Arbitration Predominates for Dispute Resolution Among Participants in the Health Care Industry

By Katherine Benesch

Arbitration has become the predominant mechanism to resolve health care business-to-business disputes. Most of these cases do not enter the courtroom because the contracts between health care parties contain mandatory binding arbitration clauses. Some provide for a two-step mediation/arbitration process. Many require arbitrators with expertise in specialized aspects of the health care industry. In addition to business-to-business disputes, business-to-consumer disputes in nursing homes and post-acute care facilities commonly have been submitted to arbitration. This has led to state statutes restricting arbitration, but these have been held to be preempted by the Federal Arbitration Act (FAA).

Arbitrator Selection in Health care Cases

Often, arbitrators in large health care disputes are specially selected for the case. In addition to requesting arbitrator candidates selected from the Health care Panel of the American Arbitration Association (AAA) or from the Panel of Arbitrators or Mediators of the American Health Lawyers Association (AHLA), parties in highly specialized health care cases often submit subject-matter questionnaires to potential neutrals, and/or interview arbitrators in advance of making their selection of a sole arbitrator or a member of a three-member panel. This enables a more targeted selection process to identify a dispute resolver with appropriate expertise. For example, a dispute involving Medicaid reimbursement under a contract with the federal government may require knowledge of the rules and regulations on termination for convenience under the Federal Acquisition Rules (the FAR), as well as knowledge of Medicaid program regulations. Disputes over the intricacies of managed care contracting and financing (whether under Medicaid or private insurance) also require specialized expertise. Disputes over what rules to apply to set reimbursement rates for experimental new drugs that have not yet been evaluated by Medicare (often the setter of base rates) require knowledge of the rate-setting process.

Parties and Types of Disputes in Health Care Cases

Parties involved in health care disputes include, among others, health systems, hospitals, physicians and medical groups, insurance carriers, state governments, practice management companies and billing and collection services, managed care plans and Affordable Care Organizations (ACOs), laboratories, large and small pharmaceutical companies, durable medical equipment companies, contract research organizations, nursing homes, assisted-living and residential care facilities. Some disputes are disagreements between payors and providers of care and treatment modalities. Increasingly, however, health care cases in arbitration involve disputes with third-party vendors of back-office services to states, pharmaceutical companies, multi-party health care systems and/or insurance plans. Disputes with vendors raise issues such as: billing and collections under Medicare/Medicaid and private insurance mechanisms, development of payment algorithms for services/providers paid for performance outcomes, and development of IT and data collection systems to measure utilization, drug trials and analyze medical records.

Particular types of frequently arbitrated health care disputes include:

1. Managed care disputes between payors and providers involving contract interpretation, payment rates, risk sharing, insurance, reimbursement and/or administrative issues;
2. Employment contract disputes between physicians and medical groups, or physicians and hospitals (including disputes arising out of covenants not to compete);
3. Medical staff, credentialing and peer review disputes;
4. Shareholder disputes with physician practices or health care entities;
5. Contract and reimbursement disputes involving health care joint ventures;
6. Disputes involving management services companies and third-party vendors with providers, governments and insurance carriers over development of billing, collection and data tracking systems, other IT, medical record and data management issues;
7. Clinical trial disputes between pharmaceutical researchers and manufacturers and contract research organizations (CROs); and
8. Disputes involving consumers' allegations of liability in nursing homes and other post-acute care facilities.

Recent Developments

Health care arbitration cases are testing many interesting principles of jurisprudence. The intersection of dispute resolution with regulatory obligations has led to

