1201 L Street, NW, Washington, DC 20005
T: 202-842-4444
F: 202-842-3860
www.ahca.org

October 14, 2015

Andrew M. Slavitt
Acting Administrator
Attn: CMS-3260-P
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-3260-P: Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities; Proposed Rule

Dear Mr. Slavitt:

The mission of the American Health Care Association (AHCA) is to improve lives by delivering solutions for quality care. As the nation's largest association of long-term and post-acute care providers, AHCA advocates for quality care and services for frail, elderly, and disabled Americans. Our members provide essential care to approximately one million individuals in 12,000 not-for-profit and proprietary member facilities.

In its Proposed Rule, *Reform of Requirements for Long-Term Care Facilities*, 80 Fed. Reg. 42,168 (July 16, 2015) (Proposed Rule), the Centers for Medicare & Medicaid Services (CMS) proposes to add a new subsection (n) to 42 C.F.R. § 483.70 that would, for the first time in the 50-year history of the Medicare and Medicaid programs, limit the exercise of federal arbitration rights belonging to skilled nursing facilities and nursing facilities (SNFs/NFs), as well as their residents.[1] CMS also solicited comments on whether it should ban the use of such agreements altogether.[2]

AHCA strongly opposes CMS's arbitration-related proposals, and comments separately on them to underscore the importance of this issue to the entire long-term care profession. As outlined below, CMS's arbitration-related proposals should be withdrawn for three independent reasons: (1) the proposals exceed CMS's statutory authority; (2) the proposals are not necessary to protect resident health and safety; and (3) many of the stated factual and legal grounds for the proposals are incorrect.

[1] Proposed Rule, 80 Fed. Reg. at 42,264–65.

[2] *Id.* at 42,211, 42,242.

1. The Arbitration-Related Proposals Exceed CMS's Statutory Authority

The Proposed Rule does not identify precisely on what statutory basis CMS believes it has the authority to regulate arbitration agreements between SNFs/NFs and their residents.[3] Importantly, the Proposed Rule wholly ignores the federal statute that protects the right of SNFs/NFs and their residents to enter into arbitration agreements, free from interference by federal agencies.

For nearly a century, the Federal Arbitration Act (FAA) has instructed that "[a] written provision in . . . a contract evidencing a transaction involving commerce to settle by arbitration a controversy thereafter arising out of such contract or transaction, . . . shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract."[4] As the Supreme Court of the United States has emphasized on several occasions—including a unanimous decision confirming the FAA's protection of arbitration agreements between SNFs/NFs and their residents—the FAA "reflects an emphatic federal policy in favor of arbitral dispute resolution."[5]

Unsurprisingly, therefore, federal and state courts have repeatedly rejected efforts to regulate the use of arbitration agreements between SNFs/NFs and their residents.[6] Although the Proposed Rule correctly observes that arbitration "is favored by the courts,"[7] the Proposed Rule ignores the federal statutory command that requires judicial favoritism of arbitration.

---

[3] *See id.* at 42,173 (describing statutory authority for long-term care requirements generally).

[4] Act of Feb. 12, 1925, ch. 213, § 2, 43 Stat. 883 (codified at 9 U.S.C. § 2).

[5] *Marmet Health Care Ctr., Inc. v. Brown*, 132 S. Ct. 1201, 1203 (2012) (per curiam) (internal quotation marks and citation omitted).

[6] *See, e.g.*, *Valley View Health Care, Inc. v. Chapman*, 992 F. Supp. 2d 1016, 1040–41 (E.D. Cal. 2014) (finding FAA preempted California statutes and regulations purporting to render unenforceable SNF/NF residents' waiver of right to commence court-based litigation); *Rainbow Health Care Ctr., Inc. v. Crutcher*, No. 07-CV-194-JHP, 2008 WL 268321, at *8 (N.D. Okla. Jan. 29, 2008) (finding FAA preempted Oklahoma statute purporting to render unenforceable SNF/NF residents' waiver of right to commence court-based litigation); *Carter v. SSC Odin Operating Co.*, 927 N.E.2d 1207, 1214–20 (Ill. 2010) (finding FAA preempted Illinois statute purporting to render unenforceable SNF/NF residents' waiver of right to commence court-based litigation); *In re Nexion Health at Humble, Inc.*, 173 S.W.3d 67, 69 (Tex. 2005) (finding FAA protected arbitration agreement between SNF/NF and its resident, and preempted a Texas statute requiring attorney's signature on arbitration agreements involving personal-injury claims); *Owens v. Coosa Valley Health Care, Inc.*, 890 So. 2d 983, 987–88 (Ala. 2004) (finding FAA protected arbitration agreement between SNF/NF and its resident); *Estate of Ruszala v. Brookdale Living Cmtys., Inc.*, 1 A.3d 806, 818–19 (N.J. Super. Ct. App. Div. 2010) (finding FAA preempted New Jersey statute purporting to render unenforceable SNF/NF residents' waiver of right to commence court-based litigation); *Triad Health Mgmt. of Ga., III, LLC v. Johnson*, 679 S.E.2d 785, 787–88 (Ga. Ct. App. 2009) (finding FAA protected arbitration agreement between SNF/NF and its resident).

[7] 80 Fed. Reg. at 42,242.

AHCA acknowledges that Congress has granted CMS statutory authority to issue regulations relating to such things as resident health and safety.[8] However, as demonstrated by a federal appellate court's recent rejection of another federal agency's attempted regulation of arbitration rights, such broadly worded statutory provisions do not supply the requisite congressional command to override the FAA.[9] Congress uses unambiguous statutory language when it intends to give a federal agency the authority to prohibit or impose conditions on the use of arbitration agreements.[10] No statute grants CMS such authority.

The legislative histories of the Medicare Act and the Medicaid Act also do not contain any evidence that Congress intended to give CMS the authority to regulate arbitration agreements. In fact, Congress has repeatedly *rejected* efforts to amend the FAA in order to regulate the use of arbitration agreements by SNFs/NFs and their residents. In the past decade, five such bills have been introduced in Congress.[11] Not one has passed even a single House of Congress.

---

[8] *See* Social Security Act § 1819(d)(4)(B), 42 U.S.C. § 1395i-3(d)(4)(B) ("A [SNF] must meet such other requirements relating to the health, safety, and well-being of residents . . . as the Secretary may find necessary."); Social Security Act § 1919(d)(4)(B), 42 U.S.C. § 1396r(d)(4)(B) (providing same with respect to NFs); *see also* Proposed Rule, 80 Fed. Reg. at 42,173 (citing foregoing statutory provisions as principal basis for imposing long-term care requirements generally).

[9] *See D.R. Horton, Inc. v. NLRB*, 737 F.3d 344, 360–62 (5th Cir. 2013) (rejecting National Labor Relation Board's assertion that broadly worded provisions of the National Labor Relations Act gave it authority to prohibit certain arbitration agreements); *see also Davis v. S. Energy Homes, Inc.*, 305 F.3d 1268, 1277–80 (11th Cir. 2002) (rejecting Federal Trade Commission regulation prohibiting arbitration of certain warranty disputes because the regulation rested on an unreasonable interpretation of the Magnuson-Moss Warranty Act in light of Supreme Court FAA precedent); *Walton v. Rose Mobile Homes LLC*, 298 F.3d 470, 478 (5th Cir. 2002) (rejecting same Federal Trade Commission regulation because the "clear congressional intent in favor of enforcing valid arbitration agreements controls"); *Chamber of Commerce of U.S. v. Reich*, 74 F.3d 1322, 1332–39 (D.C. Cir. 1996) (finding statute granting President broad procurement authority did not give him authority to issue an executive order conflicting with another federal statute); *Rainbow Health Care Ctr.*, 2008 WL 268321, at *7–8 (rejecting argument that Medicaid Act gave States discretion to regulate arbitration agreements between NFs and their residents).

[10] *See* 12 U.S.C. § 5518(b) (authorizing the Consumer Financial Protection Bureau to, "by regulation, . . . prohibit or impose conditions or limitations on the use of an agreement between a covered person and a consumer for a consumer financial product or service providing for arbitration of any future dispute between the parties"); 15 U.S.C. § 78o(o) (authorizing the Securities and Exchange Commission to, "by rule, . . . prohibit, or impose conditions or limitations on the use of, agreements that require customers or clients of any broker, dealer, or municipal securities dealer to arbitrate any future dispute between them arising under the Federal securities laws"); *see also* Department of Defense Appropriations Act, 2010, Pub. L. No. 111-118, § 8116, 123 Stat. 3409, 3454 (2009) (prohibiting expenditure of appropriated funds unless certain government contractors and subcontractors agree not to use particular arbitration agreements).

[11] *See* Fairness in Nursing Home Arbitration Act of 2012, H.R. 6351, 112th Cong.; Fairness in Nursing Home Arbitration Act of 2009, H.R. 1237, 111th Cong.; Fairness in Nursing Home Arbitration Act, S. 512, 111th Cong. (2009); Fairness in Nursing Home Arbitration Act of 2008, H.R. 6126, 110th Cong.; Fairness in Nursing Home Arbitration Act, S. 2838, 110th Cong. (2008).

Nor is there any inherent conflict between the FAA and the statutes granting CMS authority to promulgate regulations in this context. In fact, over a decade ago, CMS itself explained that "[u]nder Medicare, whether to have a binding arbitration agreement is an issue between the resident and the nursing home."[12] Five years later, the Secretary of Health and Human Services officially opposed proposed legislation that would have amended the FAA in order to render unenforceable arbitration agreements between SNFs/NFs and their residents.[13] In doing so, the Secretary explained that the "existence of a binding arbitration agreement does not in any way affect the ability of a State survey agency or CMS to cite facilities for violations of certain regulatory requirements, including those for quality of care."[14]

Accordingly, a complete ban on the use of arbitration agreements by SNFs/NFs and their residents would clearly run afoul of the FAA and exceed CMS's statutory authority. The same is true of the proposed new subsection (n) to § 483.70, which seeks to impose legal requirements that do not apply to contracts generally.

For example, there is no generally applicable contract requirement that one party must explain the agreement to the other party prior to the other party's signature (proposed § 483.70(n)(1)(i)), nor is there any generally applicable contract principle that prohibits a party from refusing to do business with another party unless that other party agrees to arbitrate future disputes (proposed § 483.70(n)(3)). The same is true of a requirement that a party wishing to arbitrate future disputes can only agree to do so by using a stand-alone arbitration agreement, which requirement the Proposed Rule's commentary—but not its regulatory text—would impose.[15] All such requirements single out arbitration for special treatment and are indistinguishable from the types of requirements the Supreme Court has held violate the FAA.[16] Therefore, CMS should withdraw its arbitration-related proposals in their entirety.[17]

---

[12] Mem. from Steven A. Pelovitz, Dir., Survey & Certification Grp., CMS, to Survey & Certification Grp. Reg'l Office Mgmt., et al. (Jan. 9, 2003) (Pelovitz Memorandum) (copy attached as Exhibit A).

[13] H.R. Rep. No. 110-894, at 13–15 (2008) (Letter from Michael O. Leavitt, Sec'y of Health & Human Servs., to H. Comm. on the Judiciary (July 29, 2008)).

[14] *Id.* at 14.

[15] 80 Fed. Reg. at 42,211.

[16] *See, e.g.*, *Doctor's Assocs., Inc. v. Casarotto*, 517 U.S. 681, 687 (1996) (finding FAA preempted state statute declaring arbitration clauses unenforceable unless notice that disputes were subject to arbitration was typed in underlined capital letters on the first page of the contract, and citing with approval commentary explaining that the FAA prevents "requiring greater information or choice in the making of agreements to arbitrate than in other contracts") (internal quotation marks and citation omitted).

[17] The proposed new subsection (n) to § 483.70 would expressly require that the agreement "[b]e entered into by the resident voluntarily." 80 Fed. Reg. at 42,265 (proposed § 483.70(n)(2)(i)). Such a requirement already exists under legal principles applicable to contracts generally. *See, e.g.*, *Casarotto*, 517 U.S. at 687 (explaining FAA does not displace "generally applicable contract defenses" such as duress); Restatement (Second) of Contracts § 175(1) (1981) ("If a party's manifestation of assent is induced by an improper threat by the other party that leaves the victim no

(footnote continued)

2. The Arbitration-Related Proposals Are Not Necessary to Protect Resident Health and Safety

As noted above, Congress has granted CMS statutory authority to promulgate regulations relating to resident health and safety, but only to the extent such regulations are, in fact, "necessary."[18] In an apparent effort to tie its arbitration-related proposals to the health-and-safety requirement imposed by the Medicare Act and the Medicaid Act, the Proposed Rule states that the

> increasing prevalence of [arbitration] agreements *could* be detrimental to residents' health and safety and *may* create barriers for surveyors and other responsible parties to obtain information related to serious quality of care issues. This results not only from the residents' waiver of judicial review, but also from the *possible* inclusion of confidentiality clauses that prohibit the resident and others from discussing any incidents with individuals outside the facility, such as surveyors and representatives of the Office of the State Long-Term Care Ombudsman.[19]

AHCA is unaware of any instance in which arbitration agreements between SNFs/NFs and their residents have precluded residents or family members from expressing quality-of-care concerns with government officials. Even if such an unusual practice existed, it would be remedied by CMS's proposed new § 483.11(i), which precludes SNFs/NFs from prohibiting or discouraging residents from communicating with government officials.[20] This latter provision does not single out arbitration for special treatment and therefore does not run afoul of the FAA.

Furthermore, the Proposed Rule merely speculates that the use of arbitration agreements could theoretically be detrimental to resident health and safety. However, as one federal court explained in rejecting a similar argument made by state officials seeking to regulate NFs' arbitration agreements, such speculation "simply perpetuates the historical prejudice against arbitration agreements that Congress sought to eradicate when it enacted the FAA some [90] years ago."[21]

---

reasonable alternative, the contract is voidable by the victim."). Therefore, the proposed regulatory language is unnecessary.

