# Health Care Matters

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## The Use of Protected Health Care Information in Mediation

By Ronald B. Ravikoff, Esq.

Mediation has become a major vehicle for resolution of health care disputes, which often extend beyond traditional medical issues. Disputes involving contractual issues between providers and the businesses they work with are now central in health care mediations. Many of these mediations require the use of protected health care information (PHI). The use of PHI is regulated by the Health Insurance Portability and Accountability Act (HIPAA). Organizations required to comply with HIPAA privacy rules are called covered entities. Covered entities include any health care provider that transmits health information in connection with transactions defined by HIPAA. Businesses that receive PHI from covered entities are called business associates and are also covered by HIPAA.

Revisions to HIPAA were made in 2013, expanding the rules applicable to business associates. Business associates must

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## Constructing an Arbitration Clause for Provider-Payor Health Care Disputes

By Martin Quinn and Barbara Reeves, Esq.

Arbitrating a significant health care reimbursement dispute is no picnic. These cases usually have multiple issues involving thousands of claims that arise under one or more contractual relationships or courses of conduct. Without firm direction by the arbitrator(s) and thorough preparation and cooperation by counsel, the process could go off the rails in a disastrous and expensive way. The road map to an effective arbitration starts with a comprehensive, detailed arbitration clause.

This brief article will focus on the features of an arbitration clause that are specific to managing significant health care reimbursement disputes. The forms available on the **JAMS website** provide excellent sample language and full explanations of the more generic features of an effective clause.

A sound arbitration clause should provide the means to deal with the following unique features of health care reimbursement disputes.

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now treat their subcontractors that use PHI in the same manner that covered entities treat their business associates. Both covered entities and business associates are now responsible for entities under their direct control receiving PHI. Typically, a business associate should also treat its independent contractors as included for purposes of complying.

In light of these regulations, if the mediation requires disclosure of PHI to the mediator, is the mediator covered by the HIPAA PHI restrictions? Should the mediator be considered a business associate?

## Mediators as Business Associates

There is no clear guidance on whether mediators who receive PHI in the course of a mediation are considered business associates. But it is now accepted that lawyers (HIPAA FOR LAWYERS AND LAW FIRMS, Hoover, J. and Coffield, R., FDCC Annual Meeting, August 2, 2014) and even court reporters (The HIPAA Regulations—What Has Changed and What You Need to Know, Gates, M., National Court Reporters Association) who receive PHI are business associates. It follows that mediators should also be treated as such.

The regulations offer three possible routes to protect PHI in mediation: (1) consent, (2) a judicial proceedings disclosure or (3) a business associate agreement (BAA). However, as discussed below, only the BAA seems practical.

## Disclosure after Consent

Disclosure of PHI may be made with the consent of the individual whose PHI is at issue. Individual consent is impractical, however, when a large amount of information needs to be reviewed. So it is not a preferred alternative for disputes where multiple individuals' data is needed.

## Judicial and Administrative Proceedings Disclosure

PHI may also be disclosed in a judicial or administrative proceeding if requested by an order from a court or tribunal. PHI may also be disclosed in response to a subpoena if certain assurances regarding notice are provided. There is, however, little support for the proposition that the mediation qualifies as a judicial or administrative proceeding.

## Are Mediators Business Associates under HIPAA?

As noted above, there seems to be no argument that lawyers who receive PHI are business associates and that lawyers' subcontractors who receive PHI would also be considered business associates.

Accordingly, it is suggested that, given the broad scope of the new business associate regulations and absent clear guidance to the contrary, mediators should be treated as business associates as well.

## What Best Mediation Practices Are Recommended?

1. **When possible, secure authorization from the individual(s) whose PHI is sought.**

2. **When the mediation is court-ordered, consider seeking a qualified protective order, which covers the mediation as part of the referral. However, there is no assurance that a mediation would qualify as a judicial or administrative proceeding, even allowing for a qualified protective order. The protective order should be considered as merely added protection for the covered entity and business associate.**

3. **Treat the mediator as business associates under HIPAA and have the mediator sign a BAA.**

Treating the mediator as a business associate and executing a BAA seems to be the safest and most practical route to follow. •

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## 1. Adding New Claims:

While the time an arbitration is pending, it is common for new disputed claims for patient treatment to arise, so there should be a mechanism for easily wrapping them into the arbitration if the parties wish.

## 2. Adding Parties:

An arbitration may well involve not only a hospital and a health plan, but also third-party payors, affiliated entities, physicians' groups, third-party administrators and employer-payors. There should be a mechanism for smoothly adding them to the arbitration if a legal basis to do so exists, as well as a provision that the absence of a third-party will not deprive the arbitrator(s) of jurisdiction.

## 3. One Arbitrator or a Panel:

Scheduling is far easier with a single arbitrator, as well as significantly more affordable. The rationale for having a panel of three arbitrators is to minimize the chance of legal or factual errors, particularly in major cases. One hospital group uses a clause that provides for a panel in cases with more than $30 million at risk, and a single arbitrator in smaller cases.

## 4. Selecting the Arbitrator(s):

Health care cases present their own vocabulary, their own body of federal and state law and their own business practices. Familiarity with this landscape is valuable, so the clause might provide that the arbitrators shall be attorneys or retired judges experienced in resolving disputes between health plans and providers.

