ALTERNATE DISPUTE RESOLUTION
IN THE CONTEXT OF MULTI-STATE MANAGED CARE DISPUTES
BETWEEN LARGE PROVIDERS AND PAYORS

By Gregory J. Pepe,
Neubert, Pepe & Monteith, P.C.

The health care market is engaged in a consolidation of both provider groups and insurers. Among other aggregations, provider groups are combining into hospital-based mega-groups and networks of community-based and hospital-based clinicians. This consolidation is creating some of the largest health care provider groups this country has ever seen. Examples on the provider side are numerous … the Trinity Health Network consists of 88 hospitals in 21 states, with roughly 100,000 employees. National lab companies, dialysis centers, and other provider groups are changing the way health care is delivered and organized. On the payor side, the proposed mergers between Anthem Blue Cross and Cigna, and between Aetna and Humana will create the largest health insurance companies in the U.S., if approved by the FTC. Clearly the move toward "bigger is better" will have profound effects on the delivery of health care, but it will also create challenges to all those involved. For instance, when large national provider groups have disputes with payor organizations over claims being denied (or about the scores of other business arrangements between them) the numbers of claims involved can run into the tens and hundreds of thousands.

Most national managed care contracts between payors and providers contain provisions for dispute resolution which prevent the filing of class action litigation, and direct the parties to arbitration to resolve their differences. These dispute resolution contract provisions require the parties to engage in arbitration.

In one such recent arbitration, a national ancillary health care service provider claimed that a national payor entity had wrongfully denied over 30,000 claims for reimbursement. The provider contract between the parties called for the parties to attempt a resolution of the dispute by unstructured negotiations, but when those negotiations failed, both parties submitted the dispute to a panel of three arbitrators. As one of the arbitrators (appointed by the national health care provider), the prospect of receiving evidence on 30,000 disputed reimbursement claims and then deciding the validity of each claim was clearly not feasible. The time involved in hearing a single claim, multiplied times 30,000 claims would make the matter virtually impossible to resolve a claim at a time.

Managed care contracting is an odd assortment of generally familiar contracting principles coupled with provisions idiosyncratic to the health care industry. Contract terms such as "medical necessity," pre-authorization, and utilization review are inserted into the contract with the assumption that the parties know what they mean. Each side to the dispute selected arbitrators who they believed were well versed in both the jargon and concepts of the health care industry and the contexts in which disputes arise between providers and payors. The two arbitrators appointed by the combatants then selected an independent arbitrator who was a retired Connecticut judge. The independent arbitrator brought judicial temperament and structure to the process, while at the same time relying on the knowledge of the industry possessed by the party arbitrators.

In many instances where providers and payors retrospectively evaluate the performance of one another (especially in cases where reimbursement has been made), both parties are accustomed to looking at a small sample of reimbursements and claims, and statistically extrapolating from that sample to assess the damages of a much larger population. Both parties were comfortable with such an approach, and the arbitrators solicited their respective positions about the best way to statistically sample the 30,000 claims at issue.

Not surprisingly, the parties could not agree on the sampling method, so the arbitrators engaged the services of a third party analyst to devise a methodology for creating a representative sample (the analyst was engaged by the arbitrators but paid for by the combatants). The analyst determined that a sample size of roughly 1,200 claims, categorized by dollar amount and reason for denial (with that many claims, entire batches of claims were denied for the same reasons, such as, failure to include a timely physician certification for the services, or missing identifier information on the claim form) would be appropriate and fair to yield a margin of error in a range acceptable by all parties. Even so, an arbitration involving 1,200 separate claims, each of which need to be presented with all underlying documentation, argued and counter-argued, seemed a daunting task to achieve a resolution. Adding to the complexity was the likelihood that many claims would carry the potential for additional penalties and interest for failure to make timely payment pursuant to the so-called "Clean Claim" requirement in the state where jurisdiction was stipulated. The arbitrators worked with both parties to agree on the approach to sampling devised by the analyst. With a structure in place for handling the volume of claims, the arbitration was set to move forward.

The nature of how health care is delivered today creates thousands of claims for payment in a single day. It is no wonder that when disputes arise between providers and payors the initial dispute (and subsequent arbitration) often involves hundreds of thousands of claims, each of which represents a discreet service and invoice. Given the context of large provider groups seeking payment from large insurance companies, these disputes create an enormous volume of documentation and a need for more sophisticated, independent panels of arbitrators familiar with the managed care paradigm, who are willing and capable of providing a fair and reasonable process for the resolution of these disputes. These disputes often involve tens of millions of dollars of unreimbursed, or over-reimbursed health care services. As a consequence, even if it requires the expenditure of additional resources, the parties involved have ample reason to take on the burden of funding and pursuing the arbitration. For the arbitrators, involvement in cases such as these will undoubtedly require attentiveness to the case details, and a substantial amount of professional time to adjudicate the disputes fairly. One thing is for certain. Even with the expenditures of large sums of money and corporate resources to pursue these types of claims, alternative dispute resolution structures represent a way to streamline the resolution when compared to affecting a resolution in court.

The emergence of large health care provider groups and networks presages large and complex arbitrations when the parties have disputes. A panel of arbitrators familiar with managed care business and clinical issues will increasingly be necessary to hear and decide these disputes if the move toward bigger and bigger health care networks is to be successful.

Gregory J. Pepe, founding principal of Neubert, Pepe & Monteith, P.C., practices in the areas of commercial finance, healthcare law, alternative dispute resolution and mediation, and general business law. Attorney Pepe represents numerous physician groups, including large integrated practices, IPAs, and PHOs and has been an advisor to a number of state medical societies, including the Connecticut State Medical Society, regarding physician practice management issues within the context of organized medicine and regarding initiation of litigation by medical societies against managed care companies.

Note: This article was originally published in the Connecticut Law Tribune, December 14, 2015, Alternative Dispute Resolution Special Section.