[18] Social Security Act § 1819(d)(4)(B), 42 U.S.C. § 1395i-3(d)(4)(B); Social Security Act § 1919(d)(4)(B), 42 U.S.C. § 1396r(d)(4)(B).

[19] 80 Fed. Reg. at 42,211 (emphasis added).

[20] *Id.* at 42,253.

[21] *Rainbow Health Care Ctr.*, 2008 WL 268321, at *7; *see also* H.R. Rep. No. 110-894, at 19 ("No record has been established demonstrating that mandatory binding arbitration is unfair to [SNF/NF residents] and their families.") (statement of Rep. Lamar Smith, et al., H. Comm. on the Judiciary).

The Proposed Rule's suggestion that "judicial review" promotes resident health and safety, while arbitration does not, is also unfounded. The suggestion appears to presume that the outcome of arbitration is always confidential, whereas the outcome of court-based litigation is always made public. However, as Stephen J. Ware, a law professor who specializes in arbitration issues, explained during a colloquy at a Senate hearing over seven years ago:

> I think it is important to remember that the public accountability we all want for negligent nursing homes can come through arbitration just as through litigation.
>
> People have used the word "secret" to describe arbitration. But, again, that gets to the rare arbitration clause that requires parties to the dispute to keep the dispute confidential, and courts tend not to enforce those. . . . So parties to arbitration who want to expose to the public the negligence are free to do so.
>
> CHAIRMAN KOHL. Yes, but that is a voluntary thing. When you go to court, it is not voluntary.
>
> MR. WARE. Well, that is certainly true that the public, members of the public, can walk into a courtroom uninvited and typically cannot do that in arbitration. That is right. But the people who have an incentive to make publicly known negligence or a dispute in arbitration, the parties and their lawyers[,] are free to do so.
>
> CHAIRMAN KOHL. Yes, but they could be paid, as so often occurs in other situations, a certain amount of money to keep it confidential.
>
> MR. WARE. Oh, yes, Senator. But when you come to a settlement agreement that has a confidentiality clause, that is an important issue that I know you have worked on. But it is an important issue in arbitration and in litigation equally. *That concern of settlement secrecy is not something particular to arbitration*.[22]

Lastly, the determination whether a new regulation is "necessary"—meaning that it is "needed for some purpose or reason; essential"[23]—must also take into account the costs imposed by the new regulation.[24] The Proposed Rule indicates that CMS made no effort to estimate the costs

---

[22] *S. 2838, the Fairness in Nursing Home Arbitration Act: Joint Hearing Before the Subcomm. on Antitrust, Competition Policy, and Consumer Rights of the S. Comm. on the Judiciary, and the S. Spec. Comm. on Aging*, 110th Cong. 24–25 (2008) (emphasis added).

[23] Black's Law Dictionary 1456 (10th ed. 2014).

[24] *See, e.g.*, *Michigan v. EPA*, 135 S. Ct. 2699, 2707 (2015) (rejecting agency's argument that it could disregard cost in determining whether a regulation was "appropriate and necessary").

that would be imposed by its proposed new § 483.70(n).[25] Such costs—on SNFs/NFs, residents, and the already-overburdened state and federal judiciaries—would be substantial. For example, not only would SNFs/NFs have to dedicate the personnel and time necessary to comply with new arbitration-specific requirements imposed by § 483.70(n), implementing a regulation with the intended effect of forcing more disputes into court could cause SNFs/NFs to cease doing business altogether in geographic markets where arbitration has brought some semblance of reason back to the dispute-resolution process. Indeed, it is the absence of such reason that motivated many SNFs/NFs to begin using arbitration agreements in the first place.[26] At a minimum, a regulation making it more difficult for SNFs/NFs and their residents to enter into arbitration agreements would undoubtedly have the effect of increasing the already-significant cost of liability insurance for SNFs/NFs, while also greatly increasing the expense of resolving claims generally.[27]

Such costs must be considered when determining whether the proposed new § 483.70(n) is, in fact, "necessary." When those potentially astronomical costs are considered, they clearly outweigh whatever speculative benefit might be achieved by subjecting more disputes to the delay and expense that accompanies "judicial review."

3. The Arbitration-Related Proposals Are Based on Incorrect Factual and Legal Assertions

Finally, even if one assumed for the sake of discussion that CMS has the statutory authority to regulate the use of arbitration agreements by SNFs/NFs and their residents in spite of the FAA, and even if one assumed for the sake of discussion that such regulations could be found theoretically necessary to promote resident health and safety, CMS's arbitration-related proposals should still be withdrawn because the Proposed Rule is predicated on several incorrect assertions.

First, the Proposed Rule suggests that CMS's arbitration proposals are driven by a recent change in business practices by SNFs/NFs. For example, the Proposed Rule asserts that the use of such agreements has grown in prevalence "in recent years."[28] In fact, SNFs/NFs and their residents have long used arbitration agreements as a means for providing efficient and timely dispute

[25] *See* 80 Fed. Reg. at 42,173 (table listing CMS cost estimates tied to specific regulatory sections, which do not include § 483.70), 42,238 (discussing costs imposed by only one provision within § 483.70, subsection (e)).

[26] *See, e.g.*, H.R. Rep. No. 110-894, at 20–21 (statement of Rep. Lamar Smith, et al., H. Comm. on the Judiciary) (discussing the explosion in runaway tort liability during the 1990s in Florida, Texas, and elsewhere as a causal factor for SNFs/NFs' use of arbitration agreements).

[27] *See* AON Global Risk Consulting, *American Health Care Association Special Study on Arbitration in the Long Term Care Industry* at 4 (June 16, 2009) (AON Report) (explaining average provider expenses for outcomes subject to arbitration agreements were 41 percent lower than outcomes not subject to such agreements) (copy attached as Exhibit B).

[28] 80 Fed. Reg. at 42,211.

resolution. A nationwide memorandum issued over a decade ago by CMS confirms that the use of arbitration agreements in this context is by no means a new phenomenon.[29] That conclusion was corroborated by a study performed by AON Global Risk Consulting at the request of AHCA.[30]

Second, the Proposed Rule states categorically that "binding arbitration requires that both parties waive the right to *any* type of judicial review or relief."[31] That is incorrect. The FAA, for example, expressly provides for judicial review of an arbitral award on several grounds, including that the award "was procured by corruption, fraud, or undue means,"[32] or that the arbitrators were "guilty of misconduct"[33] and "exceeded their powers."[34]

Third, the Proposed Rule appears to assume that arbitration agreements are not used by other types of Medicare and Medicaid providers. In fact, hospitals, physicians, and other providers use arbitration agreements with their patients.[35] CMS has provided no factual or legal justification for singling out SNFs/NFs for special treatment, nor are we aware of any legally cognizable ground for doing so.

Fourth, the Proposed Rule states that CMS was motivated to issue its arbitration-related proposals because of "concerns" raised by unidentified "stakeholders."[36] To meaningfully comment on CMS's proposals, AHCA submitted a request under the Freedom of Information Act (FOIA)[37] asking CMS to produce a copy of the "concerns" referenced in the Proposed Rule. By letter dated August 25, 2015, CMS informed AHCA that there was only one such document in CMS's files: a three-year-old letter submitted by the organization formerly known as the Association of Trial Lawyers of America (ATLA).[38]

---

[29] *See* Pelovitz Memorandum at 1 (explaining guidance was issued "in response to recent marketplace practices").

[30] *See* AON Report at 3 (discussing survey results showing widespread use of arbitration agreements prior to the Pelovitz Memorandum).

[31] 80 Fed. Reg. at 42,211 (emphasis added).

[32] 9 U.S.C. § 10(a)(1).

[33] *Id.* § 10(a)(3).

[34] *Id.* § 10(a)(4).

[35] *See, e.g.*, *Ruiz v. Podolsky*, 237 P.3d 584, 486 (Cal. 2010) (addressing enforceability of physician's arbitration agreement with patient); *Grazia v. Sanchez*, 502 N.W.2d 751, 753 (Mich. Ct. App. 1993) (addressing enforceability of hospital's arbitration agreement with patient).

[36] 80 Fed. Reg. at 42,241.

[37] 5 U.S.C. § 552.

[38] *See* Letter from Joseph Tripline, Dir., Div. of FOIA Analysis, CMS, to Lyn Bentley, Senior Dir. of Reg. Servs., AHCA (Aug. 25, 2015) (enclosing Letter from Marie Alice McLarty, Pres., Am. Ass'n for Justice, f/k/a Ass'n of Trial Lawyers of Am., to Patrick Conway, M.D., Dir., Office of Clinical Standards & Quality, CMS (Aug. 14, 2012) (ATLA Letter)) (copy attached as Exhibit C).

ATLA is an organization comprised of personal-injury lawyers. It is important to note that the ATLA Letter, which served as the catalyst for CMS's arbitration-related proposals, contains an inaccurate portrayal of the use of arbitration agreements by SNFs/NFs and their residents.

For example, the ATLA Letter claims—without any citation of authority whatsoever—that arbitration clauses are uniformly "buried in admissions documents and are drafted by attorneys using sophisticated legal terms."[39] Abundant case law demonstrates otherwise.[40] The ATLA Letter also claims—again without citation of any authority—that "[c]ourts have upheld [arbitration] clauses signed by residents who were illiterate or too disabled with dementia to understand the contract or its implications."[41] In fact, courts will invalidate arbitration agreements if they find that signatories lacked the mental capacity to contract, which is the type of generally applicable contract defense left intact by the FAA.[42] Lastly, the ATLA Letter makes the incredible assertion that "arbitration clauses bar *any* claims against a facility, even those for severe neglect and serious injuries."[43] In fact, arbitration agreements merely establish the forum in which the parties' legal claims will be decided; they do not "bar" legal claims against a facility.

ATLA's anti-arbitration correspondence is factually inaccurate, conveniently omits any mention of Congress's pro-arbitration policy choice embodied by the FAA, and is an especially faulty foundation on which to establish federal regulatory policy.

* * *

For the foregoing reasons, AHCA strongly urges CMS to withdraw its arbitration-related proposals in their entirety.

Sincerely,

Mark Parkinson
President & CEO

---

[39] ATLA Letter at 5.

[40] *See, e.g.*, *SSC Odin*, 927 N.E.2d at 1211 (describing plain language of underlying arbitration agreement); *Coosa Valley*, 890 So. 2d at 984–86 (same).

[41] ATLA Letter at 5.

[42] *See, e.g.*, *Gilmore v. Life Care Ctrs. of Am., Inc.*, 448 F. App'x 909, 910 (11th Cir. 2011) (per curiam) (affirming district court's determination that resident lacked the capacity to contract and therefore could not have entered into a valid arbitration agreement).

[43] ATLA Letter at 5.

Exhibit A:

Mem. from Steven A. Pelovitz, Dir., Survey & Certification Grp.,
Ctrs. for Medicare & Medicaid Servs., to Survey & Certification Grp.
Reg'l Office Mgmt., et al. (Jan. 9, 2003)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

Ref: S&C-03-10

DATE: January 9, 2003

FROM: Director
Survey and Certification Group

SUBJECT: Binding Arbitration in Nursing Homes

TO: Survey and Certification Group Regional Office Management (G-5)
State Survey Agency Directors

The purpose of this memorandum is to address the Centers for Medicare & Medicaid Services' (CMS) position regarding binding arbitration between nursing homes and prospective or current residents, in response to recent marketplace practices. Specifically, this memorandum addresses the use of an agreement that requires disputes between a prospective or current resident and the nursing home be resolved through binding arbitration either as a condition of admission or a condition of remaining in the nursing home. Under these agreements, the resident gives up his or her right to sue the nursing home through the judicial process.

CMS believes that its primary focus should be on the quality of care actually received by nursing home residents that may be compromised by such agreements, for the reasons set out below. Under Medicare, whether to have a binding arbitration agreement is an issue between the resident and the nursing home. Under Medicaid, we will defer to State law as to whether or not such binding arbitration agreements are permitted subject to the concerns we have where Federal regulations may be implicated. Under both programs, however, there may be consequences for the facility where facilities attempt to enforce these agreements in a way that violates Federal requirements.

Survey and Certification Guidance:

1. If a nursing home discharges a resident or retaliates due to an existing resident's failure to sign or comply with a binding arbitration agreement, the State and Region may initiate an enforcement action based on a violation of the rules governing resident discharge and transfer. A current resident is not obligated to sign a new admission agreement that contains binding arbitration. Federal regulations, at 42 C.F.R. §483.12(a)(2) limit the circumstances under which a facility may discharge or transfer a resident. None of the conditions specified in the regulation permit a facility to discharge or transfer a resident based on his or her failure to comply with the terms of a binding arbitration agreement. Additionally, a facility that retaliates against a resident who fails to sign or comply with the agreement is subject to an enforcement response based on its failure to comply with the obligation to furnish an abuse free environment under 42 C.F.R. §483.13(b) or other requirements bearing on the facility's obligation to provide quality care to all residents. The existence of a binding arbitration agreement does not in any way affect the ability of the State survey agency or CMS to assess citations for violations of certain regulatory requirements, including those for Quality of Care.

2. The Medicaid appeal procedures at 42 C.F.R. §431.200 et seq. apply to discharges or disputes of eligibility between the resident and the State Medicaid Agency and are not affected by a binding arbitration agreement.

Effective Date: This policy is in effect immediately.

Training: This policy should be shared with all appropriate survey and certification staff, their managers, and the state/regional office training coordinator.

/s/
Steven A. Pelovitz

Exhibit B:

AON Global Risk Consulting, *American Health Care Association Special Study on Arbitration in the Long Term Care Industry* (June 16, 2009)

The American Health Care Association

Special Study on Arbitration in the Long Term Care Industry

June 16, 2009

9841 Broken Land Parkway
Suite 305
Columbia, Maryland 21046

Table of Contents

Introduction

Purpose

The American Health Care Association ("AHCA") has retained Aon Global Risk Consulting ("Aon") to examine the prevalence, implementation and professional liability ("liability") claim cost impact of Alternative Dispute Resolution ("ADR" or "Arbitration") in the Long Term Care industry.

