

A Discussion about Alternative Dispute Resolution in the Healthcare Field

Preface by Harry N. Mazadoorian

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Preface

Alternative Dispute Resolution (ADR) growth can be measured by many indicators. One of the most telling indicators is the substantial escalation of ADR use in various industries. Of all the industries where ADR use has increased, the healthcare industry has seen one of the most unprecedented escalations of use. Whether we think of claims lodged by patients against medical providers or disputes among increasingly complex healthcare organizations, the trend is indeed pronounced.

A host of occurrences serve as a testament to the increasing interest in ADR within the healthcare community. Just a few of these are the creation of the American Bar Association Section of Dispute Resolution's Healthcare and ADR Committee; a medical ADR dispute resolution protocol adopted by the ABA, the American Medical Association, and the American Arbitration Association; and a discussion of ADR options in the *Handbook on Managing Conflict in Healthcare Organizations*, published by the American Hospital Association and the CPR Institute for Dispute Resolution.

A panel of Connecticut Bar Association healthcare and ADR experts recently reviewed the causes and implications of this phenomenon at a joint meeting of the Dispute Resolution and Health Law sections, and some of their comments are excerpted in this article in a question-and-answer format. Participating in the program were, Theodore J. Tucci, Patrick J. Monahan, and Stephen E. Ronai. Harry N. Mazadoorian served as the panel moderator.

Discussion

Harry Mazadoorian: Steve Ronai, can you give us a little background on the magnitude and growth of the healthcare industry, which might help us put this phenomenon in perspective?

Stephen Ronai: Our extraordinarily expensive healthcare system, which consumed \$1.8 trillion dollars and 15 percent of our gross domestic product in the last fiscal year, has fueled attempts by federal and state regulatory agencies and managed care organizations ("MCOs," "HMOs") to curb escalating healthcare costs. Those revenue reductions have necessitated countervailing formation by physicians and hospitals of provider joint venture organizations to control their service costs and to preserve their quality patient care professional service autonomies. New versions of corporate, LLC, or partnership organizational provider formats have been formed to assert bargaining leverage to combat the MCOs' imposition of "medical necessity" MCO/HMO plan coverage denials and subscriber benefit payment restrictions. To attain leverage in billing and claim payments and in the widening of MCO patient/subscriber coverage, physicians formed independent practice associations ("IPAs") and joined physician/hospital organizations ("PHOs"), formed preferred provider organizations ("PPOs"), and entered other joint ventures to provide

collective bargaining reimbursement parity. These complex hospital/physician legal frameworks inherently produce controversies, including: 1) disputes between providers and payers over MCO coverage and “medical necessity” payment denials, 2) provider exclusions from MCO provider networks, 3) provider clashes over the allocation of joint venture earned income among those contesting providers, and 4) medical staff clinical privilege limitation disputes, among others. These complex, conflict-ridden relationships between payers, providers, and regulatory agencies demonstrate a growing need for ADR for the timely resolution of these recurrent disputes.

Mazdoorian: Ted Tucci, can you give us your take on how extensive the use of ADR in the healthcare industry has become and how effective that use is?

Ted Tucci: In recent years, the use of various forms of alternative dispute resolution mechanisms has grown significantly in the healthcare industry. Stakeholders in the industry—including hospitals, physicians, and insurers—have become more accustomed to the idea that business, policy, or monetary disputes between key healthcare players can be resolved through means other than litigation. This increased awareness has led to an expansion of the types of ADR mechanisms through which healthcare disputes can be settled. Depending on the parties and issues involved, arbitration, private mediation, court sponsored mediation, and informal dispute resolution through direct negotiation have all been successfully used.

The increased success of ADR as a dispute resolution mechanism in the healthcare industry is no accident. Major players have come to appreciate that, despite their potential differences, our healthcare system cannot function in the absence of effective ongoing relationships between major players who deliver healthcare, manage healthcare systems, and pay for the delivery of healthcare. These interlocking and ongoing relationships provide a powerful incentive for participants in the healthcare field to find the most efficient and cost-effective way to resolve past disputes so that they can continue to do business together in the future.

Mazdoorian: As a follow-up question, is the use of ADR in healthcare becoming institutionalized?

Tucci: Not yet. When people think of ADR in the healthcare field, the most common and widespread perception is that ADR applies to the resolution of medical malpractice cases. While there have been some recent innovations in this area (Connecticut now has a statute that precludes alleged victims of medical malpractice from introducing expressions of apologies, fault, or sympathy as evidence of liability), the potential for ADR extends far beyond injuries caused by alleged medical negligence. Healthcare is a complex industry involving a myriad of business and contractual relationships in which ADR can and should be used as a resource to avoid litigation. Lawyers who represent various segments of the healthcare industry should give due consideration to building alternative dispute resolution provisions into contracts they negotiate for their clients.

