

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 483

[CMS–3342–F]

RIN 0938–AT18

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

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule amends the requirements that Long-Term Care (LTC) facilities must meet to participate in the Medicare and Medicaid programs. Specifically, we are repealing the prohibition on the use of pre-dispute, binding arbitration agreements. We are also strengthening the transparency of arbitration agreements and arbitration in LTC facilities. This final rule supports residents' rights to make informed choices about important aspects of their health care.

DATES: These regulations are effective on September 16, 2019.

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SUPPLEMENTARY INFORMATION:

I. Background

Prior to October 2016, the requirements for Long-Term Care (LTC) facilities to participate in the Medicare and Medicaid programs, found in 42 CFR part 483, contained no provisions specific to the use of pre-dispute, binding arbitration agreements between LTC facilities and their residents. Then, on October 4, 2016, we published in the *Federal Register* a final rule entitled “Reform of Requirements for Long-Term Care Facilities” (81 FR 68688) (2016 final rule), that, among other revisions, established several requirements regarding the use of binding arbitration agreements by long-term care facilities.

Specifically, the 2016 final rule amended 42 CFR 483.70(n) to prohibit LTC facilities from entering into pre-dispute, binding arbitration agreements with any resident or his or her representative, or requiring that a resident sign an arbitration agreement as a condition of admission to the LTC facility. It also required that an agreement for post-dispute binding arbitration be entered into by the resident voluntarily, that the parties

agree on the selection of a neutral arbitrator, and that the arbitral venue be convenient to both parties. The arbitration agreement could be signed by another individual only if allowed by the relevant state's law, if all of the other requirements in this section were met, and if that individual had no interest in the facility. In addition, a resident's right to continue to receive care at the facility post-dispute could not be contingent upon the resident or his or her representative signing an arbitration agreement. The arbitration agreement could not contain any language that prohibited or discouraged the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal and state health department employees, and representatives of the Office of the State Long-Term Care Ombudsman. In addition, when a LTC facility and a resident resolved a dispute through arbitration, a copy of the signed agreement for binding arbitration and the arbitrator's final decision was required to be retained by the facility for 5 years and be available for inspection upon request by the Centers for Medicare & Medicaid Services (CMS) or its designee.

On October 17, 2016, the American Health Care Association (AHCA) and a group of affiliated nursing homes filed a complaint in the United States District Court for the Northern District of Mississippi, Oxford Division seeking a preliminary and permanent injunction enjoining agency enforcement of the prohibition on pre-dispute, binding arbitration agreements, as provided in the regulation (§ 483.70(n)(1)) (AHCA litigation). On November 7, 2016, the district court preliminarily enjoined enforcement of that regulation prohibiting the use of pre-dispute, binding arbitration agreements (Civil Action No. 3:16–CV–00233).

As a result of the court's decision, on December 9, 2016, we issued a nationwide instruction to State Survey Agency Directors, directing them not to enforce the 2016 final rule's prohibition of pre-dispute, binding arbitration provisions during the period that the court-ordered injunction remained in effect (S&C: 17–12–NH) <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-12.pdf>.

In addition, we determined that further analysis of the arbitration provisions was warranted. We re-evaluated the provisions to determine if a policy change would achieve a better balance between the advantages and disadvantages of pre-dispute, binding

arbitration for residents and their providers and to ensure that the requirements complied with the terms of the January 30, 2017 Executive Order “Reducing Regulation and Controlling Regulatory Costs” (E.O. 13771). Based on this further analysis, we developed a revised regulatory approach to the use of arbitration agreements by Medicare and Medicaid participating LTC facilities.

On June 8, 2017, we published in the *Federal Register* a proposed rule entitled “Revision of Requirements for Long-Term Care Facilities: Arbitration Agreements” (82 FR 26649) (2017 proposed rule). The 2017 proposed rule would remove the provision prohibiting pre-dispute, binding arbitration agreements and strengthen requirements regarding the transparency of arbitration agreements in LTC facilities. The proposal would support the resident's right to make informed choices about important aspects of his or her health care.

Statutory Authority

The agency has statutory authority to issue these rules under the authority granted by the Congress in the Nursing Home Reform Act, part of the Omnibus Budget Reconciliation Act of 1987 (OBRA 87), (Pub. L. 100–203, 101 Stat. 1330 (1987)). That statute added sections 1819 and 1919 to the Social Security Act (the Act), authorizing the agency 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” (Sections 1819(f)(1) and 1919(f)(1) of the Act). In addition, sections 1819(d)(4)(B) and 1919(d)(4)(B) of the Act authorizes the Secretary to impose “such other requirements relating to the health and safety [and well-being¹] of residents as [he] may find necessary”. This final rule does not purport to regulate the enforceability of any arbitration agreement, and, assuming that it limits the right of the Secretary to protect the rights of Medicaid beneficiaries, in our view, this rule does not pose any conflict with the language of the Federal Arbitration Act (FAA).

II. Provisions of the Proposed Regulations

In the 2017 proposed rule, we proposed to revise the provision related to pre-dispute, binding arbitration at § 483.70(n). We proposed to remove provisions that we believed on reconsideration did not strike the best balance between the advantages and

¹ Section 1819 only.

disadvantages of pre-dispute, binding arbitration. Specifically, we proposed to:

- Remove the requirement at § 483.70(n)(1) precluding facilities from entering into pre-dispute, binding agreements for binding arbitration with any resident or resident's representative;
- remove the provisions at § 483.70(n)(2)(ii) regarding the terms of arbitration agreements; and
- remove the prohibition at the root statement and § 483.70(n)(2)(iii) banning facilities from requiring that residents sign arbitration agreements as a condition of admission to, or as a requirement to continue to receive care at, a facility.

We proposed to retain provisions important to transparency of arbitration agreements. Specifically, we proposed to retain that:

- The agreement be explained to the resident and his or her representative in a form and manner that he or she understands, including in a language that the resident and his or her representative understands; and require that the resident acknowledge that he or she understands the agreement,
- the agreement must not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representatives of the Office of the State Long-Term Care Ombudsman, in accordance with § 483.10(k), and
- when the facility and a resident resolve a dispute through arbitration, a copy of the signed agreement for binding arbitration and the arbitrator's final decision must be retained by the facility for 5 years and be available for inspection upon request by CMS or its designee.

Finally, we proposed to add two transparency requirements. Specifically, we proposed to require that:

- The facility ensure that the agreement for binding arbitration is in plain language, and
- the facility must post a notice in plain language that describes its policy on the use of agreements for binding arbitration in an area that is visible to residents and visitors.

In response to the 2017 proposed rule, we received over 1,000 comments concerning the changes to the requirements regarding arbitration. Many comments were submitted by organizations that advocate for the rights of older adults, residents in nursing homes, or people with

disabilities, including State Offices of the Long-Term Care Ombudsman.

