this, they're having to contend with a flood of new federal pronouncements, either as regulations or further subregulatory guidance. And trying to understand, for example, the scope of the Stark Law waivers that came out. Helping them navigate that, while being mindful of their desire to limit the outside legal spend, has been a real challenge for them.

Does it vary much by state in terms of whether providers are having to cut legal spending?

Some systems, particularly those in current hot spots, are finding the revenue degradation that hit [earlier this year] is coming back because they may find it necessary to voluntarily restrict elective procedures once again. That happened among some providers in Texas, and it's probably also had an impact on the willingness of the patient population to go into facilities in hot spots.

Is this a double whammy for Sun Belt hospitals that reduced nonemergency procedures earlier this year, just like hospitals in the Northeast, before they had lots of COVID patients?

Yeah, I think that is exactly what has happened. This didn't roll through the country uniformly. And because of that, there was probably an excessive curtailment of elective caseload in the Sun Belt before it really needed to be curtailed.

But now they're a bit smarter about how to segregate COVID work and elective caseload than they had been at the onset. They're probably well-served by the learning that has accumulated since the pandemic first surfaced.

In places where elective procedures are happening, how are hospitals faring with efforts to convince patients it's safe to come back?

Frankly, I see it as a real challenge, particularly for hospital campuses that do not have a clear separation between their outpatient and inpatient platforms.

For providers that are more tightly constrained geographically on their campus and which have combined waiting areas for inpatient and outpatient surgeries, it's a much tougher task to instill patient confidence. The mechanism to best address those concerns is going to be one-on-one, physician-to-patient conversations.

Is it fair to say that's a labor-intensive mechanism?

I think that's fair. But if you're part of a multihospital system and you can designate one of your facilities as more concentrated on COVID relief and send non-COVID cases to another campus, that's an advantage. And certainly within a hospital, it's possible to designate a floor or a wing as COVID-only.

You're based in Virginia. Why do you think the state's infection rate has been relatively moderate?

Virginia probably had more tight business restrictions early on than in the Sun Belt, and those may have helped to bend the curve sooner.

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Also, Virginia had very early experience with an outbreak in a long-term care facility [the Canterbury Rehabilitation & Healthcare Center]. That gained a lot of national notoriety, and I expect that experience created a greater sense of urgency in the long-term care community to step up efforts to mitigate the risk of spread.

We did have a spike in mid-May, then a decline, then a spike again after the Fourth of July. And while we've got a greater concentration [of infections] in our highly urbanized areas than in our rural areas, we've also got some anomalies.

Buckingham County, which is fairly rural, sits right next to Albemarle County, where Charlottesville is, but Buckingham has a five-times-greater case rate. That might be explained by some concentration in corrections facilities or in raw food processing plants where COVID contamination has been a greater challenge.

What's been the experience of providers in Virginia?

I work with clients on the front lines in northern Virginia, and the spikes there have done more to challenge the bandwidth of the health care staffs than have any capacity constraints. That latter point was surprising to me because Virginia still tightly regulates hospital bed capacity through a certificate of need program.

But early on, the [Virginia] Department of Health established a special exceptions process by which hospitals could request, on a temporary basis, additional licensed bed capacity to meet COVID-related demand. And so the numbers of beds or the numbers of ventilators never really became a significant problem in Virginia.

But I do know from talking with colleagues and health care providers that the nursing staff and the physician staff of the hospitals, particularly those in the emergency rooms and the ICUs, have really been stressed by the volume [of COVID patients].

Obesity and diabetes are COVID-19 risk factors. I know you've given some thought to whether the pandemic could usher in lifestyle changes on those fronts. What's your current thinking?

I'm very hopeful, but I'm not optimistic. For many Americans, COVID has imposed limitations on physical activity, and it's imposed social isolation to a level never seen before. To the extent that those are compounding triggers that drive the types of behavior that impact obesity and diabetes, COVID is not helping.

The thing that I am hopeful for is that we are seeing hard evidence of COVID-19's interactions with these and other risk factors that are often influenced by behavioral choices. So this may be a turning point in the broader conversation that physicians will feel the liberty to engage in with their patients.

To the extent that providers have heretofore been reticent to speak frankly as to lifestyle choices that harbor greater risk, COVID-19 is a teaching moment of the first order. COVID is illustrating in very real terms that diabetes doesn't just carry with it the adverse health consequences of diabetes, which themselves are severe. It creates this collateral risk in a pandemic situation of putting oneself among the most vulnerable in the population.

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Many attorneys expect more M&A as a result of money troubles among smaller hospitals. Are there any other M&A trends the pandemic could spark?

I do think there are going to be hospitals and perhaps health systems that have seen such a significant degradation in their balance sheets that they're going to be forced to consider affiliation transactions that they might not previously have been willing to consider.

These facilities that are stressed financially have a window of time in which they can try and right the boat. But as we see the waves of COVID cases cycling through and challenging the revenue streams, for some that situation is going to get worse, not better.

Can you give me an example of an affiliation that might make more sense now?

Yeah, there are some multihospital systems that include, within their umbrella of affiliates, risk-bearing entities that are licensed as HMOs or insurance companies [that agree to serve certain policyholders for a predetermined price]. As payors move to greater levels of value-based compensation, it seems to me that hospital systems with experience in quantifying and managing risk are probably going to be better positioned in the long haul for survival.

And so, if my hospital were stand-alone, or were part of a system that did not have affiliates with strong risk-bearing capabilities, it might be to my advantage to consider an affiliation that would bring that strength and that buffer into the financial resources that would help carry the system through the current pandemic.

Any other transactional trends to watch?

We've now got three different flavors of federal money coming into the health care delivery system through the Advance Payment Program, the Provider Relief Fund and the Paycheck Protection Program. All of those money streams have different compliance obligations and present False Claims Act risks.

So in an affiliation transaction or a merger transaction, I would be paying particular attention to the compliance measures and mechanisms put in place by recipients of those funding streams. Are they buttoned up tight in terms of risk mitigation? Did they, in seeking a PPP loan, provide certifications that can be challenged as untrue?

In closing, has your practice seen anything during the pandemic that hasn't received as much attention as it deserves?

You'll recall that before the pandemic hit, we had an increasingly tight labor market. The concern that I've got is the health care delivery workforce has now observed firsthand what can occur in a pandemic. And so, to what extent will we find it more challenging to recruit and retain a health care workforce?

And I think about that in the context of an aging demographic across the country. I worry about where we are going to have shortages of trained health care workers who are willing to step up.

To be clear, shortages of nurses and other health care workers are not a new concern. Are you worried shortages could get even more dire because of safety fears?

Yeah, I am concerned about that. Because you look at single-parent families, and then you look at the risk to health care workers from a highly communicable disease. It does call into play a profound consideration of not only the risk to themselves, but also the risk to their families of being exposed to these formidable risks that aren't present uniformly every day in the health care context.

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