Mazdoorian: Ted rightly points out that one area of healthcare ADR with the greatest potential is the area of medical malpractice claims. We’ve read a lot about the malpractice insurance crisis and escalating costs, a great deal of which is attributed to litigation and related costs. A number of the proposed solutions involve ADR, particularly mediation. For example, proposed federal legislation would mandate mediation prior to the institution of medical malpractice suits. An important

element of the mediation is the use of expressions of remorse by the healthcare provider. Ted has mentioned the Connecticut statute. In order to avoid healthcare providers from being disadvantaged by expressions of remorse, a number of other states have also initiated legislation to exclude the introduction of such expressions from subsequent litigation.

It is important to note that in Michigan, where the hospitals of the Michigan Health System have encouraged physician apologies for a number of years, a 50 percent drop in the number of filed claims has been reported.

Ted, it would appear that ADR will continue to play a major role in the healthcare dispute field. But surely it is not a panacea. When is it unlikely to work?

Tucci: The healthcare delivery and finance systems are highly regulated industries. Various aspects of physicians' practices or hospital operations are regulated by the Connecticut Department of Public Health or the Office of Healthcare Access. Healthcare insurers, managed care companies, utilization review companies, and the like are regulated by the Connecticut Insurance Department. Successful ADR is usually the product of a desire by private parties to resolve a dispute by reaching a mutually acceptable compromise. The relationship dynamics and incentives are often different when a regulator is involved in scrutinizing the activities of regulated entities. Regulators are typically interested in achieving compliance with standards imposed by statute or regulation. The compliance function in the regulatory context is often an obstacle to resolution by compromise. These differences make it more difficult to use ADR as a technique to resolve regulatory disputes.

Mazdoorian: Pat Monahan, would you share your thoughts about whether you view alternative dispute resolution as having any relationship to the development or advancement of *public policy* in healthcare?

Pat Monahan: I believe that ADR, and particularly the mediation process, has the potential to become an effective mechanism for aiding the development of public policy in healthcare. The key characteristics of mediation, namely the active involvement of an impartial third person, the interested parties' goal of reaching a resolution without declaring a "winner" or "loser," and the ability to exchange views and information informally, can be conducive to achieving consensus on certain types of contested statewide policy issues.

Mazdoorian: Any specific examples?

Monahan: A recent example of this involves the legislature's enactment last year of Public Act 05-213, An Act Concerning Access to Oral Healthcare, which revised the scope of practice for dentists, dental hygienists, and dental assistants and established conditions under which licensed dentists can practice oral and maxillofacial surgery. That statute resulted in large part from an innovative use of mediation to facilitate agreement among the interested professions and other stakeholders about what should or should not be within the scope of dentistry.

The process began in 2004 with the legislature's enactment of Special Act 04-7, An Act Concerning Oral Healthcare, which directed the Commissioner of Public Health to establish an *ad hoc* committee to examine and evaluate possible changes to the dentistry scope of practice statute for the purpose of improving access to and the quality of oral healthcare. The act also directed the commissioner to submit a report

of the results of the examination to the General Assembly, with recommendations for statutory changes.

The commissioner convened the *ad hoc* committee, which was comprised of, among others, individuals in and representing the dental and medical professions. The pertinent point for this discussion is that, in conducting the examination, the commissioner experimented with a new approach of actually mediating the differing views about the proper definition of dentistry and the other scope of practice issues before the committee. The Department of Public Health, along with the committee participants, utilized the services of a professional mediator to assist in reaching an agreement among the participants on the statutory changes that the committee would recommend to the legislature. The mediation was successful in that the committee's recommendations resulted in the enactment of Public Act 05-213, the new scope of practice statute.

Mazdoorian: As the mediator in this matter, I'd be interested in knowing what you feel are the implications, in your opinion, of this mediation.

Monahan: I applaud the Department and the committee participants for taking this innovative approach. It now serves as a concrete example for legislators, regulators, healthcare providers, and others interested in healthcare policy of how mediation is not limited to disputes between private parties and can be employed to effect change at the policy level.

Mazdoorian: Steve, let me ask you how the Connecticut practitioner can learn more about ADR and the field of healthcare:

Ronai: ADR arbitrators and mediators interested in extending their healthcare industry expertise can obtain insight into the organizational structures and the principles that support the legal framework for the entity networks and the complex contractual relationships between institutional (hospitals and nursing homes), individual (physician groups) providers, and governmental and (Medicare and Medicaid) and private (MHOs) payers. The American Health Lawyers Association (AHLA), a membership organization whose mission is to promote healthcare legal expertise through programs and publications, has its own ADR service, and the AHLA conducts healthcare training programs in dispute resolution techniques for active ADR practitioners. But it would be of greater help to ADR practitioners to become grounded in the important health law substantive legal principles than simply to pursue procedural training. Those who are interested should register and attend the AHLA "Fundamentals of Health Law" program, which is presented annually (customarily in Chicago) for the benefit of neophyte health law associates. That excellent two-day program would be of enormous educational benefit for the ADR practitioner seeking a substantive law foothold in the healthcare dispute resolution community.