Scope

Our analysis relies on information collected through a voluntary data call distributed to AHCA and Alliance for Quality Nursing Care ("Alliance") members. The call consisted of a qualitative 19 item survey and a data request of closed claims.

The qualitative survey responses were used to support conclusions on the prevalence and implementation of ADR.

The claim data were used to examine differences between liability claims closed with and without ADR agreements in place.

* * * * * *

We performed this analysis using generally accepted actuarial principles and in accordance with all relevant Actuarial Standards of Practice.

Please contact us if you have any questions regarding this report.

Respectfully submitted,

Aon Global

Christian Coleianne, FCAS, MAAA
Associate Director and Actuary
+1.410.309.0741

Donald Riggins, FCAS, MAAA, CPCU
Associate Director and Actuary
+1.410.309.4539

Conditions and Limitations

Inherent Uncertainty

Actuarial calculations produce estimates of inherently uncertain future contingent events. We believe that the estimates provided represent reasonable provisions based on the appropriate application of actuarial techniques to the available data. However, there is no guarantee that actual future payments will not differ from estimates included herein.

Extraordinary Future Emergence

Our projections make no provision for the extraordinary future emergence of losses or types of losses not sufficiently represented in the historical data or which are not yet quantifiable.

Data Reliance

In conducting this analysis, we relied upon the provided data without audit or independent verification; however, we reviewed it for reasonableness and consistency. Any inaccuracies in quantitative data or qualitative representations could have a significant effect on the results of our review and analysis.

Use and Distribution

Use of this report is limited to the AHCA and the Alliance and their members for the specific purpose described in the Introduction section. Other uses are prohibited without an executed release with Aon.

Distribution by the AHCA and the Alliance is unrestricted. We recognize that this report may be distributed to third parties. We request that Aon be notified of further distribution of this report. The report should only be distributed in its entirety including all supporting exhibits.

Executive Summary

Summary of Results

Background

In recent years, the United States Congress has considered restricting the use of pre-dispute arbitration agreements in nursing home settings. The AHCA has noted the lack of data around the prevalence, implementation and impact on liability associated with Alternative Dispute Resolution (ADR or arbitration) agreements. This study is based on voluntary participation of providers, who submitted answers to a survey and provided closed claim data, with arbitrated outcomes identified.

Survey Summary

The fourteen respondents to our qualitative survey represent the operators of about 101,000 occupied skilled nursing beds in 2008. Based on CMS data as of December 31, 2008, this translates to about 7% of the skilled nursing occupied beds in the country. The respondents include several large national corporations as well as a few regional or single state providers. Over the past five years, the respondents have operated beds in all states except Alaska, Delaware, Louisiana, Maine, New York and Vermont.

Based on the survey results, we conclude:

- ADR agreements have been offered as part of the admission process since at least 2002.
- All but one provider location was willing to accept residents without a signed ADR agreement.
- Nearly 70% of residents signed ADR agreements.
- No respondents used ADR agreements that attempted to limit awards.
- All respondents informed the applicant that the ADR agreement precluded a jury trial.
- Because nursing homes regularly accept new residents, the percentage of residents who agree to ADR agreements should be expected to rise.
- The providers primarily bear the expense associated with arbitration proceedings.
- While challenges are infrequent, the most common challenges involve the authority and capacity of the signatory to agree.

Closed Claim Summary

The eleven respondents to our closed claim data call represent the operators of about 70,000 skilled nursing occupied beds in 2008. Based on CMS data as of December 31, 2008, this is approximately 5% of the skilled nursing occupied beds in the country. Respondents provided closed claim information, with arbitration outcomes identified. The results are based on 1,518 claims closed between January 1, 2004 and December 31, 2008.

Based on the closed claim data, we conclude:

- For outcomes where ADR is not contested and outcomes that do not involve ADR, the likelihood of indemnity is the same; the presence or absence of ADR does not seem to impact whether or not indemnity is awarded.

- Average indemnity awards for outcomes subject to ADR agreements tend to be 35% lower than outcomes that are not subject to ADR agreements.
- Average provider expenses for outcomes subject to ADR agreements tend to be 41% lower than outcomes that are not subject to ADR agreements.
- Average provider total costs (indemnity plus expense) for outcomes subject to ADR agreements tend to be 37% lower than outcomes that are not subject to ADR agreements.
- About 23% of the claims with ADR agreements involved challenges to those agreements. The ADR agreements were upheld in over half of those challenges.
- Challenges to arbitration have the highest associated expense. Claims resolved after the ADR agreement is invalidated tend to have much higher total costs than those resolved after the ADR agreement is upheld. As the industry refines its ADR approach, challenges should contribute less to the expense of settlement.

Recommendations for Future Study

The industry would benefit from improved tracking of ADR as it relates to admissions and asserted claims. This would allow for better estimates of the prevalence of ADR and its impacts on claim costs, both on a national and state specific basis.

It may be useful in future research to examine open claims as well as closed claims. While the costs of these claims will be unresolved, the number of active claims proceeding with and without arbitration may be of interest.

Coding related to the disposition of the claims could not be reliably obtained. In our data call, we had attempted to learn how claims were settled; by arbitrated decision, mediated settlement, court decision, pre-trial settlement, or settlement during trial. Most respondents were unable to provide this information. This coding may have provided insights on the frequency and lifetime of settlement methods. The industry may benefit from tracking the way claims are resolved.

Because the most common challenge to ADR involves the authority and capacity of the signatory, an industry standard approach to determining and documenting authority may indicate best practices for ensuring the validity of the agreements.

Survey Findings

The respondents have offered ADR agreements as long ago as 1997, although the larger providers have more recent implementations.

We found one location for one provider that required applicants to agree to ADR only if they were transferring from another nursing home. All other locations and providers were willing to negotiate acceptance of an ADR agreement. While ADR is almost universally not a condition of admission, the agreements are offered at admission, and, once accepted, the residents rarely revoke their agreement. Almost 70% of the respondents' residents have signed arbitration agreements. This would suggest that, over time, the percentage of residents who have agreed to ADR will increase.

While all the respondents inform the applicant that the ADR agreement precludes a jury trial for subject disputes, providing additional information about ADR agreements is not common practice. Most respondents used an ADR agreement that was separate from the admission application. Of those that did not use a separate ADR agreement, all but one used special text formatting to bring attention to the agreement within the application. Respondents listed the resident as the primary authority to sign the ADR agreement, with various legal representatives as alternates. The respondents generally relied on admissions staff to verify authority.

None of the ADR agreements included limits on damages. The cost of arbitration proceedings primarily fell on the providers.

Most providers indicated their tracking systems for ADR are not robust. Admission records often include ADR agreements in the paper files. Claims files may include information on ADR agreements, but most commonly this is a text notation and not a coded field.

Per the respondents, challenges to the ADR agreements are rare. Most often, successful challenges involved whether the signatory had the proper authority or capacity to agree to ADR. Other issues cited are pressure to sign based on need for admission and the applicability of the ADR agreement to the decedent's heirs.

Closed Claim Findings

The respondents provided data on closed claims, coded for arbitration outcomes. The claims were categorized claims as Arbitrated without Challenge (ADR), Arbitrated-Contested and Found Valid (Upheld ADR), No ADR - Unenforceable ADR (Invalid ADR) and No ADR. We have combined the first two categories as Arbitrated and the second two categories as Not Arbitrated in the tables that follow.

We examined the data by state, by provider, by ADR category, by occurrence year and by year of closure.

Claim Distribution

We grouped the claims by the size of the indemnity award. This grouping was intended to show differences between claims with and without substantiated damages.

	Claims			
Indemnity Amount	**Non-Arbitration**		**Arbitration**	
No Payment	191	20.8%	121	20.2%
$0 to $25,000	151	16.4%	151	25.2%
$25,000 to $250,000	463	50.4%	291	48.5%
$250,000 to $1,000,000	98	10.7%	35	5.8%
Greater than $1,000,000	15	1.6%	2	0.3%
Total	918	100.0%	600	100.0%
Claims with Payment	727		479	

Just over 1 in 3 claims in our database were resolved under arbitration. It should be noted that more recent closure years have a higher concentration of arbitrated claims than older years. This is indicative of the growing influence of arbitration.

Claims that were subject to arbitration tended to be more concentrated in the $0-$25,000 category.

The population of claims with indemnity awards of over $1,000,000 is sparse for both arbitrated and non-arbitrated outcomes.

Indemnity

The average indemnity payment associated with an arbitrated outcome is about $90,000, about 35% less than the average indemnity payment associated with a non-arbitrated outcome of about $138,000.

	Average Indemnity	
Indemnity Amount	**Non-Arbitration**	**Arbitration**
No Payment	$-	$-
With Payment	$174,097	$113,120
Total	$137,874	$90,308

The tables below show the detail under Non-Arbitration and Arbitration. The Invalid ADR category shows outcomes where the ADR agreement was challenged and unenforceable. The Upheld ADR category shows outcomes where the ADR agreement was challenged and found valid.

Interestingly, claims where ADR is challenged are more likely to result in indemnity amounts, and those amounts tend to be higher than amounts awarded otherwise. The average indemnity amount for claims where ADR was challenged and found unenforceable was more than double any other category.

	Average Indemnity			
	Non-Arbitration		Arbitration	
Indemnity Amount	**No ADR**	**Invalid ADR**	**ADR**	**Upheld ADR**
No Payment	$-	$-	$-	$-
With Payment	$157,500	$322,791	$107,184	$146,680
Total	$122,188	$314,183	$84,379	$127,240
Number of Claims	843	75	517	83

Challenges to ADR may be more likely when the perceived injury is more serious, and the anticipation of compensation is greater. Conversely, when an injury is perceived to be less serious, the agreement is less likely to be challenged. Interestingly, for both unchallenged ADR and no ADR, plaintiffs are indemnified nearly 80% of the time. In other words, the presence or absence of ADR does not seem to impact whether or not indemnity is awarded.

	Frequency of Indemnity			
	Non-Arbitration		Arbitration	
Indemnity Amount	**No ADR**	**Invalid ADR**	**ADR**	**Upheld ADR**
No Payment	189	2	110	11
With Payment	654	73	407	72
Total	843	75	517	83
Likelihod of Indemnity	78%	97%	79%	87%

Expense

The average expense associated with an arbitrated outcome is about $33,000, while the average expense associated with a non-arbitrated outcome is about $56,000, a difference of about 41%.

When no indemnity awards are substantiated, the average expenses for arbitrated and non-arbitrated outcomes are very similar, around $15,000. But when damages are awarded, the expenses are much higher for non-arbitrated outcomes than for arbitrated outcomes.

	Average Expense	
Indemnity Amount	**Non-Arbitration**	**Arbitration**
No Payment	$16,058	$14,317
With Payment	$66,353	$37,371
Total	$55,888	$32,722

When an ADR agreement is challenged, the expenses associated with a claim are much higher, even when no damages are substantiated. In fact, average expenses associated with challenged ADR are higher than expenses associated with claims where no ADR was involved.

	Average Expense			
	Non-Arbitration		Arbitration	
Indemnity Amount	**No ADR**	**Invalid ADR**	**ADR**	**Upheld ADR**
No Payment	$15,793	$41,135	$12,357	$33,921
With Payment	$61,907	$106,179	$29,690	$80,788
Total	$51,569	$104,445	$26,002	$74,577
Number of Claims	843	75	517	83

Total Cost

When indemnity and expense components are combined, the average total cost of an arbitrated outcome is about $123,000, while the average cost of a non-arbitrated outcome is about $194,000, making arbitrated outcomes about 37% less costly.

	Average Total Cost	
Indemnity Amount	**Non-Arbitration**	**Arbitration**
No Payment	$16,058	$14,317
With Payment	$240,450	$150,491
Total	$193,763	$123,029

Similar to the breakouts above, unchallenged ADR claims have the lowest total cost. Challenged ADR claims are the highest cost claims.

	Average Total Cost			
	Non-Arbitration		Arbitration	
Indemnity Amount	**No ADR**	**Invalid ADR**	**ADR**	**Upheld ADR**
No Payment	$15,793	$41,135	$12,357	$33,921
With Payment	$219,407	$428,970	$136,874	$227,468
Total	$173,757	$418,628	$110,381	$201,817
Number of Claims	843	75	517	83

Challenge Rates

The coding allowed us to examine claims where the ADR agreements were challenged. We found that, of the 675 closed claims that involved ADR, 158, or about 23%, were challenged. Of these, 83, or just over half, were upheld. As noted above, the challenged claims were associated with higher overall costs.

	Challenge Rates	
Indemnity Amount	**Counts**	**Percent of ADR Claims**
Claims with ADR Agreements	675	100.0%
Challenged	158	23.4%
Upheld	83	12.3%

Time to Closure

We found that more recent closure years have a higher concentration of arbitrated resolutions, while older closure years have a higher concentration of non-arbitrated resolutions. This may distort time to closure results, and so we have presented the time to closure stratified by occurrence year.

From the table, there is not a consistent difference in the time to closure between arbitrated and non-arbitrated outcomes.

For older occurrence years, where there are fewer arbitrated outcomes, there is a gap between arbitrated and non-arbitrated outcomes, but this gap is favorable to arbitration for 2001, and unfavorable to arbitration for 2002 and 2003.

For 2004 and forward, the gap is much smaller, but neither arbitrated nor non-arbitrated outcomes are consistently settled more quickly. In addition, the relative number of claims in the non-arbitration dwindles for more recent occurrence years. This may be caused by non-arbitrated claims' taking longer to settle, or by the increased prevalence of arbitration among residents, and therefore claimants.

