Arbitration and Mediation Predominate for Dispute Resolution Among Participants in the Health Care Industry

By Katherine Benesch

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Arbitration and mediation have become the predominant mechanism to resolve health care business-to-business disputes. Most of these cases do not enter the courtroom, since the contracts between health care parties contain mandatory binding arbitration clauses. Many provide for a two-step mediation or arbitration process. Often, they 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. While this has led to state statutes restricting arbitration, they have been held to be preempted by the Federal Arbitration Act (FAA).

Arbitrator selection in health care cases

Often, arbitrators and mediators in large and/or complex health care disputes are selected especially for the case. In addition to requesting arbitrator candidates selected from the Healthcare 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 and mediators in advance of making their selection of a sole arbitrator, mediator, or 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 (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 when setting down reimbursement rates for experimental new drugs which have not yet been evaluated by Medicare (often the entity that sets 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 and assisted-living and residential care facilities. Some disputes are disagreements between payors and providers of care and treatment modalities. Increasingly, however, health care cases involve disputes with third-party vendors of back-office services to states, pharmaceutical companies, multi-party healthcare systems and/or insurance plans. Disputes with vendors may raise issues such as billing and collections under Medicare/Medicaid and private insurance mechanisms; development of payment algorithms for services and providers paid for performance outcomes; as well as development of IT and data collection systems to measure utilization, drug trials and analyze medical records.

Types of health care disputes frequently decided in arbitration or resolved in mediation include:

1. Managed care disputes between payors and providers involving contract interpretation, payment rates, risk sharing, insurance, billing, reimbursement and/or other administrative issues;
2. Employment contract disputes between physicians and medical groups, or physicians and hospitals (including disputes arising out of

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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 trials disputes between pharmaceutical researchers, manufacturers and 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 complex regulatory obligations has led to many challenges. A few of these are discussed below.

In *Jupiter Med. Ctr., Inc. v. Visiting Nurse Ass'n of Fla, Inc.*,[1] a hospital sought vacatur of an award because 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 FAA precluded it from vacating an arbitration decision that enforced a contract between a home healthcare 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. After a long and complex procedural course, the Florida Supreme Court decided the case. The Florida Supreme Court first considered whether the FAA applied, as both parties to the contract were Florida companies. Since 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. In *Oxford Health Plans v. Sutter*,[3] the Supreme Court also affirmed that an error of law is not a grounds for vacatur of an arbitrator's award.

Health care cases also have been the vehicle for courts to limit an arbitrator's power to compel production of documents from third parties outside of an arbitration hearing. This was the ruling by the Ninth Circuit Court of Appeals in *Vividus, LLC v. Express Scripts, Inc.*[4] There, the Court of Appeals agreed with the Second, Third, and Fourth Circuits that the FAA does not empower arbitrators to compel third parties not involved in the arbitration hearing to produce documents to parties in the arbitration.

In *CardioNet, Inc. v. Cigna Health Corp.*,[5] the Third Circuit Court of Appeals held that where a party to an arbitration agreement makes claims that fall outside the scope of the arbitration clause in an agreement, that party may pursue some of its claims in court, while claims covered under the arbitration clause, remain in arbitration.

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.[6] 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.[7] 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 an individual's right to a jury trial by signing an arbitration agreement. In a 7–1 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 than 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.[8] 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 once again are requiring residents and their families to enter into contracts that include clauses for mandatory binding arbitration of disputes with the facility.

Conclusion

Arbitration and mediation of health care cases are dynamic and challenging endeavors. 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 and mediation 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. *Oxford Health Plans v. Sutter,* 133 S. Ct. 2064 (2013).
4. 878 F.3d 703 (9th Cir. 2017).
5. 751 F.3d 165 (3rd Cir. 2014).
6. *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); *Hickory Heights Health & Rehab, LLC v. Taylor,* 2020 Ark. App. 98, No. CV-19-280 (2/12/20).
7. *Kindred Nursing Ctrs., L.P. v. Clark*, 581 U.S. ____ (2017).
8. *Am Health Care Ass'n v. Price,* 5th Cir., No. 17-60005, *dismissed* 6/2/17.