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Effective Use of Mediation and Arbitration in Health Care Disputes

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Various dynamics at play in the health care industry are likely to contribute to disputes uniquely suited for resolution through mediation and arbitration. If the Patient Protection and Affordable Care Act (PPACA) survives attacks in the courts, continued consolidation and reorganization among health care industry participants will likely occur. Moreover, Congress has significantly enhanced the federal government's ability to pursue fraud claims, and the U.S. Department of Justice (DOJ) is devoting substantial attention to investigations and prosecution of criminal and civil cases involving alleged health care fraud.

Overview of Health Care Disputes

There are many types of significant disputes in the health care industry:

- Patient safety claims against hospitals, nursing homes, physicians and other professionals, and product liability claims against drug and device manufacturers;
- Disputes among members of physician groups (or between the "group" and individual physicians) or between hospitals and physicians and other staff;
- False Claims Act (FCA) and other fraud cases against hospitals, physicians, drug and device manufacturers, pharmacies, suppliers, etc.;
- Complex disputes arising from mergers and acquisitions or from costly transactions involving technology and intellectual property;
- Payment and reimbursement disputes involving private and government payors and pharmacies, physicians, hospitals, and patients; and,
- Risk management controversies (including insurance coverage) involving issues about responsibility for patient injuries and deaths (especially those outside the norm of "garden variety" med mal claims) and for various commercial claims, for example relating to payment disputes or fraud claims.

Dispute Needs and Concerns in the Health Care Industry

Many health care industry disputes are uniquely suited to resolution outside the judicial system because of particular needs and concerns of the health care industry:

- Concerns for patient privacy and business confidentiality;
- Reduction of time and cost devoted to disputes in an industry under special

economic, political, and social pressures to control costs;
- Timely elimination of disputes that threaten the very existence of participants (e.g., government fraud claims that may threaten criminal exposure and exclusion from government contracting including Medicare and Medicaid);
- Management of important relationships with investors, lenders and financial analysts; employees/staff; and customers, vendors, and other business "partners"—all of which can suffer greatly in the midst of an ugly public dispute;
- Preservation of on-going business relationships among disputants, particularly in the context of expanding businesses, a consolidating industry, and development of new business relationships;
- Elimination of business and personal distractions among highly trained and highly compensated professional staff who truly "have better things to do" (i.e., treating patients and producing revenue) than spending days in conference rooms and courtrooms with lawyers and administrators;
- A particular aversion to public controversy on the part of educational and religious organizations who often own health care facilities or play other important roles in the delivery of health care services; and
- Satisfaction of the patient safety concerns finding expression in the Joint Commission Standards requirements for conflict management systems.

Overview of Health Care ADR

In mediation, a disinterested, impartial third-party can assist parties and their counsel in effectively communicating their respective positions to each other and in negotiating a settlement. As appropriate, the mediator may provide questions, comments, observations or opinions about parties' positions and may make suggestions or proposals about how to settle the dispute. A settlement reached in mediation is documented in a binding contract enforceable in court. In arbitration, a disinterested, impartial third-party will make binding decisions resolving the dispute and enter an award that can be enforced in court, although the decisions have a loud ring of finality to them because courts will only rarely review arbitration decisions. In both processes the mediator or arbitrator will assist parties in exchanging sufficient evidence and other information to make the process informed and fair.

Mediation and arbitration can address particular needs of disputants in health care in various ways:

- Mediation and arbitration are more private and confidential than court proceedings; even required public release of information about a dispute is better controlled in managed private processes than a multi-year public brawl in a courtroom potentially full of reporters and competitors;
- Any form of ADR should be quicker to resolution at materially reduced cost and with greater finality than disputes in the judicial system;
- ADR proceedings allow for utilization of dispute resolution professionals with applicable dispute resolution expertise, plus relevant regulatory, scientific or other health care subject matter expertise as needed;
- ADR processes provide an opportunity for thoughtful resolution of emotional and highly charged disputes surrounding medical errors, patient safety, end of life, bio-ethics, and inter-staff controversy;
- Mediation can provide a forum for resolving disputes among multiple participants who might not always be parties

to the same lawsuit, and can devise solutions sometimes not available in court.