For future research, it may be worthwhile to examine the age and distribution of active claims, coded for arbitration.

	Average Occurrence to Close in Days			
	Non-Arbitration		Arbitration	
Occurrence Year	**Avg Days**	**Claim Count**	**Avg Days**	**Claim Count**
2001	1,433	118	1,230	14
2002	1,184	153	1,358	22
2003	852	230	1,030	50
2004	758	166	702	133
2005	593	107	605	152
2006	488	97	566	141
2007	342	42	364	75
2008	203	5	180	13
All Years Combined	870	918	655	600

Data

The data call for this study was first distributed on April 8, 2009, to AHCA and Alliance members specified by Priscilla Shoemaker and Alan Rosenbloom. Subsequently, the data call was shared with a broader group of risk managers by Dan Moriarty of Kindred Healthcare. A copy of the data call e-mail is attached to this report.

A conference call to discuss the data elements was conducted on April 16, 2009.

A soft close to data collection was established at April 30, 2009, and a hard close was established on May 20, 2009.

The survey data responses were provided by thirteen respondents. The survey questions are provided as part of this report. The respondents answered questions at a state level. All states were represented by at least one respondent except for Alaska, Delaware, Louisiana, Maine, Mississippi, New York and Vermont.

Fifteen data calls were returned. A number of responses were lacking some of the required data elements. We attempted to collect the missing data elements by directly contacting the respondents.

We limited included data in the following ways:

1. Claims closed on or after January 1, 2004. This eliminates uncertainty about the outcomes and limits the impacts of claim cost inflation.
2. Occurrences on or after January 1, 2001. Our data did not include information on ADR claims prior to 2001, and so all claims related to occurrences before January 1, 2001 were excluded to ensure consistency in the claims that were compared.
3. Claims without closed dates or valid arbitration codes were excluded. Without a date of closure, the time to resolve an occurrence could not be calculated. Without a valid arbitration code, the involvement of arbitration could not be determined.

Analysis

For the survey, responses were aggregated in a spreadsheet by question, respondent and state. Filters were used to isolate non-blank results.

For the closed claim data, the submitted data was examined to ensure that the required coding elements were present. Where data elements were missing, respondents were contacted. Most respondents were able to provide the missing data. The aggregated data was examined to identify occurrence years and closure years that provided the most appropriate comparisons between arbitrated and non-arbitrated outcomes.

Description of Exhibits

Survey Exhibits

Exhibit 1 shows the survey questions.

Exhibit 2 shows the 2008 bed counts by respondent and state for survey respondents.

Exhibit 3 shows the survey questions and responses for each of the respondents.

Closed Claim Exhibits

Exhibit 4 summarizes the claims data request

Exhibit 5 shows the 2008 bed count by respondent and state for claims data respondents.

Exhibits

AMERICAN HEALTH CARE ASSOCIATION
Arbitration Data Call
Summary of Questions
Company Name

The survey consists of 19 questions, summarized here.
You may wish to print this page
Click on the question to go to the sheet.

1. By state, when were ADR agreements first offered?
2. By state, what percentage of residents signs an ADR agreement (current estimate only)?
3. By state, is the ADR agreement substantially the same? Please note material differences by state.
4. In which states that you offer ADR is the acceptance a condition of admission?
5. In which states that you offer ADR are applicants informed that the agreement is not a condition of admission?
6. In which states that you offer ADR can the applicant revoke the agreement after signing it? What percentage revokes?
7. In which states that you offer ADR is the ADR agreement presented separately from the the admission application?
8. In which states that you offer ADR is the ADR agreement set apart by bold face, larger type or different color than the rest of the application?
9. In which states that you offer ADR do you offer the applicant a separate brochure, video or other educational opportunity related to ADR agreements?
10. In which states that you offer ADR does the ADR agreement expressly define the types of disputes (collection, damaged property, malpractice, etc) that are subject to the ADR process?
11. In which states that you offer ADR is the applicant informed that the ADR agreement precludes a jury trial for subject disputes?
12. In the states that you offer ADR, who has the authority to agree to arbitration? What is your process to ensure authority?
13. In the states that you offer ADR, what are the limits on punitive and economic damages?
14. In the states that you offer ADR, how are arbitrators selected?
15. In the states that you offer ADR, how are the costs of arbitration shared?
16. In the states that you offer ADR, do the admission records identify whether an ADR agreement has been signed?
17. In the states that you offer ADR, do the claims files identify whether an ADR agreement is applicable?
18. In the states that you offer ADR, do the claims files identify unsuccessful challenges to ADR?
19. In the states that you offer ADR, what are the most common successful challenges to ADR?

American Health Care Association
Special Study on Arbitration
2008 Bed Counts
Respondents Included in Survey Data

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
Alabama	581		NA			1,509			11,647		651				
Alaska															
Arizona			NA			0	413				153				
Arkansas	894					1,436	85		675						
California					4,460	1,835				3,669	1,197				
Colorado			NA				431				1,030				
Connecticut											1,232				
Delaware															
District of Columbia						0									
Florida	407		NA			0	210		810		1,021			NA	
Georgia			NA			1,423					884			NA	
Hawaii						0	44								
Idaho			NA				271				708				
Illinois			NA			0	204						NA		
Indiana			NA			2,568	165				182		1,906		
Iowa							1,469		271	NA		76			
Kansas			NA			968	1,017			NA					
Kentucky	440		NA			910	2,447				1,453		164		
Louisiana															
Maine															
Maryland						504					387				
Massachusetts						1,813					1,611				
Michigan			NA			0							85		
Minnesota			NA			1,993						897			
Mississippi						1,024									
Missouri						1,426			540	NA					
Montana							46				409				
Nebraska						1,809	1,349					28			
Nevada			NA							NA					
New Hampshire											910				
New Jersey			NA			125					142				
New Mexico							1,338			NA	792				
New York															
North Carolina			NA			1,140					803			NA	
North Dakota															
Ohio	99		NA			412	50	1,656			2,056		748		
Oklahoma			NA								754				
Oregon		1,207					229								
Pennsylvania			NA	945		4,032		736							
Rhode Island											238				
South Carolina			NA			0								NA	
South Dakota						1,042	1,082					295			
Tennessee	497		NA			521					628				
Texas	1,286		NA	2,601			441			2,780					
Utah											84				
Vermont															
Virginia			NA			1,534									
West Virginia	143					277	139				654				
Washington		731	NA			0	445								
Wisconsin			NA			2,139									
Wyoming											34				
All States	4,346	1,938	0	3,546	4,460	30,439	11,870	2,392	13,943	6,449	18,012	1,295	2,903	0	

Notes:
Provider C is the combination of two systems which recently merged. Each system had independently implemented ADR
Provider F implemented ADR in all states except AR on 9/1/02. Subsequently, Provider F has withdrawn from several listed states.
Provider O did not submit a survey.

American Healthcare Association
Special Study on Arbitration
Survey Responses

1 By state, when were ADR agreements first offered?

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
Alabama	7/1/2007		1/1/2003			9/1/2002			1/1/2002		1/1/2008			
Alaska														
Arizona			1/1/03 & 1/1/2004			9/1/2002	9/1/2005				1/1/2008			
Arkansas	10/1/2004					9/1/2004	9/1/2005		1/1/2002					
California					10+ years	9/1/2002				1/1/2003	1/1/2008			
Colorado			1/1/03 & 1/1/2004				9/1/2005				1/1/2008			
Connecticut											1/1/2008			
Delaware														
District of Columbia						9/1/2002								
Florida	10/1/2004		1/1/2001 & 1/1/03				6/1/2004		1/1/2002		1/1/2008			6/1/2004
Georgia			1/1/03 & 1/1/2004			9/1/2002					1/1/2008			6/1/2004
Hawaii						9/1/2002	9/1/2005							
Idaho			1/1/2004				9/1/2005				1/1/2008			
Illinois			1/1/2003			9/1/2002	9/1/2005						3/1/2009	
Indiana			1/1/2004			9/1/2002	9/1/2005				1/1/2008		12/1/1997	
Iowa							9/1/2005			4/1/2009		1/1/2003		
Kansas			1/1/2003			9/1/2002	9/1/2005			1/1/2005				
Kentucky	8/1/2005		1/1/2003			9/1/2002	9/1/2005				1/1/2008		12/1/1997	
Louisiana														
Maine														
Maryland						9/1/2002					1/1/2008			
Massachusetts						9/1/2002					1/1/2008			
Michigan			1/1/03 & 1/1/2004										4/1/2008	
Minnesota			1/1/03 & 1/1/2004			9/1/2002	9/1/2005					1/1/2003		
Mississippi						9/1/2002								
Missouri						9/1/2002			1/1/2002	3/1/2006				
Montana							9/1/2005				1/1/2008			
Nebraska						9/1/2002	9/1/2005					1/1/2003		
Nevada			1/1/03 & 1/1/2004							8/4/2004				
New Hampshire											1/1/2008			
New Jersey			1/1/2004			9/1/2002					1/1/2008			
New Mexico							9/1/2005			9/1/2007	1/1/2008			
New York														
North Carolina			1/1/03 & 1/1/2004			9/1/2002					1/1/2008			6/1/2004
North Dakota							9/1/2005							
Ohio	12/1/2006		1/1/2002 & 1/1/03			9/1/2002	9/1/2005	1/1/1998			1/1/2008		1/1/2005	
Oklahoma			1/1/03 & 1/1/2004								1/1/2008			
Oregon		est. 2004					9/1/2005							
Pennsylvania			1/1/2004	8/26/2003		9/1/2002		1/1/1998						
Rhode Island											1/1/2008			
South Carolina			1/1/03 & 1/1/2004											6/1/2004
South Dakota						9/1/2002	9/1/2005					1/1/2003		
Tennessee	5/1/2006		1/1/03 & 1/1/2004			9/1/2002	9/1/2005				1/1/2008			
Texas	N/A		1/1/03 & 1/1/2004	6/26/2005			9/1/2005			1/1/2002				
Utah											1/1/2008			
Vermont														
Virginia			1/1/03 & 1/1/2004			9/1/2002								
West Virginia	8/1/2007					9/1/2002	9/1/2005				1/1/2008			
Washington		est. 2004	1/1/2004			9/1/2002	9/1/2005							
Wisconsin			1/1/2004			9/1/2002	9/1/2005							
Wyoming											1/1/2008			
All States														

Notes:
Provider C is the combination of two systems which recently merged. Each system had independently implemented ADR
Provider F implemented ADR in all states except AR on 9/1/02. Subsequently, Provider F has withdrawn from several listed states.

American Healthcare Association
Special Study on Arbitration
Survey Responses

2 By state, what percentage of residents signs an ADR agreement (current estimate only)?

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
Alabama	86.0%		90.0%			65.0%			90.0%		53.8%			
Alaska														
Arizona			90.0%			65.0%	75.0%				45.9%			
Arkansas	92.0%					65.0%	75.0%		90.0%					
California					71.0%	65.0%				72.0%	25.4%			
Colorado			90.0%				75.0%				66.2%			
Connecticut											36.0%			
Delaware														
District of Columbia						65.0%								
Florida	94.0%		90.0%			65.0%	75.0%		90.0%		81.7%			90.0%
Georgia			90.0%			65.0%					50.6%			90.0%
Hawaii						65.0%	75.0%							
Idaho			90.0%				75.0%				54.9%			
Illinois			90.0%			65.0%	75.0%						100.0%	
Indiana			90.0%			65.0%	75.0%				82.2%		90.0%	
Iowa							75.0%			80.0%		90.0%		
Kansas			90.0%			65.0%	75.0%			76.0%				
Kentucky	71.0%		90.0%			65.0%	75.0%				56.7%		90.0%	
Louisiana														
Maine														
Maryland						65.0%					23.3%			
Massachusetts						65.0%					62.8%			
Michigan			90.0%			65.0%							95.0%	
Minnesota			90.0%			65.0%	75.0%					90.0%		
Mississippi						65.0%								
Missouri						65.0%			90.0%	64.0%				
Montana							75.0%				56.9%			
Nebraska						65.0%	75.0%					90.0%		
Nevada			90.0%							72.0%				
New Hampshire											48.5%			
New Jersey			90.0%			65.0%					53.3%			
New Mexico							75.0%			93.0%	37.3%			
New York														
North Carolina			90.0%			65.0%					26.9%			90.0%
North Dakota							75.0%							
Ohio	100.0%		90.0%			65.0%	75.0%	100.0%			54.5%		90.0%	
Oklahoma			90.0%								0.0%			
Oregon		50.0%					75.0%							
Pennsylvania			90.0%	58.0%		65.0%		99.9%						
Rhode Island											60.0%			
South Carolina			90.0%			65.0%								90.0%
South Dakota						65.0%	75.0%					90.0%		
Tennessee	77.0%		90.0%			65.0%	75.0%				37.9%			
Texas	N/A		90.0%	0.0%			75.0%			83.0%				
Utah											95.8%			
Vermont														
Virginia			90.0%			65.0%								
West Virginia	47.0%					65.0%	75.0%				50.4%			
Washington		50.0%	90.0%			65.0%	75.0%				49.4%			
Wisconsin			90.0%			65.0%	75.0%							
Wyoming						65.0%					100.0%			
All States														

Notes:
For Provider C, about half of residents sign an admission that contains the ADR agreement, about 80% of the rest sign a separate ADR agreement,
Provider K notes that ADR is unenforceable in Oklahoma