III. Responses to Public Comments

We have reviewed all of the comments received and considered the concerns raised by all stakeholders. As a result, we have made some revisions to the proposed rule in response to public comments. Specifically, as discussed in detail below, we are finalizing our proposals to remove the requirement at § 483.70(n)(1) precluding facilities from entering into pre-dispute, binding agreements for binding arbitration with any resident or his or her representative, and the provisions at § 483.70(n)(2)(ii) regarding the terms of arbitration agreements. We are not finalizing the proposed removal of the provision at § 483.70(n)(2)(iii) banning facilities from requiring that residents sign arbitration agreements as a condition of admission to a facility. Therefore, facilities will continue to be prohibited from requiring any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to the facility. In addition, to address commenters' concerns that facilities may still coerce or intimidate the resident and his or her representative into signing the agreement, the facility must explicitly inform the resident or his or her representative that signing the agreement is not a condition of admission and ensure that this language is also in the agreement. We are finalizing provisions requiring that arbitration agreements be in a form and manner that the resident understands. However, we are not finalizing the proposed transparency related provisions that the facility must ensure that the agreement for binding arbitration is in "plain language" and that the facility post a notice regarding the use of agreements for binding arbitration in an area that is visible to residents and visitors. We are not finalizing the proposed removal of the provision specifying that a resident's right to continue to receive care at the facility must not be contingent upon signing an arbitration agreement. Finally, based on comments, we are adding a requirement that facilities grant to residents a 30 calendar day period during which they may rescind their agreement to an arbitration agreement. Our rationale for these changes, as well as our responses to comments we received on these issues is discussed below in detail.

A. General Comments

Comment: The overwhelming majority of commenters were opposed

to our proposal to remove the prohibition on pre-dispute, binding arbitration agreements and recommended that we keep the requirements established by the October 2016 final rule. These commenters included consumer advocates, legal organizations, health care providers and practitioners, and members of the public. Some commenters believed that the current requirements contained long overdue improvements and the proposed rule was "reversing course" on those improvements. They agreed with the reasoning in the October 2016 final rule and often quoted the language in that rule. Some commenters favored the proposed revisions and supported finalizing the revisions as proposed. Others supported the proposed revisions but recommended specific changes. One commenter stated that they would support arbitration agreements, if they were properly structured. The commenter recommended requiring a rescission period, changes in the agreement terms, and even the creation of a governmental arbitration agency. Another commenter, a non-profit, long-term care provider, favored allowing voluntary, pre-dispute, binding arbitration agreements. Although the majority of commenters expressed support for the 2016 final rule, we also received comments from associations representing the LTC industry supporting the use of pre-dispute, binding arbitration agreements.

Response: In light of this broad spectrum of opinions, we have decided to revise § 486.70(n) by removing the prohibition on pre-dispute, binding arbitration agreements and creating protections against the abuses associated with arbitration agreements. Most significantly, arbitration agreements must not be used as a condition of admission to, or as a requirement for a resident to continue to receive care at, the facility. The agreement must explicitly grant residents the explicit right to rescind the agreement within 30 calendar days of signing it. The recommendation that there be the creation of a government arbitration agency is beyond the scope of this rule.

Comment: Some commenters stated that any regulations addressing arbitration are unnecessary. They stated that, under current law, residents, as well as all consumers, are already protected against fraud, unfairness, duress, and other types of overreaching in contracts by state contract and consumer protection law. For example, they contended that state laws already require the party seeking to enforce a contract, in this case the LTC facility

seeking to compel the resident or his or her representative to arbitrate a dispute, to demonstrate that the other party consented to the agreement. They asserted that a fundamental concept of contract law is a 'meeting of the minds' and 'a manifestation of mutual assent.' Thus, if the agreement is not in a language the resident understands or he or she does not understand the agreement for some other reason, it could be held invalid or unenforceable. Some commenters also pointed out that allowing LTC facilities to make signing an arbitration agreement a condition of admission might conflict with some states' laws. Another commenter pointed out that state courts would routinely invalidate unfair arbitration provisions on generally-applicable unconscionability principles for a variety of reasons, such as limitations on a consumer/resident's substantive rights to recover certain types of damages permitted to them by federal and state law, an unreasonably shortened statute of limitations, and unfair selection or excessive fees associated with selection of the arbitrator, arbitration venue, or access to an arbitral forum. Since residents can already challenge arbitration agreements in court under state law, these commenters believed residents' rights are already being protected and the arbitration requirements in the 2016 final rule are unnecessary. Some commenters even asserted that there should be no arbitration provisions in the LTC requirements because CMS has no expertise in this area and there is no evidence that state law is failing to adequately protect its citizens, including residents, regarding arbitration. Many commenters requested that, if we finalized our proposal to remove the prohibition on pre-dispute, binding arbitration agreements, CMS should remove all provisions discussing arbitration requirements. They stated that having no requirements regarding arbitration would be better for the residents than having any. Another commenter stated that, since much of the reimbursement received by these facilities is from the Medicare and Medicaid programs, which are funded by taxpayers, there should never be any limitations on the rights and remedies provided by state law.

Response: We agree with the commenters that many states' contract and consumer protection laws offer residents, as well as others, protections from unfair contracts, including pre-dispute, binding arbitration agreements that are unconscionable or are otherwise unenforceable under state contract law.

This is why we revisited the protections promulgated in the October 2016 final rule. However, even though state law may provide some protection for residents, commenters raised a number of concerns that convinced us that these protections are limited and do not protect the unique needs of Medicare and Medicaid beneficiaries. Commenters pointed out that state laws differ and would likely offer varying levels of protection to residents. The requirements in this final rule offer consistent levels of protection to all residents in LTC facilities that are certified by the Medicare and Medicaid programs. Commenters also stated that many residents would find it difficult, if not impossible, to challenge these agreements in court. The resident or his or her family would generally have to retain an attorney. Since most residents' care is being paid for by either Medicare or Medicaid, some residents may not have the resources to pay an attorney. Many commenters also noted that engaging an attorney to challenge an arbitration agreement is also difficult because, should the challenge prove unsuccessful, the damages awarded through arbitration are generally lower than those awarded through judicial proceedings. If the award is smaller, the attorney's fee would likely also be smaller if the attorney took the case on a contingency basis. In addition, one commenter presented evidence of several instances indicating that challenging an arbitration agreement, even if successful, could result in years of delay before the claim could be resolved. The commenter cited 14 cases involving claims of abuse or neglect where the resident or their family successfully challenged the enforceability of an arbitration agreement. The commenter noted that it required between two and four years to resolve the issue of the enforceability of the binding arbitration before addressing the underlying abuse and neglect claim. Commenters said that some attorneys could determine that the delay associated with a particular case did not justify the resources and time needed to challenge the enforceability of a binding arbitration agreement. Some commenters were concerned that facilities could make it more difficult for residents to challenge arbitration agreements. Thus, some residents or their representatives would find it difficult, perhaps almost impossible, to retain an attorney to challenge the arbitration agreement in court. State law protections would be meaningless to residents if, as a practical matter, they did not have the ability to challenge

these agreements in court. Thus, we believe that relying solely on state contract or consumer protection law, enforced primarily by private action, could in fact result in little to no real protections for the residents.