Current Use of ADR in Health Care

Although at least three organizations (JAMS, American Arbitration Association, American Health Lawyers Association (AHLA)) offer health care-specialized panels of mediators and arbitrators, the health care industry has been slow to adopt ADR. There could be many possible explanations why ADR is underutilized in health care. One possible explanation is that health care lawyers as a group might not have the same opportunities for exposure to mediation and arbitration as full-time litigation counsel (think employment, construction, insurance defense and family law) who may participate in a dozen or more mediations or arbitrations per year. Many health care lawyers are "specialists" in every sense of the word, but they are often "health care specialists" who work with their health care clients on a variety of regulatory, transactional and litigation legal issues. Other health care lawyers, especially in the health fraud bar, have come to health law practice after years of practice in white collar criminal prosecution and defense work with little ADR experience. Some private lawyers in fraud cases are skeptical about whether government agencies are genuinely interested in mediating fraud cases, although anecdotal interviews with both private and government lawyers reflect both genuine interest and successful experience on the part of both federal and state governments in mediating appropriate health fraud cases.

Against this backdrop, there are many types of health care disputes in which ADR can make a positive impact. Two particular examples include disputes related to professional business relationships of physicians and government health care fraud cases.

Government Fraud Cases

Among the most difficult disputes facing participants in the health care industry are FCA cases brought by federal or state agencies (often initiated by relators) for alleged fraud in connection with payments under government health care programs including Medicare and Medicaid. The high stakes involved in these cases is one important reason why parties should carefully consider attempting settlement through mediation.

Federal False Claims cases can result in civil penalties including treble damages plus $5500 to $11,000 per claim, corporate and individual criminal liability, and exclusion from government health care programs. Most states provide for similar liabilities. The U.S. Department of Justice has reported that it recovered over $2.5 billion in 2010 and $4.6 billion since January 2009 in health care fraud cases. Several reported recoveries against pharmaceutical and device companies have exceeded $100 million. According to the U.S. Department of Justice, "Fighting fraud committed against public health care programs is a top priority for the Obama Administration."
http://www.justice.gov/opa/pr/2010/November/10-civ-1335.html.

Recent legislative changes have enhanced the ability of the federal government and FCA *qui tam* relators to pursue False Claims:

- PPACA § 6402 amended the federal Anti-Kickback Law to make clear that violations of the Anti-Kickback Law can be brought under the FCA.
- The Fraud Enforcement and Recovery Act (FERA) imposed FCA liability for overpayments, expanded DOJ's power to issue civil investigative demands, and amended the FCA anti-retaliation pro-

visions to protect contractors and agents in addition to employees.
- PPACA further defined overpayment liability to provide that retention of an overpayment for over 60 days after identification by a provider can become a false claim.

Government investigations of possible FCA cases provide opportunities to use mediation to satisfy important goals and interests of both government and accused, while also potentially saving time, money and other important resources. The consequences to private businesses of an FCA case are potentially catastrophic in the form of monetary, criminal, and exclusion liabilities. A mediated settlement agreement may avoid (or at least diminish) exclusion and criminal responsibility while quantifying civil monetary exposure at a known, agreed upon level. Even where a potential FCA defendant genuinely (and perhaps correctly) views a potential claim as defensible, such an approach to mediation and settlement may often have some merit because, among other reasons, a defendant can utilize a mediated settlement to avoid the potentially enormous financial cost of lengthy further investigation, discovery, motion practice, and trial, the adverse impact on relationships, and a drain on the time and energies of senior management and legal personnel. From the government's perspective, substantial and adequate financial payments can be recovered without the time, risk, and cost attendant to a trial against a well-heeled and committed defendant. Similarly, governments can devote very substantial, but nonetheless limited, financial, legal, and investigatory resources to health care fraud cases, and a mediated settlement may allow government agencies to move on to other important investigations.