American Healthcare Association
Special Study on Arbitration
Survey Responses

3 By state, is the ADR agreement substantially the same? Please note material differences by state.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
Alabama	Same		Same			Same			Same		Same			
Alaska														
Arizona			Same			Same	Same				Same			
Arkansas	Same					Same	Same		Same					
California					Same	Same				Different	Different			
Colorado			Same				Same				Different			
Connecticut											Same			
Delaware														
District of Columbia						Same								
Florida	Different		Same			Same	Same		Same		Same			Different
Georgia			Same			Same					Same			Different
Hawaii						Same	Same							
Idaho			Same				Same				Same			
Illinois			Same			Same	Different						Same	
Indiana			Same			Same	Same				Same		Same	
Iowa							Same			Same		Same		
Kansas			Same			Same	Same			Same				
Kentucky	Same		Same			Same	Same				Same		Same	
Louisiana														
Maine														
Maryland						Same					Same			
Massachusetts						Same					Same			
Michigan			Same			Same							Same	
Minnesota			Same			Same	Same					Same		
Mississippi						Same								
Missouri						Same			Same	Same				
Montana							Same				Same			
Nebraska						Same	Same					Same		
Nevada			Same							Same				
New Hampshire											Same			
New Jersey			Same			Same					Same			
New Mexico							Same			Same	Same			
New York														
North Carolina			Same			Same					Same			Different
North Dakota							Same							
Ohio	Same		Same			Same	Same	Same			Same		Same	
Oklahoma			Same											
Oregon		Same					Same							
Pennsylvania			Same	Same		Same		Same						
Rhode Island											Same			
South Carolina			Same			Same								Different
South Dakota						Same	Same					Same		
Tennessee	Different		Same			Same	Same				Same			
Texas			Same	Same			Same			Same				
Utah											Same			
Vermont														
Virginia			Same			Same								
West Virginia	Same					Same	Same				Same			
Washington		Same	Same			Same	Same				Same			
Wisconsin			Same			Same	Same							
Wyoming						Same					Same			
All States														

Notes:
Provider A: FL follows Florida Arbitration Code instead of FAA NAF; TN is mediation first
Provider J uses a different form in California
Provider K uses different fonts, colors and bolded emphasis in CA; Colorado has a 90 day revocation period, longer than the standard 20 days period
Provider N forms have substantial differences in each state

American Healthcare Association
Special Study on Arbitration
Survey Responses

4 In which states that you offer ADR is the acceptance a condition of admission?

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
Alabama	Not		Not			Not			Not		Not			
Alaska														
Arizona			Not			Not	Not				Not			
Arkansas	Not					Not	Not		Yes					
California					Not	Not				Not	Not			
Colorado			Not				Not				Not			
Connecticut											Not			
Delaware														
District of Columbia						Not								
Florida	Not		Not			Not	Not		Yes		Not			Not
Georgia			Not			Not					Not			Not
Hawaii						Not	Not							
Idaho			Not				Not				Not			
Illinois			Not			Not	Not						Not	
Indiana			Not			Not	Not				Not		Not	
Iowa							Not			Not		Not		
Kansas			Not			Not	Not			Not				
Kentucky	Not		Not			Not	Not				Not		Not	
Louisiana														
Maine														
Maryland						Not					Not			
Massachusetts						Not					Not			
Michigan			Not			Not							Not	
Minnesota			Not			Not	Not					Not		
Mississippi						Not								
Missouri						Not			Yes	Not				
Montana							Not				Not			
Nebraska						Not	Not					Not		
Nevada			Not							Not				
New Hampshire											Not			
New Jersey			Not			Not					Not			
New Mexico							Not			Not	Not			
New York														
North Carolina			Not			Not					Not			Not
North Dakota							Not							
Ohio			Not			Not	Not	Not			Not		Not	
Oklahoma	Not		Not								Not			
Oregon		Not					Not							
Pennsylvania			Not	Not		Not		Not						
Rhode Island											Not			
South Carolina			Not			Not								Not
South Dakota						Not	Not					Not		
Tennessee	Not		Not			Not	Not				Not			
Texas			Not	Not			Not			Not				
Utah											Not			
Vermont														
Virginia			Not			Not								
West Virginia	Not					Not	Not				Not			
Washington		Not	Not			Not	Not				Not			
Wisconsin			Not			Not	Not							
Wyoming						Not					Not			
All States														

Notes:
Provider A notes one facility in AR requires ADR if the applicant was previously a resident in a LTC facility
Provider C notes that the ADR agreement is embedded in about half of its admissions applications, but they are willing to negotiate.
Provider I notes for question 5 that they will negotiate the ADR agreement with applicants.

American Healthcare Association
Special Study on Arbitration
Survey Responses

5 In which states that you offer ADR are applicants informed that the agreement is not a condition of admission?

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
Alabama	Yes		Yes			Yes			Yes		Yes			
Alaska														
Arizona			Yes			Yes	Yes				Yes			
Arkansas	Yes					Yes	Yes		Yes					
California					Yes	Yes				Yes	Yes			
Colorado			Yes				Yes				Yes			
Connecticut											Yes			
Delaware														
District of Columbia						Yes								
Florida	Yes		Yes			Yes	Yes		Yes		Yes			Yes
Georgia			Yes			Yes					Yes			Yes
Hawaii						Yes	Yes							
Idaho			Yes				Yes				Yes			
Illinois			Yes			Yes	Yes						Yes	
Indiana			Yes			Yes	Yes				Yes		Yes	
Iowa							Yes			Yes		Yes		
Kansas			Yes			Yes	Yes			Yes				
Kentucky	Yes		Yes			Yes	Yes				Yes		Yes	
Louisiana														
Maine														
Maryland						Yes					Yes			
Massachusetts						Yes					Yes			
Michigan			Yes			Yes							Yes	
Minnesota			Yes			Yes	Yes					Yes		
Mississippi						Yes								
Missouri						Yes			Yes	Yes				
Montana							Yes				Yes			
Nebraska						Yes	Yes					Yes		
Nevada			Yes							Yes				
New Hampshire											Yes			
New Jersey			Yes			Yes					Yes			
New Mexico							Yes			Yes	Yes			
New York														
North Carolina			Yes			Yes					Yes			Yes
North Dakota							Yes							
Ohio	Yes		Yes			Yes	Yes	Yes			Yes		Yes	
Oklahoma			Yes								Yes			
Oregon		Yes					Yes							
Pennsylvania			Yes	Yes		Yes		Yes						
Rhode Island											Yes			
South Carolina			Yes			Yes								Yes
South Dakota						Yes	Yes					Yes		
Tennessee	Yes		Yes			Yes	Yes				Yes			
Texas			Yes	Yes			Yes			Yes				
Utah											Yes			
Vermont														
Virginia			Yes			Yes								
West Virginia	Yes					Yes	Yes				Yes			
Washington		Yes	Yes			Yes	Yes				Yes			
Wisconsin			Yes			Yes	Yes							
Wyoming						Yes					Yes			
All States														

Notes:
Provider A notes one facility in AR requires ADR if the applicant was previously a resident in a LTC facility
Provider I notes that they will negotitate the ADR agreement with applicants.

American Healthcare Association
Special Study on Arbitration
Survey Responses

6 In which states that you offer ADR can the applicant revoke the agreement after signing it? What percentage revokes?

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
Alabama	Yes		Yes			Yes			Yes		Yes			
Alaska														
Arizona			Yes			Yes	No				Yes			
Arkansas	Yes					Yes	No		No					
California					Yes	Yes				Yes	Yes			
Colorado			Yes				No				Yes			
Connecticut											Yes			
Delaware														
District of Columbia						Yes								
Florida	Yes		Yes			Yes	No		No		Yes			Yes
Georgia			Yes			Yes					Yes			Yes
Hawaii						Yes	No							
Idaho			Yes				No				Yes			
Illinois			Yes			Yes	No						Yes	
Indiana			Yes			Yes	No				Yes		Yes	
Iowa							No			Yes		Yes		
Kansas			Yes			Yes	No			Yes				
Kentucky	Yes		Yes			Yes	No				Yes		Yes	
Louisiana														
Maine														
Maryland						Yes					Yes			
Massachusetts						Yes					Yes			
Michigan			Yes			Yes							Yes	
Minnesota			Yes			Yes	No					Yes		
Mississippi						Yes								
Missouri						Yes			No	Yes				
Montana							No				Yes			
Nebraska						Yes	No					Yes		
Nevada			Yes							Yes				
New Hampshire											Yes			
New Jersey			Yes			Yes					Yes			
New Mexico							No			Yes	Yes			
New York														
North Carolina			Yes			Yes					Yes			Yes
North Dakota							No							
Ohio	Yes		Yes			Yes	No	Yes			Yes		Yes	
Oklahoma			Yes								Yes			
Oregon		No					No							
Pennsylvania			Yes	Yes		Yes		Yes						
Rhode Island											Yes			
South Carolina			Yes			Yes								Yes
South Dakota						Yes	No					Yes		
Tennessee	Yes		Yes			Yes	No				Yes			
Texas			Yes	Yes			No			Yes				
Utah											Yes			
Vermont														
Virginia			Yes			Yes								
West Virginia	Yes					Yes	No				Yes			
Washington		No	Yes			Yes	No				Yes			
Wisconsin			Yes			Yes	No							
Wyoming						Yes					Yes			
All States														

Notes:
Provider B, Provider G and Provider I are the only providers that do not allow the applicant to revoke
Provider E had the highest estimated revocation at less than 5%.
All other providers listed revocation at 2% or less.
Provider F and Provider K do not have systems to track revocations.

American Healthcare Association
Special Study on Arbitration
Survey Responses

7 In which states that you offer ADR is the ADR agreement presented separately from the admission application?

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
Alabama	Yes		Yes			Yes			Yes		Yes			
Alaska														
Arizona			Yes			Yes	No				Yes			
Arkansas	Yes					Yes	No		No					
California					Yes	Yes				Yes	Yes			
Colorado			Yes				No				Yes			
Connecticut											Yes			
Delaware														
District of Columbia						Yes								
Florida	Yes		Yes			Yes	No		No		Yes			Yes
Georgia			Yes			Yes					Yes			Yes
Hawaii						Yes	No							
Idaho			Yes				No				Yes			
Illinois			Yes			Yes	No						Yes	
Indiana			Yes			Yes	No				Yes		Yes	
Iowa							No			Yes		Yes		
Kansas			Yes			Yes	No			Yes				
Kentucky	Yes		Yes			Yes	No				Yes		Yes	
Louisiana														
Maine														
Maryland						Yes					Yes			
Massachusetts						Yes					Yes			
Michigan			Yes			Yes							Yes	
Minnesota			Yes			Yes	No					Yes		
Mississippi						Yes								
Missouri						Yes			No	Yes				
Montana							No				Yes			
Nebraska						Yes	No					Yes		
Nevada			Yes							Yes				
New Hampshire											Yes			
New Jersey			Yes			Yes					Yes			
New Mexico							No			Yes	Yes			
New York														
North Carolina			Yes			Yes					Yes			Yes
North Dakota							No							
Ohio	Yes		Yes			Yes	No	No			Yes		Yes	
Oklahoma			Yes								Yes			
Oregon		Yes					No							
Pennsylvania			Yes	Yes		Yes		No						
Rhode Island											Yes			
South Carolina			Yes			Yes								Yes
South Dakota						Yes	No					Yes		
Tennessee	Yes		Yes			Yes	No				Yes			
Texas			Yes	No			No			Yes				
Utah											Yes			
Vermont														
Virginia			Yes			Yes								
West Virginia	Yes					Yes	No				Yes			
Washington		Yes	Yes			Yes	No				Yes			
Wisconsin			Yes			Yes	No							
Wyoming						Yes					Yes			
All States														

Notes:
Provider C notes that about half of its applications contain an embedded ADR agreement.
Provider G uses boldfaced type to highlight the ADR language

American Healthcare Association
Special Study on Arbitration
Survey Responses

8 In which states that you offer ADR is the ADR agreement set apart by bold face, larger type or different color than the rest of the application?

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
Alabama	No		No			Yes			Yes		Yes			
Alaska														
Arizona			No			Yes	Yes				Yes			
Arkansas	No					Yes	Yes		Yes					
California					Yes	Yes				Yes	Yes			
Colorado			No				Yes				Yes			
Connecticut											Yes			
Delaware														
District of Columbia						Yes								
Florida	No		No			Yes	Yes		Yes		Yes			No
Georgia			No			Yes					Yes			No
Hawaii						Yes	Yes							
Idaho			No				Yes				Yes			
Illinois			No			Yes	Yes						Yes	
Indiana			No			Yes	Yes				Yes		Yes	
Iowa							Yes			No		No		
Kansas			No			Yes	Yes			No				
Kentucky	No		No			Yes	Yes				Yes		Yes	
Louisiana														
Maine														
Maryland						Yes					Yes			
Massachusetts						Yes					Yes			
Michigan			No			Yes							Yes	
Minnesota			No			Yes	Yes					No		
Mississippi						Yes								
Missouri						Yes			Yes	No				
Montana							Yes				Yes			
Nebraska						Yes	Yes					No		
Nevada			No							No				
New Hampshire											Yes			
New Jersey			No			Yes					Yes			
New Mexico							Yes			No	Yes			
New York														
North Carolina			No			Yes					Yes			No
North Dakota							Yes							
Ohio	No		No			Yes	Yes	No			Yes		Yes	
Oklahoma			No								Yes			
Oregon		Yes					Yes							
Pennsylvania			No	Yes		Yes		No						
Rhode Island											Yes			
South Carolina			No			Yes								No
South Dakota						Yes	Yes					No		
Tennessee	No		No			Yes	Yes				Yes			
Texas			No	No			Yes			No				
Utah											Yes			
Vermont														
Virginia			No			Yes								
West Virginia	No					Yes	Yes				Yes			
Washington		Yes	No			Yes	Yes				Yes			
Wisconsin			No			Yes	Yes							
Wyoming						Yes					Yes			
All States														

Notes:
Provider G puts the ADR agreement in bold type

American Healthcare Association
Special Study on Arbitration
Survey Responses

9 In which states that you offer ADR do you offer the applicant a separate brochure, video or other educational opportunity related to ADR agreements?