## 5. Initial Meet-and-Confer:

It cannot be overstated how much a sound process depends in these cases on cooperation among experienced counsel. Requiring a robust meet-and-confer attended by first-chair counsel and party representatives with the requisite knowledge and authority is an essential start. The agenda should be to develop a process and timeline for (a) exchanging information about disputed claims, (b) the phasing of the hearing and (c) any other case management hurdles. Parties may decide to present pure legal issues, if any, in a first phase. Frequently, the remainder of a health care dispute divides naturally into a number of phases, separated by legal issue, chronology of claims or by type of claim (inpatient/outpatient, PPO/HMO, contracted/non-contracted). The outcome of this meet-and-confer should ideally be a joint draft Case Management Order to present to the panel as an agenda for the initial Case Management Conference. If any disputes remain, they should be presented as well.

## 6. Initial Case Management Conference/Order:

Every arbitration should commence with a thorough Case Management Conference with the arbitrator(s), either in person or by conference call. The intent is to determine the process and set the timeline for the remainder of the case through hearing and award—decide whether to bifurcate or phase issues, schedule dispositive motions, allow sampling of claims, provide discovery scope and deadlines and decide other process issues. Since health care cases typically require decision on masses of claims and issues, this Conference and the resulting Order are even more critical.

## 7. Exchange of Spreadsheets:

It is almost always essential to provide for an early exchange of spreadsheets of claims for which a party seeks recovery or offset. A clause might provide for the claimant to provide a spreadsheet within 90 days after the demand or 30 days after the Case Management Order is entered. A responsive spreadsheet might be required in 30 days. The clause should direct counsel to confer about discrepancies or omissions from the spreadsheets so that the panel will ultimately deal with "apples and apples."

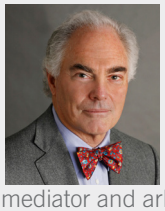
## 8. Sampling:

In these cases, it is almost always necessary for counsel to select a handful of disputed claims to present in detail to the arbitrator(s), with the expectation that the decision will be extrapolated to the entire body of disputed claims. Such sampling is more typical with respect to contractual and rate disputes than with medical necessity claims, which typically turn on individual facts. The clause should expressly allow sampling, require counsel to confer on a methodology to be used and expressly allow the arbitrator(s) to base an award upon such sampling.

## 9. Discovery:

Despite the complexity of these cases, discovery can often be limited to an exchange of relevant documents. Few, if any, fact depositions may be required, although expert depositions are routinely allowed. Some clauses bar all non-expert discovery beyond the document exchange, except by leave of the arbitrator(s). One clause now in use bars the arbitrator(s) from ordering extensive search and production of electronic information. In drafting the clause, consider how limiting discovery can save cost and time without sacrificing fairness.

With an arbitration clause in place that deals with the above issues, the parties and the arbitrator(s) will find it much easier to produce a streamlined and focused process. •



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# Consolidation and Conflict in the Health Care Industry

**By Viggo Boserup, Esq., CEDS**

The health care industry has experienced a significant increase in consolidations among providers of facilities and services alike. From drugs to devices to service providers, 2014 saw the largest consolidation within the health care industry in the past 20 years. These consolidations were spurred primarily by two distinct factors in the market.

The first is the reduction of reimbursements from both insurers and governmental agencies. Both 2013 and 2014 saw some of the most dramatic reductions in Medicare and Medicare-related reimbursements to service providers.

The second factor is the effect of health care reform requiring a redesign of the clinical delivery system. The Affordable Care Act (ACA) represents a transition from fee-for-service reimbursement to a results-based reimbursement. It is no longer about how many services a provider can provide, but the quality of those services, often referred to as "population health."

Mergers have been utilized to accommodate the foregoing two factors by realigning services to achieve greater scale of operations, an improvement in quality of care and/or enhanced access to care. Variations on mergers with these goals in mind include strategic partnerships and shared-service agreements essentially consisting of purchasing networks.

These changes all bring greater opportunity for conflict. They include contractual disputes over purchase price adjustments, valuations due to earn-out provisions, representations and warranties and countless other contractual provisions contained in the governing documents. Likewise, non-contractual disputes will arise out of the natural friction occurring in any combination of two previously independent companies.

## Contractual Disputes

Dispute resolution should be addressed in the acquisition agreement itself, and the arbitration clause in that agreement should be crafted with greater care than is typically the case. Parties should attempt to incorporate the rules of arbitration providers specifically designed for arbitration in order to avoid the ambiguity inherent in references to statutes designed for civil litigation. The number of arbitrators and the possibility of appellate review should also be considered.

Given the unknowns created by these changes, it is possible that buyers in such transactions may insist upon earn-out provisions, in which final numbers are dependent upon future revenue or profit. The earn-out portion of any transaction may constitute a significant portion of the purchase price and thus is a likely source of future conflict.

## Non-Contractual Disputes

The mix of new bosses, new co-workers and changed goals will create its own set of pressures with which we have had prior experience. The shift to the emphasis on population health under the ACA, however, places most providers in uncharted territory. They will be creating goals and metrics for values that have little, if any, historical bases. This uncertainty should cause parties to seriously consider the need for compromise in the form of negotiation or mediation.

The volume of consolidations in health care will apparently continue to increase. The conflicts inherent in any mixture of entities and cultures, as well as the conflicts likely to arise from the redesign of the clinical delivery system, will also continue to rise in number. Contract disputes should be dealt with through a thoughtfully articulated dispute resolution process set forth in the governing documents themselves. Other disputes likely to arise are common to the workplace and lend themselves to other existing processes, including early negotiation and mediation. •

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