We believe the LTC requirements finalized in this rule are essential to ensure that arbitration agreements are not barriers to the resident receiving care and that there is no interference with federal, state, or local officials investigating quality of care issues. Therefore, in this final rule, we are retaining the existing requirement at § 483.70(n)(1), which prohibits the facility from using an arbitration agreement as a condition of admission. We are also retaining the requirement that an arbitration agreement cannot be used as a condition of admission to, or right to continue to receive care at, the facility. In addition, facilities must explicitly inform the resident or his or her representative that it is his or her right not to sign the agreement and this language must also be in the arbitration agreement. This provision will ensure that no resident or his or her representative will have to choose between signing an arbitration agreement and receiving care at the LTC facility. Although we are not finalizing a prohibition on pre-dispute, binding arbitration agreements, we believe that the requirements we are finalizing in this rule will provide the protections residents and their representatives will need to avoid being compelled to arbitrate disputes with LTC facilities without voluntarily and knowingly choosing to do so. The LTC facility must not require the resident or his or her representative sign an agreement for binding arbitration as a condition of admission to, or as a requirement for the resident to continue to receive care at, the facility. The facility must also ensure that the agreement is explained to the resident or his or her representative in a form and manner that he or she understands, and that individual(s) must acknowledge that he or she understands the agreement. The agreement must also explicitly grant the representative or his or her representative the right to rescind the agreement within 30 calendar days of signing it. This allows the resident to seek legal advice, if he or she chooses to do so. These requirements ensure that a decision on whether to sign the agreement is made only after the resident or his or her representative understands what he or she is agreeing to and that there is time to reconsider a decision to sign the agreement and seek legal advice, if he or she chooses

to do so. We believe that these protections address the concerns of the commenters who contended that LTC facilities were taking advantage of or coercing residents to sign these agreements.

We are also finalizing § 483.70(n)(2), which specifies that the agreement cannot contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including federal and state surveyors, other federal or state health department employees, and representatives of the Office of the State Long-Term Care Ombudsman. This is the same requirement that was located at § 483.70(n)(2)(iv) in the 2016 final rule. Commenters informed us that a significant number of claims subjected to arbitration address quality of care issues. They also stated that it is quite often the case that the arbitral forum itself does not provide a way for the beneficiaries to seek full redress for their injuries. Commenters further stated that, when this happens, many substandard nursing homes continue providing poor care because the consequences for their conduct are insignificant. In light of these comments, we have concluded that the Secretary's statutorily-mandated duty to protect the health and safety of residents mandates that we create protections that assist LTC residents in knowingly and willingly entering into arbitration agreements that provide a neutral and fair arbitration process.

Comment: Several commenters were concerned about the effect that federal rules on arbitration might have on state laws addressing arbitration. They expressed particular concern that a federal regulation might be viewed as superseding state arbitration laws that are designed to protect residents and their families. State courts have invalidated arbitration agreements due to, among other reasons, unconscionability, fraud, and duress. Other state laws protect consumers from one-sided or cohesion contracts. The commenters claimed that these protections could not be overridden by the FAA because they apply to all consumer contracts and not arbitration agreements specifically. They expressed concern that a facility might argue that being in compliance with the current regulation would demonstrate that the arbitration agreement in question was not unconscionable. Other commenters believed that the arbitration requirements could conflict with the current consumer protection laws in some states and result in facilities avoiding or believing that those

protections would no longer apply to residents, perhaps even those designed to prevent elder abuse. Some commenters were concerned that facilities would argue that their arbitration agreements were fair and that the court should compel arbitration because they complied with the arbitration requirements in the federal LTC requirements. This could make it more difficult for residents and their families to challenge an arbitration agreement in court. Other commenters also pointed out that, since it was against LTC facilities' interests to get residents or their families to sign arbitration agreements that could be struck down by a state court, they would not do so.

Response: We understand the commenters' concerns; however, we do not believe the requirements finalized in this rule will be detrimental to residents. These protections are in no way designed to supersede or interfere with state laws or other state contract and consumer protection laws. Many of these state laws provide for more protections than are set forth in the LTC requirements, and we believe it is in the best interests of the residents to have maximum protection afforded by law to protect their rights. This regulation is not intended in any way to preempt these state laws except to the extent any such laws are actually in conflict with this regulation. This regulation provides additional protections, and it is our hope that state court judges will understand this when deciding whether an arbitration agreement complies with any protections afforded residents under state law. In addition, the purpose of our LTC facility requirements are to protect the health, safety, welfare, and rights of residents. CMS establishes these minimum requirements that LTC facilities must meet to receive payment reimbursement from the Medicare and Medicaid programs. Hence, we do not believe that the arbitration requirements finalized in this rule would negatively impact any challenge to an arbitration agreement in state court.

Comment: Some commenters asserted that the confidential nature of arbitration could result in LTC facilities being able to hide, or avoid the consequences of, providing substandard or poor care. Commenters stated that since arbitration proceedings and the arbitrator's final decision are not matters of public record, that by allowing pre-dispute, binding arbitration agreements, LTC facilities could avoid some of the consequences of poor care, such as larger jury awards than those generally awarded in arbitration proceedings and a bad reputation that could dissuade

potential residents from seeking admission to a facility.

Response: As discussed above, commenters have raised a variety of concerns about the confidential nature of arbitration. We share their concerns, and we are therefore finalizing the requirements mandating that LTC facilities retain copies of the signed arbitration agreement and the arbitrator's final decision for each dispute resolved through arbitration. They must retain these documents for 5 years after the resolution of the dispute, and make them available for inspection by CMS or its designee. This will allow us to gather data on how arbitration is being conducted in LTC facilities. We note the sincere concerns of many individual commenters that residents are not being treated fairly in facilities that use pre-dispute, binding arbitration agreements and that quality of care is negatively impacted by the use of these agreements. We believe that collecting these data would play a part in helping us determine the validity of these allegations on quality of care. For more information on our efforts to improve the quality of care in nursing homes, please see the Nursing Home Quality Initiative web page at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/index.html>.

