August 7, 2017

Seema Verma

Administrator

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Room 445-G, Hubert H. Humphrey Building

200 Independence Ave. S.W.

Washington, D.C. 20201

**Re: Medicare and Medicaid Programs; Revision of Requirements for Long-Term Care Facilities: Arbitration Agreements**

**CMS–3342–P**

**RIN 0938–AT18**

**Submitted electronically through** [**http://www.regulations.gov**](http://www.regulations.gov)

Dear Administrator Verma:

[Brief introduction of organization submitting comments, with explanation of why your organization is interested in the federal nursing home regulations.]

We are writing in opposition to the proposed rule regarding nursing home pre-dispute arbitration agreements. This proposed rule is unfair to residents and families and would harm residents’ rights, safety, and quality of care. In addition, it would promote providers’ interests at the expense of resident well-being. CMS should be concerned about residents, not reducing provider burden.

We urge the Centers for Medicare and Medicaid Services (CMS) to withdraw the proposed regulations and restore the ban on pre-dispute arbitration for the reasons we outline below.

**Pre-dispute binding arbitration agreements are inherently unfair.**

The use of pre-dispute binding arbitration agreements in the nursing facility setting is fundamentally unfair to residents and their loved ones. An essential component of any decision-making process is gathering the information needed to make the best decision. Yet pre-dispute binding arbitration agreements force persons to make a decision without any information at all about the dispute, even in cases of alleged severe neglect, serious injuries or death. It is unreasonable to assume that residents or their loved ones are able to comprehend the likelihood of grievous harm or poor care occurring within a facility when these agreements are signed upon admission.

Furthermore, nursing facility admission is a difficult and confusing time for residents and their families. They are most often under extreme pressure to find nursing facility placement. As a result, they are generally unaware of what they are signing and unlikely to be able to fully appreciate they are relinquishing a critical right, let alone understand the significant and irreversible consequences of that decision.

Arbitration stacks the deck against residents.

* Potential residents have no power to bargain with nursing homes, while all the power rests with the facilities.
* The terms of the agreements are unfair to residents. They frequently allow the nursing facility to select the arbitrator, the state in which the arbitration will occur, and the rules for the arbitration process. There is a strong incentive for arbitrators to find in favor of the facility since this can assure them of repeat business.
* Some arbitration agreements limit the resident’s right to conduct discovery and/or cap the damages that a resident may recover, “even for tragic and possibly preventable deaths.”[[1]](#footnote-1)

**Pre-dispute binding arbitration agreements restrict resident choice.**

CMS is wrong in asserting that its proposed regulation would support a resident’s ability to make choices.[[2]](#footnote-2)

Choice of facility

Prospective residents and their families often have little actual choice of nursing facilities due to their geographic location, specific needs, or the necessity of immediate placement when facing imminent hospital discharge.

Authorizing pre-dispute binding arbitration agreements would further limit resident choice. An ever-growing number of facilities use these agreements. It is already difficult enough for individuals to find a nearby nursing facility that provides quality care and is willing to admit them. To find one that also does not include arbitration agreements at admission makes matters even more difficult. Unless potential residents and their family members are able to defer placement to keep looking or accept placement in a nursing facility outside their community, they often have no alternative but to accept a facility with a pre-dispute binding arbitration agreement.

Of particular concern, CMS’s proposed regulation would leave residents in a worse position than they are in today by authorizing nursing facilities to require a resident to agree to arbitration as a condition of admission. Permitting pre-dispute binding arbitration agreements as a condition of admission turns residents into hostages; they must sign the agreement and lose their constitutional rights or not receive the care they desperately need.

Choice between court or arbitration

As noted above, pre-dispute binding arbitration forces potential residents and their families to make a decision between court and arbitration without the information they need to make an informed choice. The most significant factor in ensuring informed choice is that the decision to agree to arbitration occurs after the harm is done. This way, the resident is making the choice at a point when he or she has knowledge of the nature of the dispute and is fully focused on the legal consequences of agreeing to arbitration. This is most certainly not the case at the time of admission.

Further, if facilities are permitted to admit only those residents who sign an arbitration agreement, residents are robbed of any choice if they need care.

**Proposed transparency provisions are meaningless.**

It is disingenuous of CMS to claim that it is protecting the interests of LTC residents by requiring that the agreement be in plain language, explained in a form and manner residents understand, and that residents acknowledge they understand the agreement. Such provisions do not negate the fact that pre-dispute arbitration agreements severely restrict resident choice, and essentially eliminate it when they are a condition of admission. And no amount of transparency can change the basic power dynamic of the admissions process — incoming residents and their families are generally in a time of great stress, and the terms of the admission agreement are drafted exclusively by the facility.

These proposed transparency requirements do not make up for taking away resident choice – the provisions just mean that residents will understand in plain language that they have no choice.