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
Alabama	No		No			No			No		Yes			
Alaska														
Arizona			No			No	Yes				Yes			
Arkansas	No					No	Yes		No					
California					No	No				No	Yes			
Colorado			No				Yes				Yes			
Connecticut											Yes			
Delaware														
District of Columbia						No								
Florida	No		No			No	Yes		No		Yes			Yes
Georgia			No			No					Yes			Yes
Hawaii						No	Yes							
Idaho			No				Yes				Yes			
Illinois			No			No	Yes						No	
Indiana			No			No	Yes				Yes		No	
Iowa							Yes			No		Yes		
Kansas			No			No	Yes			No				
Kentucky	No		No			No	Yes				Yes		No	
Louisiana														
Maine														
Maryland						No					Yes			
Massachusetts						No					Yes			
Michigan			No			No							No	
Minnesota			No			No	Yes					Yes		
Mississippi						No								
Missouri						No			No	No				
Montana							Yes				Yes			
Nebraska						No	Yes					Yes		
Nevada			No							No				
New Hampshire											Yes			
New Jersey			No			No					Yes			
New Mexico							Yes			No	Yes			
New York														
North Carolina			No			No					Yes			Yes
North Dakota							Yes							
Ohio	No		No			No	Yes	Yes			Yes		No	
Oklahoma			No								Yes			
Oregon		No					Yes							
Pennsylvania			No	Yes		No		Yes						
Rhode Island											Yes			
South Carolina			No			No								Yes
South Dakota						No	Yes					Yes		
Tennessee	No		No			No	Yes				Yes			
Texas			No	Yes			Yes			No				
Utah											Yes			
Vermont														
Virginia			No			No								
West Virginia	No					No	Yes				Yes			
Washington		No	No			No	Yes				Yes			
Wisconsin			No			No	Yes							
Wyoming						No					Yes			
All States														

Notes:
Provider F refers applicants to the NAF website for more information.
Provider K offers a separate brochure

American Healthcare Association
Special Study on Arbitration
Survey Responses

10 In which states that you offer ADR does the ADR agreement expressly define the types of disputes (collection, damaged property, malpractice, etc) that are subject to the ADR process?

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
Alabama	Yes		Yes			Yes			No		Yes			
Alaska														
Arizona			Yes			Yes	Yes				Yes			
Arkansas	Yes					Yes	Yes		No					
California					Yes	Yes				Yes	Yes			
Colorado			Yes				Yes				Yes			
Connecticut											Yes			
Delaware														
District of Columbia						Yes								
Florida	Yes		Yes			Yes	Yes		No		Yes			Yes
Georgia			Yes			Yes					Yes			Yes
Hawaii						Yes	Yes							
Idaho			Yes				Yes				Yes			
Illinois			Yes			Yes	Yes						Yes	
Indiana			Yes			Yes	Yes				Yes		Yes	
Iowa							Yes			Yes		No		
Kansas			Yes			Yes	Yes			Yes				
Kentucky	Yes		Yes			Yes	Yes				Yes		Yes	
Louisiana														
Maine														
Maryland						Yes					Yes			
Massachusetts						Yes					Yes			
Michigan			Yes			Yes							Yes	
Minnesota			Yes			Yes	Yes					No		
Mississippi						Yes								
Missouri						Yes			No	Yes				
Montana							Yes				Yes			
Nebraska						Yes	Yes					No		
Nevada			Yes							Yes				
New Hampshire											Yes			
New Jersey			Yes			Yes					Yes			
New Mexico							Yes			Yes	Yes			
New York														
North Carolina			Yes			Yes					Yes			Yes
North Dakota							Yes							
Ohio	Yes		Yes			Yes	Yes	Yes			Yes		Yes	
Oklahoma			Yes								Yes			
Oregon		Yes					Yes							
Pennsylvania			Yes	Yes		Yes		Yes						
Rhode Island											Yes			
South Carolina			Yes			Yes								Yes
South Dakota						Yes	Yes					No		
Tennessee	Yes		Yes			Yes	Yes				Yes			
Texas			Yes	Yes			Yes			Yes				
Utah											Yes			
Vermont														
Virginia			Yes			Yes								
West Virginia	Yes					Yes	Yes				Yes			
Washington		Yes	Yes			Yes	Yes				Yes			
Wisconsin			Yes			Yes	Yes							
Wyoming						Yes					Yes			
All States														

Notes:
Provider F and Provider I note that collections are defined in their agreements.

American Healthcare Association
Special Study on Arbitration
Survey Responses

11 In which states that you offer ADR is the applicant informed that the ADR agreement precludes a jury trial for subject disputes?

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
Alabama	Yes		Yes			Yes			Yes		Yes			
Alaska														
Arizona			Yes			Yes	Yes				Yes			
Arkansas	Yes					Yes	Yes		Yes					
California					Yes	Yes				Yes	Yes			
Colorado			Yes				Yes				Yes			
Connecticut											Yes			
Delaware														
District of Columbia						Yes								
Florida	Yes		Yes			Yes	Yes		Yes		Yes			Yes
Georgia			Yes			Yes					Yes			Yes
Hawaii						Yes	Yes							
Idaho			Yes				Yes				Yes			
Illinois			Yes			Yes	Yes						Yes	
Indiana			Yes			Yes	Yes				Yes		Yes	
Iowa							Yes			Yes		Yes		
Kansas			Yes			Yes	Yes			Yes				
Kentucky	Yes		Yes			Yes	Yes				Yes		Yes	
Louisiana														
Maine														
Maryland						Yes					Yes			
Massachusetts						Yes					Yes			
Michigan			Yes			Yes							Yes	
Minnesota			Yes			Yes	Yes					Yes		
Mississippi						Yes								
Missouri						Yes			Yes	Yes				
Montana							Yes				Yes			
Nebraska						Yes	Yes					Yes		
Nevada			Yes							Yes				
New Hampshire											Yes			
New Jersey			Yes			Yes					Yes			
New Mexico							Yes			Yes	Yes			
New York														
North Carolina			Yes			Yes					Yes			Yes
North Dakota							Yes							
Ohio	Yes		Yes			Yes	Yes	Yes			Yes		Yes	
Oklahoma			Yes								Yes			
Oregon		Yes					Yes							
Pennsylvania			Yes	Yes		Yes		Yes						
Rhode Island											Yes			
South Carolina			Yes			Yes								Yes
South Dakota						Yes	Yes					Yes		
Tennessee	Yes		Yes			Yes	Yes				Yes			
Texas			Yes	Yes			Yes			Yes				
Utah											Yes			
Vermont														
Virginia			Yes			Yes								
West Virginia	Yes					Yes	Yes				Yes			
Washington		Yes	Yes			Yes	Yes				Yes			
Wisconsin			Yes			Yes	Yes							
Wyoming						Yes					Yes			
All States														

Notes:
Every provider includes this.
Provider A, Provider F and Provider I note that this is bolded text.

American Healthcare Association
Special Study on Arbitration
Survey Responses

12 In the states that you offer ADR, who has the authority to agree to arbitration? What is your process to ensure authority?

	Authority	Process
A	Power of Attorney or Guardianship; Resident; Responsible Party	
B	Resident/Legal Representative	Applicable party to provide copy of appropriate POA or other guardianship documents.
C	Resident/Legally Authorized Representative	Obtain paperwork such as POA/Guardianship documents showcasing authority to sign.
D	Resident or Legal Representative	Ensure that we have the legal document from a Power of Attorney or Guardian indicating Authorized Representation
E	patient &/or legally qualified individual	
F		
G	RESIDENT OR LEGAL REPRESENTATIVE	
H	resident or representative	resident or representative signs, no process in place to ensure their legal authority
I	Resident, POA Legal Representative, Responsible Party, Spouse, Child-Sponsor.	Education of admission coordinators
J	Admissions	Training
K	Admitted Resident/Patient Legal Representative	Admission Coordinator reviews authenticating documents
L	Entity's option to compel	We reserve the only right to compel arbitration
M	Resident/POA/HCPOA	Legal documentation
N	guardian, DPOAHC, POA, next of kin	order of priority on policy, verified at time of execution

Notes:

American Healthcare Association
Special Study on Arbitration
Survey Responses

13 In the states that you offer ADR, what are the limits on punitive and economic damages?

Notes:
This question was reworded for subsequent distribution to read:

In the states that you offer ADR, does the ADR agreement limit punitive and/or economic damages beyond the state's legislated limits?

None of the respondents limits recovery to less than statutory limits.

American Healthcare Association
Special Study on Arbitration
Survey Responses

14 In the states that you offer ADR, how are arbitrators selected?

Provider	States	Process
A	Alabama	Arbitrator will be an individual selected jointly by the Resident or the Resident's Representative and the Facility in accordance with the procedures set forth in the National Arbitration Forum's Code of Procedure.
A	Arkansas	If the parties cannot agree upon a single, neutral arbitrator, then each side shall choose a single non-neutral arbitrator (a total of two), who will then choose a third arbitrator.
A	Florida	If the parties cannot agree upon a single, neutral arbitrator, then each side shall choose a single non-neutral arbitrator (a total of two), who will then choose a third arbitrator.
A	Kentucky	If the parties cannot agree upon a single, neutral arbitrator, then each side shall choose a single non-neutral arbitrator (a total of two), who will then choose a third arbitrator.
A	Ohio	The arbitrator(s) shall be mutually selected by the parties in accordance with the procedures established by the Arbitration Services Provider.
A	Tennessee	The parties shall work together in good faith to select a mutually agreeable Arbitration Service Provider. If they cannot select one, the National Arbitration Forum shall conduct the arbitration of all claims. Any arbitrator shall be an attorney licensed to practice law, neutral and free from bias or interest in the claim, and knowledgeable of the issues presented in the claim.
A	West Virginia	Arbitrator(s) shall be mutually selected by the parties in accordance with the procedures established by the Arbitration Services Provider.
B	All States	JAMS, a private arbitration service, per the ADR agreement.
C	All States	Mutual selection by both parties.
D	Pennsylvania	Select from a listing by the American Arbitration Association
D	Texas	via a mediator
E	California	Through either an Arbitration Panel/Service or by Agreement of the Parties
F	All States	
G	All States	BY NAF RULES
H	All States	Our form offers three arbitrators, opposing legal counsel agrees on the selection
I	All States	Arbitrators may be selected by mutual consent of the parties. Arbitration vendors are also specified in the agreements.
J	All States	JAMS
K	All States	The arbitration shall be conducted by only one (1) arbitrator (the “Arbitrator”). If the Parties cannot reach an agreement on selection of the Arbitrator within 20 days after the Demand then, on the 21st day, each Party shall select one arbitrator (the “Selected Arbitrators”). The Selected Arbitrators shall choose the final arbitrator (the “Final Arbitrator”), and the Final Arbitrator shall serve as the sole Arbitrator for this dispute.
L	All States	Both parties must agree on 3 chosen from list of 10 potential supplied by AAA. If cannot agree there would be appt from National Roster
M	All States	National Arbitration Forum (stated in the Agreement)
N	Florida	only one arbitrator unless parties cannot agree on one within 30 days, then each party selects an arbitrator each and those arbitrator select a 3rd to create a panel
N	Georgia	Panel of 3 arbitrators, one each selected by the parties and the 3rd selected by a 3rd party the parties agree upon;
N	North Carolina	only one arbitrator unless parties cannot agree on one within 30 days, then each party selects an arbitrator each and those arbitrator select a 3rd to create a panel
N	South Carolina	only one arbitrator unless parties cannot agree on one within 30 days, then each party selects an arbitrator each and those arbitrator select a 3rd to create a panel

Notes:

American Healthcare Association
Special Study on Arbitration
Survey Responses

15 In the states that you offer ADR, how are the costs of arbitration shared?

Provider	States	Process
A	Alabama	Any National Arbitration Forum fee in excess of $50, including compensation paid to the arbitrator for hearing arbitration, will be paid by Facility, unless the Resident (or Representative) objects. If the Resident objects, then the fees will be borne equally by the Facility and the Resident (or Representative)
A	Arkansas	Any initial administrative fees related to the commencement of arbitration shall be paid by the facility; any additional administrative fees and costs, including the fees of the arbitrator, shall be split with the Facility paying 2/3 and the Resident paying 1/3.
A	Florida	Any initial administrative fees related to the commencement of arbitration shall be paid by the facility; any additional administrative fees and costs, including the fees of the arbitrator, shall be split with the Facility paying 2/3 and the Resident paying 1/3.
A	Kentucky	Any initial administrative fees related to the commencement of arbitration shall be paid by the facility; any additional administrative fees and costs, including the fees of the arbitrator, shall be split with the Facility paying 2/3 and the Resident paying 1/3.
A	Ohio	Any filing or administration fees in excess of $100, as well as any compensation owed to the arbitrator(s) shall be paid by the Facility, unless another party objects and wishes to share equally in such costs.
A	Tennessee	Any initial fee charged by the Arbitration Service Provider in excess of $100 shall be paid by the Facility. All other fees, including compensation to the arbitrators, incurred in the course of the arbitration, shall be paid in equal parts by the parties unless otherwise agreed upon in writing.
A	West Virginia	Any filing or administration fees in excess of $100, as well as any compensation owed to the arbitrator(s) shall be paid by the Facility, unless another party objects and wishes to share equally in such costs.
B	All States	Facility pays 100%, unless Facility is prevailing party, in which case costs are split 50/50.
C	All States	By both parties.
D	Pennsylvania	Facility shall pay all of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator. However, each Party shall pay for its own Party arbitrator, counsel fees, witness fees, or other expenses incurred by a Party for such Party's own benefit.
D	Texas	the person requesting the ADR has the burden of cost
E	California	Each party covers their own costs & expenses
F	All States	At present, fees are governed by the NAF rules. Plaintiff pays to file. NAF can shift fees to defendant on motion, which happens with some regularity. We will agree to an arbitrator outside NAF if plaintiff agrees.
G	All States	NAF Rules
H	All States	split 50/50
I	All States	Typically the insured pays all arbitrations costs. Few offer sharing of the fees
J	All States	50/50
K	All States	Fees and costs are divided equally among the parties
L	All States	Operating Entity Pays
M	All States	If family not represented, we pay. If represented, costs are split.
N	All States	provider pays up to 5 days of the cost of the arbitration service and proceedings then costs are split; each provider pays their own atty fees