Comment: Some commenters agreed with our proposal to rescind the prohibition on pre-dispute, binding arbitration agreements. One organization stated that there was no policy justification for the prohibition or even regulating arbitration in any way because arbitration does not affect a resident's health, safety, or welfare. Another commenter disagreed with some of our statements in the 2016 final rule. This commenter noted that non-profit LTC providers are mission-driven and focus on providing the highest quality of care to their residents. The commenter noted that studies show that non-profit providers consistently provide the quality of care and service that exceeds that of for-profit LTC providers, because they do not have shareholders, investors, or owners that could pressure the facility to increase profits. The commenter also noted that there was no identified widespread deficiency in the care provided by non-profit LTC providers that would justify or be addressed by the prohibition of voluntary pre-dispute, binding arbitration agreements between the facility and its residents. The commenter stated the threat of excessive jury verdicts was unnecessary to provide incentive for non-profit

providers to either maintain or improve the quality of care they provide to their residents. A non-profit provider that served, and was set up to accommodate the Jewish community was concerned that a blanket prohibition on voluntary, pre-dispute, binding arbitration agreements would violate exercise of freedom of religion in violation of the Religious Freedom and Restoration Act. The commenter noted that under some interpretations of Talmudic law, disputes are not to be settled in secular courts. The commenter was concerned that if a resident either dies or another individual has authority to act for them, such other individual could file a lawsuit against the facility, and that such suit could conceivably be contrary to the deceased/incapacitated resident's beliefs. Essentially, they asserted that the relationship between the residents of their facility and the facility itself was not merely a commercial transaction since both the provider and the resident share mutual goals, aligned interests, and trust. However, they also stated that they did not object to common sense requirements that ensure that the agreement was voluntary. The commenter indicated that they would not object to requiring that the agreement be in plain language, explained to the resident in a form and manner he or she understands, and the resident must acknowledge that he or she understands the agreement.

Response: We appreciate that some data like the Nursing Home Data Compendium 2015 Edition (NHDC), indicate that non-profit LTC facilities tend to provide a better quality of care than some for-profit facilities, as evidence by fewer health deficiencies found on surveys. See https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/nursinghomedatacompendium_508-2015.pdf (Accessed May 25, 2018). However, all ownership types of LTC facilities, including non-profits, have been cited for health deficiencies, sometimes very serious ones that result in a finding of actual harm or immediate jeopardy (NHDC, pp. 92–97). We agree with the commenters that completely prohibiting the use of pre-dispute, binding arbitration agreements could be too burdensome for some LTC facilities, regardless of whether they are non-profit or for-profit LTC facilities, because it would deny facilities a method of dispute resolution that can be faster and more economical than resolving the dispute in court. Thus, as we have noted previously, we are modifying the original rule to provide a

balance between LTC facilities' desire for arbitration and the need for protections for LTC facility residents.

Regarding the commenter that was concerned that prohibiting a LTC facility from entering into pre-dispute, binding arbitration agreements with its residents could violate a resident's wishes, especially if they pass away or become incapacitated, we acknowledge that situation could happen. Since we have finalized the removal of that prohibition, we believe the commenter's concern has been addressed.

Comment: Some commenters stated that the proposed changes to the 2016 final rule were contrary to the evidence we presented and the comments we received when promulgating the 2016 rule. One commenter stated that the 2017 proposed rule did not address the evidence upon which we based the LTC facility requirements in the 2016 final rule. They asserted that the 2017 proposed rule was improper because it constituted a complete reversal of the policy in the 2016 final rule and, as such, CMS could not modify the 2016 rule without identifying or citing new evidence that justified the proposed changes. This commenter believed that the 2016 final rule presented an extensive literature review and an analysis of public comments that overwhelmingly demonstrated that pre-dispute, binding arbitration agreements should be prohibited. They insisted that the 2016 final rule constituted a carefully considered policy and should not be reversed on weak or non-existent evidence. Another commenter stated that, since the overwhelming number of comments opposed the use of pre-dispute, binding arbitration agreements because of the dangers they pose to the health, safety, and welfare of residents in LTC facilities, there is no reasonable basis for reversing the policy in 2016 final rule. The commenter stated that the 2016 final rule was clearly well justified by the evidence, the comments, and solid legal authority. They asserted that the modifications to the 2016 final rule contained in the 2017 proposed rule lacked the same level of support that underpinned the 2016 final rule. One commenter cited *Federal Communications Commission v. Fox Television Stations, Inc.* (566 U.S. 502, 129 S.Ct. 1800 (2009)) (*FCC vs. Fox*), in which the U.S. Supreme Court addressed the legal standard governing whether an agency's reversal of a prior action is arbitrary and capricious. Based upon this opinion, the commenter stated that the critical protections in the 2016 final rule could not be rescinded without supplying a reasoned, record-based explanation for reversing its

assessment of the evidence and comments that demonstrated the negative impact of forced arbitration on LTC residents.

Response: In the 2017 proposed and this final rule, we have provided a rationale for the requirements that are being finalized. As we noted earlier, the vast majority of commenters from the LTC industry have argued for the continued use of arbitration agreements for reasons of cost and efficiency. This regulation is designed to strike a balance between those concerns and protecting the needs of LTC residents. Furthermore, one court has preliminarily enjoined the agency from enforcing the prohibition against pre-dispute, binding arbitration agreements. Given our reconsideration of the available evidence and based on our review of the comments we received, as well as the comments received for the 2017 proposed rule, we believe the policies set forth in this final rule better balance the need for resident protections with the potential burden on LTC facilities' need for efficient and cost-effective operation. The court in *FCC vs. Fox* clearly indicated that an agency action would not be subject to heightened scrutiny simply because it changed its policy. It need only demonstrate that—(1) it is changing its position; (2) the new policy is permissible under the statute; (3) it has good reasons for the new policy and for the change of policy; and (4) that it believes the new policy is better. (*FCC v. Fox*, 566 U.S. 502, 515, 129 S.Ct. 1800, 1811.) We have explained our reasoning for the changes to the requirements and believe that these finalized requirements constitute a better policy. Concerning the “evidence” and comments referred to by the commenter, there was very little statistical data (although a great deal of anecdotal evidence and reportage) upon which we made our decisions that supported this provision of the 2016 final rule. Many comments were based upon anecdotal or personal experiences, and some commenters provided articles published in various general and legal periodicals. However, there was little solid social science research evidence to support these assertions. In light of the lack of statistical data, we believe the best way to strike a balance between the stakeholders supporting arbitration and residents having a complete understanding of the consequences of entering into an arbitration agreement is to issue regulations that ensure that these agreements not be used as a condition of admission to, or as a requirement for a resident to continue to

receive care at, the facility and the arbitration process is transparent to the resident and his or her representative. In addition, the requirement to retain copies of the arbitration agreement and the arbitrator's final decision will allow us to learn how arbitration is being used by LTC facilities and how this is affecting the residents.

Comment: Some commenters believed that the proposed changes to the arbitration requirements were politically motivated. Some believed that the motivation for these changes, which they believe benefit the providers at the detriment of the residents' rights, resulted from the change in administrations. One commenter noted the sudden and remarkable change between allowing pre-dispute, binding arbitration agreements in the 2017 proposed rule as compared to the 2016 final rule, which prohibited these agreements, despite CMS having earlier stated that "there is significant evidence that pre-dispute arbitration agreements have a deleterious impact on the quality of care for [nursing home] patients" in the 2016 final rule (81 FR 68791). One commenter even stated that they thought these changes would personally benefit some in the current administration.