When a mediation occurs prior to the unsealing of a relator's FCA complaint, a defendant may also have a chance to vindicate an interest in privacy, or at least in diminished public and media scrutiny. A defendant's settlement of an FCA case will be public and likely publicized with some fanfare. But on the day after the announcement, investors, lenders, financial analysts, employees, vendors, customers, and other key constituencies will start to view the issue in the rear-view mirror, rather than through the continuing scrutiny of a pending case with a still uncertain outcome. The government in turn gets a chance to make a splashy announcement, satisfying the important goal of potentially deterring future putative wrongdoers, without the cost of a longer investigation and trial, and without the risk of sending the wrong deterrence message if the trial is not successful.

Finally, use of mediation in government fraud cases provides a "forum" for resolution of issues with multiple parties and agencies. Settlement of *qui tam* matters under the FCA can be particularly challenging because each settlement typically has multiple parties, including DOJ, the Inspector General of HHS (which has administrative authority to exclude the defendant from Medicare), the relator(s), and the defendant(s). If a defendant seeks a release of any state liability for Medicaid claims, a settlement will also require the involvement of state authorities, which ordinarily include a state Assistant Attorney General, and sometimes many of them. Although DOJ and most state Attorneys General will require most FCA settlements to be approved at various levels of management (for example, Assistant U.S. Attorneys and trial counsel at DOJ cannot ordinarily make binding settlement offers and commitments), this challenge should rarely be significant because final, "official" higher levels of approval are obtained routinely in the mediation and settlement of many types of cases involving federal, state, and local governments.

ADR in Physician Business/Employment Disputes

When physicians' relationships with one another or with other providers are fractured, a host of claims may ensue, including: for repayment of loans; for breach of non-compete, non-solicitation, and anti-theft provisions; for breach of fiduciary duty; for

violation of federal, state and local laws prohibiting employment discrimination; and for violation of federal and state anti-fraud laws. Both mediation and arbitration can potentially assist parties in attaining several often mutually shared goals in these physician fights.

When physicians' business arrangements with one another sour, a principal goal is (or should be) to get the business and legal issues resolved quickly, inexpensively, and fairly. Many of these business organizations and contracts can benefit from contractual requirements that the parties arbitrate all disputes among the parties. These disputes often escalate into ugly charges among former colleagues about quality of care, billing legalities, employment discrimination and harassment, or "stealing" patients, employees, and technology. Ordinarily, neither side benefits from airing those charges publicly. A well drafted arbitration clause in the organizational documents for a professional practice or other contract documenting the business arrangements between physicians can require an appropriate type of expertise on the part of the arbitrator (including certain types or years of experience as arbitrator and/or in health care cases), and a hearing within a few months after an exchange of necessary documents and information but without the lengthy contentious discovery process that often makes litigation in the courts so protracted and costly. A business arbitration, when properly managed by an experienced arbitrator, should almost always be quicker and less costly than a comparable lawsuit in court.

Mediations in physician disputes are particularly well suited to focusing the parties on the real business disputes needing resolution and away from the inevitable hurt feelings and sometimes exaggerated mutual claims of personal and professional misconduct. Mediation is private and confidential and can result in the amicable termination of business relationships or the salvation and perhaps redirection of those relationships through negotiated outcomes often not achievable through the legal system—both points having special import at times in physician cases. Finally, mediations are successful in settling a very substantial majority of cases where attempted, but as mediations result in settlement only when the parties agree upon an outcome, it is not overly simplistic to say that in contrast with litigation, where a judge or a jury makes the parties' basic business decisions for them, the parties to a mediation decide the outcome.

R. Wayne Thorpe, Esq. has been a full-time ADR neutral since 1998. He has served as mediator, arbitrator, special master, case evaluator and in other neutral roles in more than 1,400 cases, in at least 15 states, involving all kinds of civil disputes, including at least 100 health care disputes. He can be reached at wthorpe@jamsadr.com.