Mazdoorian: This all sounds very promising. Let me close by asking you to comment on some possible areas of future or expanded use of ADR in the healthcare field.

Ronai: From my perspective, the two most important patient care provider constituencies within the healthcare industry will be experiencing a greater recurrence and concentration of disputes. Hospitals and other institutional providers of healthcare will be "facing-off" against physicians and other individual providers

of healthcare that provide patient care services at those institutions. Hospitals will increasingly engender conflict and controversy as they seek to limit medical staff (MS) membership to those physicians who sustain their hospital patient admission profiles and who remain “loyal” to the hospital’s economic interests. Hospitals may seek to terminate or reject MS membership/clinical privilege applicants if those physicians seek to develop ambulatory service centers, specialty hospital centers (cardiac, orthopedic), and other profitable specialty services that strip the hospital of substantial revenue. To insulate the hospital from physician conflict-of-interest commercial activity, MS members may be subjected to new and restrictive MS bylaw qualifications. Hospitals will attempt to persuade the medical staff leadership to amend its MS bylaws to impede the access of certain competitive and self-serving MS membership applicants. Hospitals will also seek to terminate the MS membership and clinical privileges of vested MS members through the application of “loyalty” or “economic credentialing” MS bylaw criteria, as attempts to cutoff and combat the physician’s scope of practice expansion and the economic competition with the hospital.

Mazdoorian: And what implications might these developments have for the ADR community?

Ronai: It is likely that healthcare lawyers and ADR specialists will be called upon to resolve disputes concerning: a) MS bylaw membership criteria modifications that will implement new “economic credentialing” criteria, b) disputes related to clinical privilege limitations or terminations of a MS members privileges by the MS department’s peer review committee, c) rejection of physicians’ MS initial admission applications or the non-renewal of a current MS members’ two-year reappointment applications on the basis of the application of the “economic credentialing” MS membership criteria.

To serve ably in the resolution of these disputes, ADR experts will be called upon to learn and study the clinical patient care standards that each of the physicians may have allegedly failed to observe. They will also have to study how the MS peer review processes function if they are to serve effectively in the settlement or adjudication of these disputes.

Tucci: As the business of delivering and paying for healthcare continues to change and become more complex in response to market, political, and legal developments, this will result in increased opportunities for the use of ADR to resolve disputes in the healthcare industry. For example, hospitals and physicians are increasingly entering into joint ventures and other cooperative business arrangements to deliver care outside of the traditional hospital setting. As these business relationships grow and become increasingly sophisticated, there will be a need to find a way to resolve disputes among these partners in a way that allows the collaborative relationships to continue. Building in an ADR mechanism as part of the business relationship between physicians and hospitals may be the best way to address that need.

In the area of healthcare insurance, the recent settlements of the physician class actions against managed care organizations have introduced a new level of transparency in the claims handling and payment process as well as new ways to address claim payment disputes. In many of these settlements, mechanisms exist to allow the parties to engage in various types of informal or formal dispute resolution procedures before litigation is pursued. These new ADR tools should lead to more efficient resolution of payment disputes between insurers and physicians.

Mazadoorian: Gentlemen, thank you. It appears that the growth and complexity in healthcare activities has already relied and, will even more greatly rely, on ADR processes in the future. There are certainly some challenging and exciting developments lying ahead.

Biographical

Harry N. Mazadoorian is the Distinguished Professor of Dispute Resolution Law from Practice at Quinnipiac University School of Law. He has mediated and arbitrated a number of healthcare related disputes and is the editor of the *Mediation Practice Book*.

Stephen E. Ronai is of counsel with the firm of Murtha Cullina LLP in New Haven. He is the former chairman of the Connecticut Hospital Association Board of Directors and is the former director of the American Health Lawyer's Association. He is also an adjunct professor at Quinnipiac University School of Law and teaches a seminar entitled, "The Regulation of the Healthcare Industry."

Theodore J. Tucci is a partner at Robinson & Cole LLP and is co-chair of the firm's Health Law Group. He represents healthcare clients in litigation, administrative, and regulatory matters. He also has extensive experience in peer review and medical staff privileges matters.

Patrick J. Monahan is general counsel and vice president, patient care regulation, of the Connecticut Hospital Association. He is involved in all aspects of the CHA's advocacy on behalf of CHA members, and he oversees legal and compliance matters for CHA and its affiliates. Prior to joining CHA, he was in private practice, focusing on healthcare and litigation.