Notes:

American Healthcare Association
Special Study on Arbitration
Survey Responses

16 In the states that you offer ADR, do the admission records identify whether an ADR agreement has been signed?

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
Alabama	No		Yes			Yes			Yes		No			
Alaska														
Arizona			Yes			Yes	Yes				No			
Arkansas	No					Yes	Yes		Yes					
California					No	Yes				Yes	No			
Colorado			Yes				Yes				No			
Connecticut											No			
Delaware														
District of Columbia						Yes								
Florida	No		Yes			Yes	Yes		Yes		No			Yes
Georgia			Yes			Yes					No			Yes
Hawaii						Yes	Yes							
Idaho			Yes				Yes				No			
Illinois			Yes			Yes	Yes						No	
Indiana			Yes			Yes	Yes				No		No	
Iowa							Yes			Yes		Yes		
Kansas			Yes			Yes	Yes			Yes				
Kentucky	No		Yes			Yes	Yes				No		No	
Louisiana														
Maine														
Maryland						Yes					No			
Massachusetts						Yes					No			
Michigan			Yes			Yes							No	
Minnesota			Yes			Yes	Yes					Yes		
Mississippi						Yes								
Missouri						Yes			Yes	Yes				
Montana							Yes				No			
Nebraska						Yes	Yes					Yes		
Nevada			Yes							Yes				
New Hampshire											No			
New Jersey			Yes			Yes					No			
New Mexico							Yes			Yes	No			
New York														
North Carolina			Yes			Yes					No			Yes
North Dakota							Yes							
Ohio	No		Yes			Yes	Yes	Yes			No		No	
Oklahoma			Yes								No			
Oregon		Yes					Yes							
Pennsylvania			Yes	No		Yes		Yes						
Rhode Island											No			
South Carolina			Yes			Yes								Yes
South Dakota						Yes	Yes					Yes		
Tennessee	No		Yes			Yes	Yes				No			
Texas			Yes	Yes			Yes			Yes				
Utah											No			
Vermont														
Virginia			Yes			Yes								
West Virginia	No					Yes	Yes				No			
Washington		Yes	Yes			Yes	Yes				No			
Wisconsin			Yes			Yes	Yes							
Wyoming						Yes					No			
All States														

Notes:
Provider D indicated in Pennsylvania the ADR is a separate document that is maintained separately from the medical record.
Provider F has started an electronic record of whether and ADR has been signed, but is not confident in the recordkeeping yet.
Provider F requires a letter to opt out of the ADR agreement, which is kept on file.

American Healthcare Association
Special Study on Arbitration
Survey Responses

17 In the states that you offer ADR, do the claims files identify whether an ADR agreement is applicable?

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
Alabama	Yes		Yes			Yes			Yes		Yes			
Alaska														
Arizona			Yes			Yes	Yes				Yes			
Arkansas	Yes					Yes	Yes		Yes					
California					Yes	Yes				Yes	Yes			
Colorado			Yes				Yes				Yes			
Connecticut											Yes			
Delaware														
District of Columbia						Yes								
Florida	Yes		Yes			Yes	Yes		Yes		Yes			Yes
Georgia			Yes			Yes					Yes			Yes
Hawaii						Yes	Yes							
Idaho			Yes				Yes				Yes			
Illinois			Yes			Yes	Yes						Yes	
Indiana			Yes			Yes	Yes				Yes		Yes	
Iowa							Yes			Yes		Yes		
Kansas			Yes			Yes	Yes			Yes				
Kentucky	Yes		Yes			Yes	Yes				Yes		Yes	
Louisiana														
Maine														
Maryland						Yes					Yes			
Massachusetts						Yes					Yes			
Michigan			Yes			Yes							Yes	
Minnesota			Yes			Yes	Yes					Yes		
Mississippi						Yes								
Missouri						Yes			Yes	Yes				
Montana							Yes				Yes			
Nebraska						Yes	Yes					Yes		
Nevada			Yes							Yes				
New Hampshire											Yes			
New Jersey			Yes			Yes					Yes			
New Mexico							Yes			Yes	Yes			
New York														
North Carolina			Yes			Yes					Yes			Yes
North Dakota							Yes							
Ohio	Yes		Yes			Yes	Yes	Yes			Yes		Yes	
Oklahoma			Yes								Yes			
Oregon		Yes					Yes							
Pennsylvania			Yes	No		Yes		Yes						
Rhode Island											Yes			
South Carolina			Yes			Yes								Yes
South Dakota						Yes	Yes					Yes		
Tennessee	Yes		Yes			Yes	Yes				Yes			
Texas			Yes	No			Yes			Yes				
Utah											Yes			
Vermont														
Virginia			Yes			Yes								
West Virginia	Yes					Yes	Yes				Yes			
Washington		Yes	Yes			Yes	Yes				Yes			
Wisconsin			Yes			Yes	Yes							
Wyoming						Yes					Yes			
All States														

Notes:

American Healthcare Association
Special Study on Arbitration
Survey Responses

18 In the states that you offer ADR, do the claims files identify unsuccessful challenges to ADR?

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
Alabama	No		Yes			Yes			Yes		Yes			
Alaska														
Arizona			Yes			Yes	Yes				Yes			
Arkansas	Yes					Yes	Yes		Yes					
California					No	Yes				No	Yes			
Colorado			Yes				Yes				Yes			
Connecticut											Yes			
Delaware														
District of Columbia						Yes								
Florida	Yes		Yes			Yes	Yes		Yes		Yes			Yes
Georgia			Yes			Yes					Yes			Yes
Hawaii						Yes	Yes							
Idaho			Yes				Yes				Yes			
Illinois			Yes			Yes	Yes						Yes	
Indiana			Yes			Yes	Yes				Yes		Yes	
Iowa							Yes			No		No		
Kansas			Yes			Yes	Yes			No				
Kentucky	Yes		Yes			Yes	Yes				Yes		Yes	
Louisiana														
Maine														
Maryland						Yes					Yes			
Massachusetts						Yes					Yes			
Michigan			Yes			Yes							Yes	
Minnesota			Yes			Yes	Yes					No		
Mississippi						Yes								
Missouri						Yes			Yes	No				
Montana							Yes				Yes			
Nebraska						Yes	Yes					No		
Nevada			Yes							No				
New Hampshire											Yes			
New Jersey			Yes			Yes					Yes			
New Mexico							Yes			No	Yes			
New York														
North Carolina			Yes			Yes					Yes			Yes
North Dakota							Yes							
Ohio	No		Yes			Yes	Yes	Yes			Yes		Yes	
Oklahoma			Yes								No			
Oregon		No					Yes							
Pennsylvania			Yes	No		Yes		Yes						
Rhode Island											Yes			
South Carolina			Yes			Yes								Yes
South Dakota						Yes	Yes					No		
Tennessee	No		Yes			Yes	Yes				Yes			
Texas			Yes	No			Yes			No				
Utah											Yes			
Vermont														
Virginia			Yes			Yes								
West Virginia	No					Yes	Yes				Yes			
Washington		No	Yes			Yes	Yes				Yes			
Wisconsin			Yes			Yes	Yes							
Wyoming						Yes					Yes			
All States														

Notes:
Most providers indicated that have never received a challenge
Provider J indicated they will begin tracking these in the future.
Provider A has not attempted to enforce an ADR agreement
Provider K has coding to track challenges, but has not had any challenges to arbitration.
Provider F is working to improve tracking

Exhibit 3.19

American Healthcare Association
Special Study on Arbitration
Survey Responses

19 In the states that you offer ADR, what are the most common successful challenges to ADR?

Provider	States	
A	Alabama	For each state, the company's most difficult challenge is the arbitration agreement is often signed by someone without authority to waive a resident's right to a jury trial, such as a responsible party signing the admission paperwork who does not have a valid POA or guardianship.
B	All States	N/A
C	All States	That the Agreements were not signed appropriately or that the Agreement is unconscionable.
D	All States	unknown
E	California	Intent, understanding &/or capacity of the executing party
F	All States	
G	All States	Wrong person signed the form
H	All States	Pressure to sign based on the need for admission
I	All States	Signatory Challenges based upon who has the right to bind the resident, or signatory can not waive a jury trial
J	All States	Not signed by the appropriate person.
K	All States	No successful challenges to date
L	All States	Have not had a challenge
M	All States	Defective agreement
N	Florida	not enough experience to make determination
N	Georgia	authority of person signing the document to bind the patient/estate; authority of person signing the document to bind heirs (even when the person signing is the only heir); whether state law or FAA applies (pretty settled it is FAA); had one upheld when patient himself signed and was still alive, hand another upheld because plaintiff's lawyer did not have our medical records at the time suit was filed so the expert affidavit was questionable and judge seemed to dismiss to binding arbitration to avoid the affidavit issue.
N	North Carolina	not enough experience to make determination
N	South Carolina	whether state law or FAA applies; authority of person signing

Notes:
Provider K noted that ADR agreements are unenforceable in Oklahoma

AMERICAN HEALTH CARE ASSOCIATION

Arbitration Data Call
Claims and Exposure Detail

Instructions

Please provide the following for **all claims closed since January 1, 2004:**

1. Paid indemnity, paid expense, occurrence date, report date, closed date, geographical state, claim ID.

2. An arbitration code to represent whether ADR applied:

A1: ADR / Uncontested
A2: ADR / Contested and Valid
N1: No ADR
N2: ADR / Unenforceable

3. A disposition code that best describes the ultimate settlement of the claim:

A: Arbitrated decision,
M: Mediated settlement,
C: Court decision,
S: Settled before proceedings,
T: Settled during trial

We can accept item 1 as a carrier loss run, Excel document, Adobe document, or other electronic document.

Items 2 and 3 can be provided with item 1, or as separate tables listing identifying claims numbers and the applicable arbitration and disposition code.

Respondents were also asked to provide:
- Occupied Bed Count or Licensed Bed Count with Occupancy Rates
- By State
- By Bed Type (Skilled Nursing, Assisted Living, Independent Living, Home Health, Other)
- For 2004 and subsequent

American Health Care Association
Special Study on Arbitration
2008 Bed Counts
Respondents Included in Claim Data

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
Alabama	581								11,647						585
Alaska															
Arizona															820
Arkansas	894								675						
California					4,460					3,669					3,356
Colorado															483
Connecticut															872
Delaware															
District of Columbia															
Florida	407								810						
Georgia															681
Hawaii															
Idaho															769
Illinois															
Indiana													1,906		4,333
Iowa									271						
Kansas															
Kentucky	440												164		2,029
Louisiana															
Maine															948
Maryland															
Massachusetts															5,492
Michigan													85		
Minnesota															
Mississippi															
Missouri									540						293
Montana															280
Nebraska															
Nevada															217
New Hampshire															640
New Jersey															
New Mexico															
New York															
North Carolina															2,649
North Dakota															
Ohio	99							1,656					748		2,133
Oklahoma															
Oregon		1,207													232
Pennsylvania								736							129
Rhode Island															249
South Carolina															
South Dakota															
Tennessee	497														1,336
Texas	1,286									2,780					
Utah															548
Vermont															204
Virginia															764
West Virginia	143														
Washington		731													800
Wisconsin															2,224
Wyoming															424
All States	4,346	1,938			4,460			2,392	13,943	6,449			2,903		33,493

Notes:
Provider C was unable to provide bed counts
Provider D was unable to provide closed dates and was excluded
Provider F was able to provide 25 arbitrated outcomes out of 1,555 closed claims. Provider F has been excluded as a measure of industry representation
Provider G was unable to provide arbitration coding
Provider K was able to provide 1 arbitrated outcome out of 940 closed, coded claims. Provider K has been exlcuded as a measure of industry representation
Provider L provided 1 non-zero closed claim and was excluded
Provider N did not provide bed counts
Provider O did not submit a survey

Exhibit C:

Letter from Joseph Tripline, Dir., Div. of FOIA Analysis, Ctrs. for Medicare & Medicaid Servs., to Lyn Bentley, Senior Dir. of Reg. Servs., Am. Health Care Ass'n (Aug. 25, 2015)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop N2-20-16
Baltimore, Maryland 21244-1850

Office of Strategic Operations and Regulatory Affairs/Freedom of Information Group
Refer to: Control Number 082120157063 and PIN 2AF3

AUG 2 5 2015

Lyn Bentley
American Health Care Association (AHCA)
1201 L Street, NW
Washington, DC 20005

Dear Ms. Bentley:

This letter is in response to your Freedom of Information Act (5 U.S.C. § 552) request of 8/10/2015 which you sent to the Centers for Medicare & Medicaid Services (CMS). Within your correspondence you requested a copy of all written concerns submitted by the stakeholders regarding the proposed rule [Reform of requirements for Long Term Care Facilities, 80 Fed. Reg. 42,168) (July 16, 2015)] that states that unidentified "stakeholders" raised various "concerns" regarding the use of arbitration agreements, which affect CMS determination of whether to propose any regulations on the use of arbitration agreements (80 Fed. Reg. at 42, 241).

Our agency initiated a search for records falling within the scope of your request, and located seven (7) pages of responsive records. We are releasing these documents to you in their entirety, without deletions.