Response: While there has been a change in Administration since the 2016 Final Rule was published, we disagree that change was the sole or primary reason for the proposed changes. As discussed above, at least one district court has rendered a decision that preliminarily enjoins us from enforcing the prohibition against pre-dispute, binding arbitration agreements. Following that ruling, we undertook a re-evaluation of the arbitration-related requirements in order to determine if a different approach would better serve both residents and facilities. That approach is reflected in this final rule, which includes some of the requirements in the 2016 Final Rule.

Comment: Some commenters that are opposed to pre-dispute, binding arbitration agreements asserted that post-dispute, binding arbitration agreements could be appropriate in a LTC setting. Since the agreement would be signed after the circumstances of the dispute had occurred, the resident could make an informed decision about settling the dispute with the facility through binding arbitration. However, other commenters were in favor of our proposal to remove the prohibition or ban on pre-dispute, binding arbitration agreements because they believed it was the equivalent of banning all arbitration. These commenters contended that parties often are unwilling to consider

arbitration after a dispute arises. After a dispute arises, parties often have an emotional investment in resolving the dispute solely in their favor. This emotional investment often results in the parties not being able to evaluate the dispute logically or rationally. They may also believe that a willingness or offer to negotiate or submit the dispute to arbitration may appear as weakness. As a result, at least one of the parties would virtually always reject arbitration in favor of judicial proceedings, while another commenter asserted that pre-dispute, binding arbitration agreements were the most efficient way to ensure that parties do, in fact, arbitrate their disputes.

Response: As the comments make clear, there are strong arguments both for and against pre-dispute, binding arbitration agreements. This is a key reason why we are modifying this rule in an attempt to create a balance between both sides. As discussed above, we are finalizing our proposal to remove the prohibition on pre-dispute, binding arbitration agreements. Facilities and their residents will be able to enter into both pre-dispute and post-dispute binding arbitration agreements as long as facilities comply with the requirements that we are finalizing in this rule.

Comment: Some commenters were opposed to our proposal to remove the requirements at § 483.70(n)(2)(ii)(A), (B), and (C) in the 2016 Final Rule. Those requirements were that the agreement must: (A) Be entered into by the resident voluntarily, (B) Provide for the selection of a neutral arbitrator agreed upon by both parties, and (C) Provide for selection of a venue convenient to both parties. Commenters contended that these protections were critical for residents as they, at least partially, addressed the unequal bargaining power between the resident or his or her representative and the facility. Another commenter said that the selection of a neutral arbitrator was a key component of the LTC facility's accountability and consumer protection. One commenter pointed out that since residents have explicit rights to select their pharmacist and doctor, residents should also have a voice in the selection of the arbitrator and the location of the arbitration.

Response: We agree with the commenters. We believe these components are standard elements of arbitration and expect that these elements would be covered in the arbitration agreement. To ensure that the resident or his or her representative has the benefit of these components, this final rule retains the requirement that the facility provide for the selection

of a neutral arbitrator agreed upon by both parties and provide for the selection of a venue convenient to both parties. However, we will remove the requirement that the resident or his or her representative sign the agreement voluntarily as we believe this provision is redundant. Other requirements in this section ensure that the agreement is explained and the resident or his or her representative knows that he or she does not have to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. In addition, we are finalizing a right for the resident or his or her representative to rescind the agreement within 30 calendar days of signing it. This provides the resident or his or her representative an opportunity to reconsider the agreement or, if they choose, seek legal advice. We believe that this right to rescind the agreement, as well as the requirements to provide for a neutral arbitrator agreed upon by both parties and the selection of a venue convenient to both parties, provide sufficient protection against an agreement that does not treat the resident fairly.

Comment: Some commenters appeared to interpret the district court's holding in the AHCA litigation as a ban on all arbitration agreements or other arbitration-specific requirements. Another commenter contended that the district court said that the forum for the dispute, whether resolved through judicial proceedings or arbitration, had no meaningful effect on the health, safety, and well-being of residents.

Response: We disagree with the commenter. As noted above, in our discussion of the relevant litigation, the only issue before the court was whether CMS could enforce § 483.70(n)(1)'s prohibition of pre-dispute, binding arbitration agreements. The court did not address issues beyond the arbitration prohibition.

Comment: Some commenters were against our proposal to remove the prohibition on pre-dispute, binding arbitration agreements because they believe the agreements are inherently unfair. They did not believe that any LTC facility requirements could overcome that inherent unfairness. They pointed to the imbalance of power between the resident and the facility, the facility having drafted the agreement with terms that would be favorable to the LTC facility, not the resident. In addition, staff rarely have the authority to re-negotiate the terms of the agreement with an individual prospective resident. Most residents and their representatives are likely unfamiliar with the implications of the

use of arbitration as a form of alternative dispute resolution and the consequences of signing the agreement. In addition, many commenters noted that residents would likely not seek legal advice before they sign the agreement. Other commenters contended that the inherent unfairness in using pre-dispute, binding arbitration agreements in LTC facilities is demonstrated by policy statements issued by various national legal and arbitration associations opposing the use of these agreements in health care disputes.

Response: We believe that the LTC requirements finalized in this rule will address the concerns identified by these commenters. We further acknowledge that various legal and arbitration associations have issued policy statements opposing the use of these agreements in health care disputes. In the 2016 final rule, we noted that three major legal or arbitration associations have made policy statements opposing continued use of pre-dispute, binding arbitration agreements (81 FR 68797). We believe these requirements address many of the concerns upon which those policy statements were based. As discussed below, the facility must not require the resident to sign one of these agreements as a condition of admission to, or as a requirement to continue to receive care at, the facility. The facility must also explicitly inform the resident or his or her representative that he or she is not required to sign the agreement as a condition of admission to or a requirement to continue to, or as a requirement to continue to receive care at, the facility; this language must be included in the agreement. This requirement will ensure that the resident or his or her representative is not placed into the position of deciding between signing an arbitration agreement or potentially the resident not receiving the care at the facility that he or she needs. The facility must ensure that the agreement is explained to the resident or his or her representative and he or she acknowledges that he or she understands the agreement. These requirements ensure that the facility has explained the agreement and should provide the resident or his or her representative with the opportunity to ask questions before he or she acknowledges that they understand the agreement. The agreement must also now explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. This will provide the resident with the opportunity to

reconsider the agreement and, if they chose, seek legal advice within that 30-day rescission period. The right to rescind must also be explained by the facility when it explains the rest of the agreement and the resident or his or her representative must acknowledge that he or she understands the right to rescind the agreement, as well as the remaining provisions in the agreement. We believe that the right to rescind the agreement within 30 calendar days of signing it addresses the commenters' concern that the requirements finalized in this rule are insufficient to protect residents' rights. We believe that the transparency requirements, the requirement that an arbitration agreement must not be used as a condition of admission, and that the facility must explicitly inform the resident or his or her representative of his or her right not to sign the agreement, will address the resident's ability to negotiate with the facility as well as provide residents, their representatives, and their families with the protections they need to ensure that they understand the agreement and can make a voluntary decision on whether to sign the agreement. They will further ensure that residents will not be forced to sign arbitration agreements to receive the care they need.