In addition, there is an inherent conflict when the same entity responsible for ensuring that residents understand what arbitration means has a vested interest in having those residents agree to arbitration.

**Pre-dispute arbitration agreements negatively impact residents’ health and safety.**

Pre-dispute binding arbitration lessens nursing facility accountability by forcing residents into secret proceedings when seeking redress. The secretive nature of the forced arbitration process hides allegations of abuse, neglect and poor care from the public and regulators, which diminishes the consequences of negligent care by providing cover for poorly performing facilities. Fewer consequences can allow substandard care to continue.

Because arbitration proceedings are held behind closed doors and confidential, potential residents and others are less likely to know about a facility’s care problems.[[3]](#footnote-3) This deprives consumers of information they need when selecting a nursing facility. It also shields poor performing facilities from the negative impact on their reputation, public opinion, and public pressure that could serve as a deterrent to substandard care.

For these and related reasons, pre-dispute arbitration agreements diminish the overall quality of care. The importance of these care issues cannot be emphasized enough. Common legal claims against nursing facilities involve pressure ulcers, infections, broken bones, malnutrition, dehydration, asphyxiation (due to improper use of restraints), and sexual assault.[[4]](#footnote-4)

**CMS lacks authority to promulgate the proposed rule.**

CMS cites the following authority for the proposed regulation:

* Authority to promulgate regulations that are “adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.”[[5]](#footnote-5)
* Authority to establish “such other requirements relating to the health and safety [and well-being] of residents as the Secretary may find necessary.”[[6]](#footnote-6)
* Authority to establish “other right[s]” for residents, in addition to those set forth in statute, to “protect and promote the rights of each resident.”[[7]](#footnote-7)

Since all of this authority is predicated upon protecting residents, none of it can justify the proposed regulation.  The proposed regulation would *not* protect residents; it would instead deprive residents of protections that they currently hold under state law.

The state-law issue is unconscionability. Arbitration agreements are frequently challenged as being unconscionable under state law, due to (among other things) the vulnerability of nursing facility residents and the traumatic, chaotic nature of many nursing facility admissions.  If CMS’s proposed regulations were to become law, facilities almost certainly would cite the minimal federal requirements (plain language, language that a resident understands, etc.) as CMS’s seal of approval for the facility’s arbitration agreements.  This will interfere with a court’s ability to independently evaluate, under state law, whether an arbitration agreement was unconscionable.[[8]](#footnote-8)

Worse, CMS’s authorization of arbitration as a condition of admission would directly conflict with the many state unconscionability cases that find that an arbitration agreement was obtained in a procedurally unconscionable manner if the resident was forced to sign it in order to be admitted.  A mandatory arbitration provision is a textbook contract of adhesion — a provision that a consumer is forced to accept — and does not in any way promote a consumer’s ability to make choices.[[9]](#footnote-9)  Thus, by authorizing facility’s use of mandatory arbitration agreements, CMS would be depriving consumers of rights and choices, limiting residents’ rights under state law, and acting outside the scope of its statutory authority.

**Arbitration can be lengthy and expensive.**

CMS has based a large part of its argument in favor of removing the ban on pre-dispute arbitration on its contention that arbitration allows for “expeditious resolution without the costs and expense of litigation.”[[10]](#footnote-10) However, there are many instances when arbitration can be both lengthy and expensive.

Arbitration is expensive

Arbitration is often touted as a lower cost, less burdensome alternative to the traditional legal system. However, in reality, arbitration is extremely costly and may actually be more expensive than bringing a claim to court.[[11]](#footnote-11) Forced arbitration can cost thousands of dollars in upfront costs that many individuals, and in particular seniors with health concerns, cannot afford.[[12]](#footnote-12) And, because forced arbitration is completely private, the costs to both parties are higher than litigation.[[13]](#footnote-13) In court systems, the government pays the salaries of the judges and most of the administration costs.[[14]](#footnote-14) But in forced arbitration, the parties must pay all of the costs to arbitrate.[[15]](#footnote-15)

Arbitration is often very lengthy

Despite having granted the plaintiff’s motion for preliminary injunction in *American Health Care Association v. Burwell*, the Judge wrote in his ruling that in claiming that arbitration is a fast and efficient process, the plaintiffs did not look at nursing home arbitration as a whole.[[16]](#footnote-16) Based on his own observations and experiences of arbitration, the Judge notes that numerous issues can arise in arbitration, such as mental competency, that can only be resolved by an actual trial – which is time-consuming.[[17]](#footnote-17) He cites one of his own cases that was “nothing but expense and delay”[[18]](#footnote-18) and writes that “nursing home arbitration litigation is an inefficient and wasteful form of litigation.”[[19]](#footnote-19)

**CMS ignores costs to residents and taxpayers.**

Nursing facilities claim that banning arbitration raises costs because of lawsuits. As discussed above, arbitration lessens the degree of nursing home accountability. Less accountability for poor care, abuse, and neglect could lead to more, not fewer, injuries, **and greater costs** to taxpayer-funded programs like Medicare. A U.S. Department of Health and Human Services Office of Inspector General (OIG) report entitled, *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries,[[20]](#footnote-20)* determined that in one year, Medicare paid an estimated $2.8 billion in hospital costs to treat residents harmed during their stay in a skilled nursing facility stay. Moreover, the proposed regulation does not even address the costs – both the financial and the incalculable physical and emotional suffering – borne by residents who are harmed by nursing facilities that escape accountability.