challenges to awards. In *Jupiter Med. Ctr., Inc. v. Visiting Nurse Ass'n of Fla, Inc.*,[1] a hospital sought vacatur of an award as it strongly believed that the arbitrator interpreted the contract and discharge planning procedures in a manner that rendered them illegal if enforced because the hospital could be required to violate Stark, Anti-Kickback and Medicare laws and regulations. The Florida Supreme Court found that the Federal Arbitration Act (FAA) precluded it from vacating an arbitration decision that enforced a contract between a home health care agency (VNA) and a hospital (Jupiter Medical Center). After the arbitration panel awarded damages and fees for breach of contract, Jupiter Medical Center filed a motion to vacate the award because it either mandated illegal conduct or imposed damages for a party's failure to engage in such conduct. There was a provision in the contract that required it to be construed in accordance with all laws, and in particular, to comply with the Anti-Kickback Statute. After a long and complex procedural course, the case was decided by the Florida Supreme Court. In deciding the case, the Florida Supreme Court first considered whether the FAA applied to the case, as both parties to the contract were Florida companies. However, because the case involved referral of Medicare patients, the court concluded the transaction involved interstate commerce, and the FAA applied. The Court then reviewed the United States Supreme Court decision in *Hall St. Assocs., L.L.C. v. Mattel, Inc.*,[2] which determined that the FAA bases for vacating or modifying an arbitral award are limited (at 9 U.S.C. §§ 10 and 11), and alleged illegality of the contract is not one of the bases for vacatur.

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A variety of states have sought to limit pre-dispute arbitration clauses in agreements between consumers and nursing homes or other post-acute care facilities. Whether these state laws are preempted by the FAA has been questioned repeatedly. Pre-dispute arbitration agreements in post-acute care facilities have been a subject of much litigation over the past few years.[3] In a recent victory for arbitration in general, related to post-acute care facilities, the United States Supreme Court, on May 15, 2017, struck down a decision by the Kentucky Supreme Court, which had invalidated nursing home residents' agreements to arbitrate.[4] The issue in the case was whether the FAA preempts a state-law contract rule that requires a document appointing a power of attorney to refer explicitly to arbitration, before the attorney-in-fact can waive the individual's right to a jury trial by signing an arbitration agreement. In a 7 to 1 decision analyzing the purpose of the FAA, the Supreme Court declared that if a state law treats arbitration differently—either overtly or covertly—from other kinds of contracts, then the FAA will preempt that law. The FAA prohibits state rules that place arbitration agreements on a different footing from other contracts. This decision is consistent with the U.S. Supreme Court's prior decisions invalidating rules that obstruct the FAA's objective of promoting arbitration.

On June 2, 2017, the Department of Justice filed an unopposed motion to dismiss its challenge to a decision that had enjoined a rule barring nursing homes from requiring residents to enter into agreements containing pre-dispute arbitration clauses. The motion was granted by the U.S. Court of Appeals for the Fifth Circuit.[5] This challenge arose after the Centers for Medicare and Medicaid Services issued an extensive nursing home regulation that became final in September 2016. The regulation, promulgated by the Obama administration, included a ban preventing nursing homes from enforcing pre-dispute arbitration clauses in their residents' contracts. The U.S. District Court for the Northern District of Mississippi blocked the rule from taking effect nationwide in November 2016. As a result of the withdrawal of this appeal, nursing homes may once again require residents and their families to enter into contracts that include clauses for mandatory binding arbitration of disputes with the facility. Consumer groups, however, have indicated that they intend to file a motion to intervene in the proceedings. Thus, this case may reappear.

Conclusion

Arbitration of health care cases is a dynamic and challenging endeavor. The matters discussed above present only a few of the exciting issues that arise every day in this fast-paced field of changing law and fact. Health care contracts intersect with convoluted, complex and constantly changing regulatory schemes. It is for this reason that parties seek neutrals, who are knowledgeable not only in arbitration techniques but also in state and federal health care and insurance regulation, as well as industry practices and payment mechanisms.

Endnotes

1. 154 So.3d 1115 (2014) (*review denied*, U.S., No. 14-944 5/4/15).
2. *Hall St. Assocs., L.L.C. v. Mattel, Inc.*, 552 U.S. 576 (2008).
3. *See, e.g., Richmond Health Facilities-Kenwood, LP v. Nichols*, 811 F.3d 192 (6th Cir. 2016); *Barrow v. Dartmouth House Nursing Home*, 88 Mass. App. Ct. 128, 14 N.E.3d 318 (2014); *Gross v. GGNSC Southaven, LLC*, No. 15-60248 (5th Cir Mar. 14, 2016).
4. *Kindred Nursing Ctrs., L.P. v. Clark*, 581 U.S. ____ (2017).
5. *Am Health Care Ass'n v. Price*, 5th Cir., No. 17-60005, *dismissed* 6/2/17.

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