Comment: One commenter pointed out that in proposed § 483.70(n)(2)(i) the agreement had to be explained to the resident and his or her representative in a form and manner that he or she would understand, including a language that the resident or his or her representative would understand. However, in proposed § 483.70(n)(2)(ii), we stated that only the resident would have to acknowledge that he or she understands the agreement.

Response: We agree with the issue that the commenter pointed out. Section 483.70(n)(2)(ii) should also provide for the resident's representative to be able to acknowledge that he or she understands the agreements. Therefore, we have revised the language of that section to provide for the representative to acknowledge he or she understands the agreement.

B. Authority To Regulate Arbitration in LTC Facilities

Comment: Some commenters, particularly an association that represents LTC facilities, stated that the Secretary had no legal authority to regulate arbitration in any manner. They indicated that section 2 of the FAA provided that arbitration agreements are "valid, irrevocable, and enforceable save upon such grounds as exist at law or equity for the revocation of any

contract" (9 U.S.C. 2). The last section of this clause, "save upon such grounds as exist at law or equity for revocation of any contract" is commonly referred to as the savings clause. The savings clause holds that arbitration agreements can be invalidated by generally applicable contract defenses, such as fraud, duress or unconscionability. Thus, the commenters stated that arbitration agreements or contracts should be treated as any other contract, and that the FAA's mandate could only be overcome by these generally applicable contract defenses. Some of these commenters also cited the district court's conclusion that the prohibition on pre-dispute, binding arbitration clauses was inconsistent with the requirement to treat arbitration contracts equally with all other contractual arrangements and that prohibition could not fit into the savings clause. Other commenters, however, strongly disagreed with the district court's decision in the AHCA litigation.

One commenter stated that the current LTC requirements already contain other limitations on the admissions contract. Specifically, the facility's contract cannot: (1) Request or require residents to waive their rights set forth in the federal regulations or in applicable state, federal or local licensing or certification laws; (2) request or require oral or written assurance that the resident is not eligible for, or will not apply for, Medicare or Medicaid benefits; (3) request or require residents to waive potential facility liability for losses of personal property; (4) request or require a third-party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility; and (5) charge, solicit, accept or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility (42 U.S.C. 1395i-3(c)(5), 1396r(c)(5), and 42 CFR 483.15(a)). The commenter stated that since federal law already targets multiple specific contract provisions for more stringent treatment, the 2017 proposed requirements actually provide special deference to arbitration agreements and as a result contradict and ignore the entire regulatory purpose and context of the LTC requirements. This commenter, in other words, claimed that since there are already restrictions on what can be in the admission contract, by removing the current restrictions on binding arbitration, we are actually giving

preferential treatment to arbitration agreements. In addition, the commenter appeared to be encouraging us to continue pursuing the AHCA litigation. Another commenter believed that the analysis contained in the 2016 final rule provided strong support for the Secretary to regulate arbitration agreements in LTC facilities.

All of these commenters stated there was Supreme Court precedent that the FAA mandate could only be overcome by a specific contrary congressional command. Since both the Medicare and Medicaid statutes are silent on arbitration, these individuals stated there was no contrary congressional command that gives the Secretary the authority to regulate arbitration. These commenters also stated that the district court properly rejected the arguments that the Secretary had authority based on her right to establish “rights” under the Medicare and Medicaid statutes and that she had authority to regulate these agreements, if the Secretary believed the regulation was necessary for the health, safety, and well-being of LTC residents.

Response: We recognize that the FAA is the overall federal statute addressing arbitration agreements. However, the FAA is concerned with general commercial contracts, whereas these rules arise under the Medicare and Medicaid statutes. The Medicare and Medicaid statutes explicitly grant the Secretary authority to ensure the protection of Medicare and Medicaid beneficiaries. Thus, this rule addresses a set of concerns that are unrelated to the reasons behind the FAA, as well as the statutory provisions contained within the FAA. Thus, while this rule modifies the original provisions regarding pre-dispute, binding arbitration clauses, we remain mindful of the comments claiming that these agreements potentially harm residents. We will, therefore, continue monitoring whether there is an effect on beneficiaries and, if we determine that the use of arbitration agreements poses a risk to the well-being of Medicare and Medicaid beneficiaries, we may revisit and revise the current policy. After reexamining the issue and reviewing public comments we received, at this point we believe that a balance can be struck that accommodates the use of arbitration agreements while also protecting the rights of LTC facility residents. Thus, we are finalizing the removal of the prohibition on pre-dispute, binding arbitration agreements and the provisions regarding the content of the agreement and implementing requirements we believe will provide greater transparency in the arbitration process.

Comment: Some commenters stated that CMS did not have the authority to change the arbitration requirements established by the 2016 final rule because removing or modifying the 2016 rule’s prohibition of pre-dispute, binding arbitration agreements would harm residents’ rights. These commenters pointed to the authorities contained in the Medicare and Medicaid statutes that the agency cited as authority for promulgating the 2016 Final Rule. Specifically, they agreed with the 2016 final rule’s conclusions that the Medicare and Medicaid statutes provided the Secretary: (1) Authority to promulgate regulations that are adequate to protect the health, safety, welfare, and rights of resident and to promote the effective and efficient use of public moneys (42 U.S.C. 1395i-3(f)(1) 1396r(f)(1)); (2) Authority to establish such other requirements relating to the health and safety and well-being of residents as the Secretary may find necessary (42 U.S.C. 1395i-3(d)(4)(B), 1396r(d)(4)(B)); and (3) Authority to establish other rights(s) for residents, in addition to those set forth in statute to protect and promote the rights of each resident (42 U.S.C. 1395i-3(c)(1)(A)(xi), 1396r(c)(1)(A)(xi) and the 2017 proposed rule (82 FR 26651) for a list of authorities). Based upon these authorities, these commenters stated that the Secretary lacked authority to remove requirements that would re-establish practices that are detrimental to residents, especially when one of the stated reasons for the changes is to reduce burden on providers. Another commenter added that the policy changes were contrary to the “person-centered care” framework established by federal law, policy, and regulation.