We urge you to withdraw the proposed regulation and retain the ban on pre-dispute binding arbitration. If, for whatever reason, you are unwilling to continue the current ban on pre-dispute arbitration, we recommend that you revise the federal nursing facility regulations so that they do not address arbitration at all. The proposed regulations are, by far, worse than nothing.

Thank you for the opportunity to comment and for your consideration of our comments.

Sincerely,

Your Name Your Title

1. 81 Fed. Reg. at 68,795. [↑](#footnote-ref-1)
2. 82 Fed. Reg. at 26,649 (“support the resident's right to make informed choices about important aspects of his or her health care”), 26,651 (“enabling residents to make informed choices about important aspects of his or her healthcare”), & 26,653 (“supports the resident's right to make informed choices about important aspects of his or her healthcare”). [↑](#footnote-ref-2)
3. 81 Fed. Reg. at 68,794. [↑](#footnote-ref-3)
4. *See, e.g.*, Eric Carlson, Long-Term Care Advocacy § 10.11 (Lexis Publishing 2016) (fact patterns in published nursing facility court rulings). [↑](#footnote-ref-4)
5. 42 U.S.C. §§ 1395i-3(f)(1), 1396r(f)(1). [↑](#footnote-ref-5)
6. 42 U.S.C. §§ 1395i-3(d)(4)(B), 1396r(d)(4)(B). [↑](#footnote-ref-6)
7. 42 U.S.C. §§ 1395i-3(c)(1)(A)(xi), 1396r(c)(1)(A)(xi); *see also* 82 Fed. Reg. at 26,651 (listing of authority). [↑](#footnote-ref-7)
8. *See, e.g.*, Eric Carlson, Long-Term Care Advocacy § 10.13[4][d][i] & [ii] (collected unconscionability cases). [↑](#footnote-ref-8)
9. Ostroff v. Alterra Healthcare Corp., 433 F. Supp. 2d 538, 544 (E.D. Pa. 2006) (mandatory arbitration; procedural unconscionability); Howell v. NHC Healthcare-Fort Sanders, Inc., 109 S.W.3d 731, 7735 (Tenn. Ct. App. 2003) (same). [↑](#footnote-ref-9)
10. 82 Fed. Reg. at 26,651 [↑](#footnote-ref-10)
11. Arbitration Study: Report to Congress, Pursuant to Dodd-Frank Wall Street Reform and Consumer Protection Act § 1028(a), CONSUMER FIN. PROTECTION BUREAU, Appendix A at 43 (2015), *available at* http://files.consumerfinance.gov/f/201503\_cfpb\_arbitration-study-report-to-congress-2015.pdf. [↑](#footnote-ref-11)
12. Lisa A. Nagele-Piazza, *Unaffordable Justice: The High Cost of Mandatory Employment Arbitration for the Average Worker*, University of Miami Business Law Review, Vol. 23, p. 40-68 (2014), *available at* http://repository.law.miami.edu/umblr/vol23/iss1/4. [↑](#footnote-ref-12)
13. CFPB Arbitration Study, *supra* note 9, Appendix A at 43. [↑](#footnote-ref-13)
14. Id. [↑](#footnote-ref-14)
15. Id. [↑](#footnote-ref-15)
16. American Health Care Association et al v. Burwell et al., No. 3:16-cv-00233 (N.D.M.S. Nov. 7, 2016), p. 4. [↑](#footnote-ref-16)
17. American Health Care Association et al v. Burwell et al., No. 3:16-cv-00233 (N.D.M.S. Nov. 7, 2016), pp. 5-6. [↑](#footnote-ref-17)
18. American Health Care Association et al v. Burwell et al., No. 3:16-cv-00233 (N.D.M.S. Nov. 7, 2016), p.6. [↑](#footnote-ref-18)
19. American Health Care Association et al v. Burwell et al., No. 3:16-cv-00233 (N.D.M.S. Nov. 7, 2016), p. 39. [↑](#footnote-ref-19)
20. https://oig.hhs.gov/oei/reports/oei-06-11-00370.pdf [↑](#footnote-ref-20)