Sincerely yours,

Joseph Tripline
Director, Division of FOIA Analysis – A
Freedom of Information Group

Enclosure

AMERICAN ASSOCIATION for JUSTICE
Formerly the Association of Trial Lawyers of America (ATLA®)

August 14, 2012

Patrick Conway, M.D.
Director, Office of Clinical Standards and Quality
Centers for Medicare & Medicaid Services
Patrick.Conway@cms.hhs.gov

RE: Office of Clinical Standards and Quality Review of the Conditions of Participation (referred to here as "Requirements of Participation" or RoPs)

Dear Dr. Conway:

The American Association for Justice (AAJ), formerly known as the Association of Trial Lawyers of America (ATLA®), hereby submits comments in response to the Office of Clinical Standards and Quality's review of 42 CFR 483 Subpart B and the Conditions of Participation (referred to here as "Requirements of Participation" or RoPs), pursuant to Executive Order 13563, "Improving Regulations and Regulatory Review" issued on January 2011 and Executive Order, "Identifying and Reducing Regulatory Burdens" released in May 2012.

AAJ, with members in the United States, Canada and abroad, is the world's largest trial bar. It was established in 1946 to safeguard victims' rights, strengthen the civil justice system and protect access to the courts. AAJ applauds CMS for taking steps to improve safety standards for nursing home and long-term care residents. AAJ considers it critically important for CMS to fully evaluate the enormous impacts any change in the current regulations would have on the health and welfare of residents.

It is AAJ's understanding that the Clinical Standards Group has undertaken this review with the goal "in reviewing these regulations is to evaluate the extent to which they are current, effective, and supportive of stakeholder efforts to improve the care provided to this vulnerable population." (See e-mail dated August 06, 2012 from Sheila C. Blackstock to Sarah Rooney) It is also our understanding that your review "encompasses currency, person-centered care, quality improvement and consideration of redundant, overly burdensome or obsolete provisions." (See e-mail dated August 06, 2012 from Sheila C. Blackstock to Sarah Rooney) With this understanding, AAJ strongly encourages CMS to only consider changes to the current regulations that would increase and incentivize patient safety through improved accountability

and transparency, and to undertake such a review in an open and public process in which all interested parties can actively partake.

Evidence illustrates a need for Increased Focus on Improved Safety and Accountability Standards

Eliminating "redundant, overly burdensome or obsolete provisions" within the requirements is a worthy goal, but should only be done in areas where there will be no negative impacts on quality of care and resident safety; on balance, the best interests of residents should always be paramount. Long-term care residents make up a substantial portion of the U.S. population and because of older age, limited income, and decreased health are a particularly vulnerable population. Accordingly, the conduct of those entrusted with caring for this population should be held to high standards and should be held fully accountable for the care they provide. "More than 1.6 million Americans live in nursing homes. Hospitalizations are common in this population; in 2006, 23.5% of the people admitted to a post-acute care skilled-nursing facility were rehospitalized within 30 days. Several studies suggest that many of these hospitalizations are inappropriate, avoidable, or related to conditions that could be treated outside the hospital setting — and they cost more than $4 billion per year. Avoidable hospitalizations are also common among long-stay residents of nursing homes."[1]

Further, despite claims that some requirements are "overly burdensome," there exists ample evidence to suggest that not enough is being done to protect residents and ensure accountability. For example, according to the U.S. Government Accountability Office (GAO), "In CMS's performance assessment for fiscal year 2009, many state survey agencies had difficulty meeting some of CMS's nursing home complaint standards, most of which also assess performance with regard to incidents—specific care issues that nursing homes are required to report. In particular, 19 state survey agencies had difficulty investigating actual harm-high complaints and incidents within the required time frame."[2]

Additionally, in relation to the complaints received, the GAO concluded: "CMS's complaints data showed that state survey agencies received 53,313 complaints about nursing homes in 2009. The number and types of complaints varied among states. For example, 11 states received 15 or fewer complaints per 1,000 nursing home residents while 14 states received more than 45. State survey agencies assess the severity of a complaint and assign a priority level, which dictates if and when an investigation must be initiated. About 10 percent of complaints were prioritized as immediate jeopardy, requiring investigation within 2 working days of receipt, while 45 percent were prioritized as actual harm-high, requiring investigation within 10 working days of

---

[1] Joseph G. Ouslander and Robert A. Berenson, *Reducing Unnecessary Hospitalizations of Nursing Home Residents*, New England Journal of Medicine, September 29, 2011.

[2] *More Reliable Data and Consistent Guidance Would Improve CMS Oversight of State Complaint Investigations*, Government Accountability Office, April 2011.

prioritization. State survey agencies investigated all but 102 complaints that required an investigation. Among investigated complaints, 19 percent were substantiated and resulted in the citation of at least one federal deficiency. The percentage of immediate jeopardy and actual harm-high complaints that were substantiated with at least one federal deficiency cited was higher if the investigation was initiated on time.

A slightly older report also issued by the GAO in March 2007 found that sanctions imposed by the CMS on the worst nursing homes are often rescinded before taking effect because homes correct the deficiencies during a grace period. Unfortunately, the homes often revert to noncompliance after the sanction is removed—a phenomenon called the yo-yo pattern. The GAO reviewed records of 63 of the most dangerous facilities from 2000 to 2005 and discovered that almost half of the homes cycled in and out of compliance during that time frame, some of them seven or more times. Despite knowing that the homes posed a danger to residents, the CMS often imposed the lower end of the allowable range of monetary penalties and did not exercise its discretionary authority to terminate the homes' government funding. The report noted a Texas facility that failed to report a sexual abuse incident and did not document reference checks for four of its employees. Although the CMS could have imposed a fine of up to $3,000 per day, it instead fined the home $250 per day.[3]

Further, according to an investigation of CMS records by USA Today, between 2000 and 2006, citations for "immediate jeopardy"—noncompliance that has caused or is likely to cause serious harm or death—rose 22 percent. Immediate jeopardy is usually found in cases where patients are being abused or neglected. In 2006 alone, there were 2,000 immediate jeopardy violations at 850 nursing homes. Although those were the most serious citations, they account for only 6 percent of more than 33,000 total citations handed out to the facilities.[4]

Inappropriate Staffing and Supervision

One of the areas where the need for increased oversight and accountability is clear is in the area of inappropriate hiring decisions—specifically, the hiring of those with certain criminal convictions and then allowing them unsupervised access to residents. A 2011 Inspector General report stated: "Our analysis of FBI –maintained criminal history records revealed that 92 percent of nursing facilities employed at least one individual with at least one criminal conviction. Nearly half of nursing facilities employed five or more individuals with at least one conviction. Forty-four percent of employees with convictions were convicted of crimes against property (e.g., burglary, shoplifting, writing bad checks), making it the most common type of crime committed. Overall, 5 percent of nursing facility employees had at least one conviction in FBI - maintained criminal history records."[5]

---

[3] Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents, GAO Rep. to Ranking Minority Member, Comm. on Fin., U.S. Sen., No. GAO-07-241, March 2007.
[4] Brad Heath, Nursing Home Citations Climb 22%, USA Today, December 18, 2007.
[5] Nursing Facilities' Employment of Individuals With Criminal Convictions, Office of the Inspector General of the U.S. Department of Health and Human Services, March 2011.

Inappropriate Use of Antipsychotic Drugs

Another specific example of inadequate requirements is with the misuse of antipsychotic drugs within nursing homes and long-term care facilities. A recent study on the overuse of antipsychotic drugs in nursing homes conducted by the Office of the Inspector General of the Department of Health and Human Services found that 99 percent of "records reviewed for elderly nursing facility residents receiving atypical antipsychotic drugs during the first 6 months of 2007 lacked evidence to indicate that they met all Federal requirement(s) for nursing facility resident assessments and care plans."[6]

According to the GAO: "Fourteen percent of elderly nursing home residents had Medicare claims for atypical antipsychotic drugs. Of the 2.1 million elderly nursing home residents, 304,983 had at least 1 Medicare claim for an atypical antipsychotic drug from January 1 through June 30, 2007. Claims for elderly nursing home residents accounted for 20 percent of the total 8.5 million claims for atypical antipsychotic drugs for all Medicare beneficiaries during the review period. Claims for these residents amounted to $309 million."[7] Additionally, "Eighty-three percent of Medicare claims for atypical antipsychotic drugs for elderly nursing home residents were associated with off-label conditions; 88 percent were associated with the condition specified in the FDA boxed warning."[8]

Abusive Use of Mandatory Binding Arbitration Clauses

When regulations fail to adequately protect nursing home residents and harm occurs, families turn to the civil justice system in order to get answers and hold wrongdoers accountable. For the vast majority of families, filing a claim against a provider is a last resort, but is done because families seek to hold those responsible for the neglect and abuse of their loved one accountable. Often times, families also file a claim to find out what happened to their loved one, as providers routinely fail to provide information about their loved one's care. However, the recent increased use of mandatory, binding arbitration clauses are preventing families from seeking justice. "An examination of admission contracts used by North Carolina nursing homes and telephone survey of North Carolina nursing homes revealed that 43 percent of nursing homes now incorporate pre-dispute binding arbitration provisions into their admission contracts. All of the major nursing

---

[6] *Nursing Facility Assessments and Care Plans for Residents Receiving Atypical Antipsychotic Drugs*, Office of the Inspector General of the U.S. Department of Health and Human Services, July 2012.
[7] *Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents*, Government Accountability Office, May 2011.
[8] *Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents*, Government Accountability Office, May 2011.

home chains operating in North Carolina use pre-dispute binding arbitration agreements in at least some portion of their admission contracts, while smaller operators use them sporadically."[9] Mandatory binding arbitration clauses buried in nursing home admissions contracts are depriving nursing home residents and their families of their constitutional rights. During one of the most stressful times in their lives—admission to a nursing home—residents and their families are unknowingly signing away their right to hold a nursing home accountable if the nursing home causes the resident serious injury or even death.

Nursing home corporations insert forced arbitration clauses in their contracts to ensure that they will never be held publicly accountable for their actions, no matter how egregious their conduct. The contracts are offered on a take-it-or-leave-it basis, usually within the admission forms, and the contracts typically allow the nursing home to select the arbitrator, the state in which the arbitration will occur, and the rules for the arbitration process. Particularly abusive are those clauses which require families bear the significant costs associated with arbitration. Finally, after a biased decision is rendered, the arbitration provisions deny the opportunity for judicial review. Given the abusive and one-sided nature of mandatory arbitration clauses, CMS should examine whether limiting the use of arbitration clauses would better serve and protect the best interests of long-term care residents.

Forced arbitration has the following attributes, which make CMS intervention especially necessary:

- With forced arbitration, residents have little or no choice but to accept the terms because residents cannot refuse to sign the admission agreement if they want to be admitted to the facility – and frequently they have little or no choice about which facility they enter, especially in rural areas. Sixty percent of nursing home admissions occur after a medical emergency and under pressure from hospital discharge planners to take the first available bed.
- Additionally, residents and their families lack an understanding of forced clauses. The clauses are buried in admissions documents and are drafted by attorneys using sophisticated legal terms. Further, these clauses are difficult, if not impossible to overturn in a court. Courts have upheld clauses signed by residents who were illiterate or too disabled with dementia to understand the contract or its implications.
- The system is stacked against residents and their families because arbitrators have a clear financial incentive to rule in favor of the corporation. When a dispute arises, a provider will often refer the case to an arbitrator who previously decided cases in the provider's favor. Accordingly, arbitrators are motivated to rule for providers to attract their future

[9] Lisa Tripp. 2011. "Arbitration Agreements Used by Nursing Homes: An Empirical Study and Critique of AT&T Mobility v. Concepcion" Available at: http://works.bepress.com/lisa_tripp/1

business. Because arbitration decisions are not required to be made public, the resident or family has no chance of uncovering the arbitrator's potential bias. And unlike judges, arbitrators are private individuals chosen by one party and are not legally bound to follow any laws or rules of evidence. Arbitrators can make it virtually impossible for a family to obtain the information necessary to prove their case. Arbitrators are not even required to explain their rulings.

- Arbitration is costly. In most cases, families must pay filing fees and the arbitrators' costs, which can amount to thousands of dollars. For many, the upfront costs and ongoing fees are prohibitive. In addition, the provider is often allowed to choose the location of the arbitration, making it inconvenient and even more costly for the resident or family.
- Arbitrations occur in secret. Society benefits from an open legal process that exposes neglect and abuse. One of the most important benefits of civil lawsuits is the discovery process, which often discloses shoddy corporate practices, such as staff reductions, that lead to neglect. Forced arbitration, on the other hand, restricts residents' ability to get information and keeps abusive business practices hidden.
- Forced arbitration clauses bar *any* claims against a facility, even those for severe neglect and serious injuries. Typical nursing home claims involve failure to prevent and treat pressure sores that led to infection, amputated limbs, and/or death; suffocation on bedrails and other restraining devices; choking; broken limbs resulting from physical assault or staff negligence; sexual assault; renal failure and other conditions caused by dehydration; malnutrition and severe weight loss; severe burns; drowning; gangrene; extreme, untreated pain; disfiguring contractures; and other avoidable conditions.

CMS Review should be Open and Transparent

Any review undertaken by the Clinical Standards Group to change the Requirements of Participation should only be done in an open and transparent manner, with full and fair opportunity for public review and comment. In addition, CMS should engage in discussions with a broad array of organizations in order to ensure it has complete information to weigh when considering any changes. The impact of changing these requirements is enormous and affects a particularly vulnerable population; accordingly, those changes should only be implemented through the proper rulemaking procedures established under the Administrative Procedures Act. AAJ appreciates the opportunity to comment. We look forward to engaging further as this rulemaking moves forward to working with CMS to ensure that the rights all long-term care residents are protected and promoted and that any changes to the requirements are those that will increase safety and ensure accountability.

AAJ appreciates this opportunity to submit comments in response to Office of Clinical Standards and Quality Review of the Conditions of Participation. We hope the Agency takes this opportunity to increase patient health, welfare and safety as this process continues. If you have any questions or comments, please contact Sarah Rooney, AAJ's Regulatory Counsel at (202) 944-2805.

Sincerely,

Mary Alice McLarty,
President
American Association for Justice