Response: While these commenters have reiterated concerns we raised in the 2016 final rule, other commenters have asserted that there are ways to protect the rights of residents without placing a complete prohibition on pre-dispute, binding arbitration agreements. The requirements we are finalizing in this rule are designed to accomplish the same goals as the 2016 rule, namely, protecting resident’s rights in matters concerning the arbitration process. We believe the concept of “person-centered care”, a crucial concept in the 2016 final rule, continues to be addressed in the requirements finalized in this rule. The facility must explain the agreement to the resident or his or her representative in a form and manner that the individual understands, and the individual must acknowledge that they understand the agreement. The agreement cannot be used as a condition

of admission to, or as a requirement to continue to receive care at, the facility, so that the resident is not forced or coerced into signing the agreement to obtain, or continue to receive, the care that he or she needs. The facility must also explicitly inform the resident and his or her representative that they are not required to sign the agreement as a condition of admission and that this language in the agreement. The requirement that facilities retain copies of the signed agreements to binding arbitration and the arbitrators’ final decisions will allow CMS to ensure that arbitration agreements are not used in a manner detrimental to quality of care concerns. We believe that these regulations will protect residents.

C. Impact on Health & Safety

Comment: Some commenters insisted that allowing LTC facilities to enter into pre-dispute, binding arbitration agreements would have a negative effect on residents because LTC facilities would be able to avoid some, or perhaps all, of the consequences of providing poor or inadequate care to their residents, including responsibility for illegal or even criminal acts. They stated that the threat of litigation was necessary to provide adequate incentive for the facilities to provide adequate care and a safe environment for the residents. When facilities use these agreements, their insurance premiums are lower since arbitration awards are usually lower than those received through judicial proceedings. Other commenters pointed out that there are also no public records of the arbitration proceedings. The public, including potential residents and their families, would likely not be aware of or even have the ability to learn of instances of poor care. Without the threat of lawsuits, some facilities might believe they are less accountable for the care they provide, which could result in substandard care and worse health outcomes for the residents. At best, binding arbitration would not provide sufficient incentive to improve resident care. One commenter stated that LTC facilities were already understaffed and the staff they do have are poorly trained. Since settling disputes through arbitration lowers the costs to the facilities, arbitration provides no incentive for facilities to increase the number of staff or improve their training. However, another commenter pointed out that the financial burden of LTC facilities being potentially subject to liability for damages determined by jury verdicts are spread out among the various nursing homes via standardized insurance premiums. Since the burden

associated with poor or substandard care is spread among all insured nursing homes, there is little incentive for any particular home to improve its care even if the facility is potentially exposed to the risk of jury-imposed damages.

Another commenter pointed out that if LTC facilities provided appropriate care to their residents, they would not need to be so concerned with pre-dispute, binding arbitration agreements. Some commenters were also troubled about what they believed was an emphasis on eliminating unnecessary burden to providers over protecting LTC facility residents and ensuring that they receive proper care.

Response: While some commenters state that the existence of pre-dispute, binding arbitration agreements leads to a lower quality of care for residents, a significant number of other commenters have stated that there is, in fact, no link between arbitration and quality of care. At this point, all sides of the issue have credible arguments supporting their position. However, while both sides have good arguments, as noted earlier, there is little solid social science research evidence demonstrating that arbitration agreements necessarily have a negative effect on quality of care. As a result, we have determined that the best solution is to implement a regulation that accommodates arbitration while also protecting LTC facility residents from unfairly coerced agreements. We agree with the commenters that litigation and damage awards provide a way to hold LTC facilities accountable for substandard care. At the same time, however, it is not the only way to hold LTC facilities accountable for the quality of care they deliver.

We believe that these final regulations also hold facilities accountable in several additional ways. Specifically, we are finalizing the requirement that LTC facilities retain copies of the signed arbitration agreement and the arbitrator's final decision for each dispute resolved through arbitration for 5 years after resolution of that dispute. We also note that § 483.10(j) gives residents the right to voice grievances to the facility or any other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. These grievances could involve care and treatment received or not received, the behavior of staff or other residents, as well as any other concerns regarding the nursing home. LTC facilities must make prompt efforts to resolve the grievance. Section 483.12 requires, among other things, that residents be free from abuse, neglect, and exploitation. In accordance

with section 1150B of the Act, 42 U.S.C. 1320b–25, any reasonable suspicion of a crime against a resident of an LTC facility must be reported to CMS and to one or more relevant law enforcement entities. All LTC facilities that are eligible to be paid through the Medicare and Medicaid programs must be certified and comply with our LTC facility requirements. One of those requirements, § 483.35, requires facilities to have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practical physical, mental, and psychosocial well-being of each resident. Specifically, we are finalizing the prohibition that facilities must not require any resident or his or her representative to enter into an agreement for binding arbitration as a condition of admission to the facility. We are also retaining the prohibition on facilities requiring a current resident or his or her representative to sign an agreement in order to continue to receive care at the facility. The facility must also explicitly inform the resident or his or her representative of these prohibitions and this language must be included in the agreement. This holds the facility accountable by ensuring that the facility cannot coerce or apply unreasonable pressure on a resident or his or her representative by implying the resident would not receive the care he or she needs without signing the agreement. We are also finalizing the requirements that the facility ensure that the agreement is explained to the resident and his or her representative, and that the resident or his or her representative acknowledge that he or she understands the agreement. This holds the facility accountable by ensuring that the agreement is explained to, and understood by, the resident or his or her representative before the agreement is signed. We are also finalizing the requirement that the agreement explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. This holds the facility accountable by ensuring that the resident or his or her representative has the opportunity to reconsider his or her decision and seek legal advice, if they choose to do so. We are also finalizing the requirement that the agreement not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and

representative of the Office of the Long-Term Care Ombudsman. This requirement holds the facility accountable by ensuring that neither the resident nor anyone else could be intimidated or discouraged from discussing the circumstances around the dispute with surveyors or others responsible for evaluating the quality and safety of the resident's care and the facility's compliance with regulatory requirements. In addition, we are finalizing the requirement that LTC facilities retain copies of the signed arbitration agreement and the arbitrator's final decision for 5 years after any dispute is resolved through arbitration and make these documents available for inspection upon request by CMS or its designee. This holds LTC facilities accountable because it allows surveyors to review the issues raised in the arbitration and to determine if they raise concerns about the quality and safety of the resident's care and the facility's compliance with regulatory requirements. Surveyors can then incorporate problems identified through arbitration into the current survey in order to determine if the LTC facility has taken steps to prevent the problem from reoccurring. The LTC requirements are enforced through both routine and complaint surveys and certification process. We note that the survey and certification provisions set forth in sections 1819(g)(2)(A)(iii) and 1919(g)(2)(A)(iii) of the Act and in 42 CFR 488.308 require that each skilled nursing facility and nursing facility be subject to a standard survey no later than 15 months after the last day of the previous standard survey and that the statewide average interval between standard surveys of skilled nursing facilities and nursing facilities not exceed 12 months. As part of the standard Long Term Care Survey Process, surveyors ask for and review the facility's admission packet, which would include arbitration agreements presented to residents. If violations of these requirements are found, LTC facilities could face, among other things, being cited with deficiencies, being put on a correction plan, or even losing or not obtaining certification in the Medicare program. For more information on CMS' efforts to improve the quality of care in nursing homes, please see the Nursing Home Quality Initiative web page at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/index.html>.

Comment: Some commenters agreed with our proposal to remove the

prohibition on pre-dispute, binding arbitration agreements. They claimed that the prohibition of these agreements would substantially increase the cost of resolving disputes which, in turn, would reduce the financial resources available for resident care. In addition to the increased costs of judicial litigation, these commenters claimed their insurance premiums will rise if disputes cannot be resolved through arbitration. This, too, they claim, would reduce the resources a provider could use for improving the quality of care. These commenters further asserted that rising insurance premiums would either cause some nursing homes to cease operations or bear an additional substantial financial burden. Since Medicare and Medicaid compensation rates are fixed, according to the commenter, nursing homes could be forced to make cuts that could affect resident care and would likely have to increase costs to those who are not on one of these government programs. This could make care unaffordable for families without improving the quality of care. Instead of being beneficial to residents, prohibiting pre-dispute, binding arbitration agreements could actually result in being detrimental to all residents, regardless of payor. However, other commenters pointed out that facilities also have a burden associated with using pre-dispute, binding arbitration agreements and that prohibiting them would reduce burden for the providers. Using pre-dispute, binding arbitration agreements for every resident is both a time-consuming and unnecessary process if the facility is providing appropriate care for its residents.

Response: While there is little empirical evidence supporting the consequences claimed by these commenters, we also agree that prohibiting pre-dispute, binding arbitration agreements could impose an unnecessary burden on LTC facilities. Prohibiting the use of these agreements would deny facilities a method of resolving disputes that is potentially more cost effective and efficient. We also agree with the commenters that stated that facilities have a burden associated with using pre-dispute, binding arbitration agreements due to the regulatory requirements with which the facilities must comply. Even before these requirements became effective, there was a burden associated with using these agreements, such as developing the agreement, speaking to and obtaining consent from residents or their representatives, and maintain copies of the agreements. However, since no facility is required to use these

agreements, any burden associated with them is the facility's choice. However, we disagree with one commenter's contention that for facilities that are providing appropriate care the burden associated with pre-dispute, binding arbitration agreements is time-consuming or unnecessary. Even facilities that provide appropriate care could have disputes with their residents. Thus, these regulations allow the use of arbitration so long as LTC facilities comply with the requirements finalized in this rule.

Comment: One commenter supported our proposal to remove the prohibition on pre-dispute, binding arbitration agreements because they believe it disrespectful to seniors and their families' capability, dignity, and autonomy. State law presumes seniors are fully competent unless there is evidence to the contrary. They noted that mental deterioration only results from certain diseases, not aging alone. Constitutional and other legal rights cannot be taken away solely because of age and certainly not without due process. Yet, the prohibition on pre-dispute, binding arbitration agreements presumes that residents are not competent to make an informed and appropriate choice concerning an arbitration agreement. The commenter believed it is insulting and ignorant to suggest that every senior who enters into a pre-dispute, binding arbitration agreement is either coerced, uninformed, or has been taken advantage of by the facility. These same individuals are signing many different documents during the admissions process, including the contract with the LTC facility, and these are not being questioned. This prohibition essentially denies residents the legal right to enter into voluntary contracts due to the assumption of incompetence of the resident. The choice to sign one of these agreements can hardly be considered less reasonable or valid than the choices made by residents that are influenced by promises of a lawyer seeking to sue the nursing home. However, other commenters, including a national association of health care providers, stated that residents cannot make an informed decision concerning whether to sign a pre-dispute, binding arbitration agreement without knowledge of the circumstances surrounding the dispute, which can only be known after the dispute arises. Other commenters stated that during the admissions process, residents are not likely to contemplate the possible disputes that could arise later as a result of the actions or lack of action by the LTC facility's management

or staff, including physical abuse and neglect, sexual assault, and even wrongful death of the resident. Further, residents are frequently admitted during a time of stress and often after a decline in their health or directly from the hospital and these circumstances make it extremely difficult for LTC residents or their representatives to make an informed decision about arbitration.

Response: The prohibition against pre-dispute, binding arbitration agreements was never intended to convey any disrespect to residents. However, we cannot ignore the comments we received from patient advocacy groups and other health care providers that raised a number of concerns about the way LTC residents are presented with arbitration agreements and the harm that results when residents unwittingly sign arbitration agreements that are later found to be against their best interests. Therefore, the intent was solely to address these concerns.

Comment: Numerous commenters opposed any regulation that does not prohibit facilities from requiring that a resident or his or her representative sign a pre-dispute, binding arbitration agreement as a condition of admission. They stated that no person in need of care should be put in the position of choosing between signing one of these agreements or not receiving care. Nursing home care is often sought during a time of crisis. The individual has usually suffered a serious injury, surgery, or some other condition that has resulted in a substantial decrease in their health or their ability to care for themselves. In most cases, the choice of nursing home is severely limited. All of these factors create stress for both the individuals who need care, their families, and other caregivers. Some commenters stated that it was unrealistic to presume that these individuals are in a position to fully understand the consequences of a pre-dispute, binding arbitration agreement. Other commenters noted that the number of LTC facilities practically available to an individual may be extremely limited. For example, it is entirely reasonable for a resident to want to remain close to family and friends. However, many times there is only one nursing home within a reasonable geographic distance of the resident's family or friends. Likewise, factors such as the type of payment the facility will accept, the health care and services it offers, and the availability of beds limit an individual's choice of facilities. Therefore, many residents may only have a few, and perhaps only one or two, suitable facilities from

which to choose. Once a facility is selected, commenters stated that some residents believe they have no choice but to sign the agreement in order to obtain the care they need.

Response: We agree with the commenters that a pre-dispute, binding arbitration agreement should not be a condition of admission. In the 2017 proposed rule, we proposed removing the prohibition set forth at § 483.70(n)(1) against using these agreements as a condition of admission because we did not believe that the prohibition struck the right balance between the advantages and disadvantages with pre-dispute, binding arbitration agreements. However, the overwhelming number of commenters who commented on this proposal were against allowing the facility to make signing a pre-dispute, binding arbitration agreement a condition of admission. We agree that many residents or their families usually do not have many LTC facilities to choose from and the existence of one of these agreements as a condition of admission is not likely to be a deciding factor in choosing a facility. We also agree that no one should have to choose between receiving care and signing an arbitration agreement. Therefore, we have finalized § 483.70(n)(1) to state that the facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. In addition, the facility must inform the resident or his or her representative of these rights and ensure that this language is in the agreement.

Comment: Some commenters were concerned that allowing pre-dispute, binding arbitration agreements to be used as a condition of admission would encourage LTC facilities that do not use these agreements to begin using them. Another commenter questioned whether this could eviscerate one of the fundamental protections under the FAA and contract law, that a contract is not enforceable if it is entered into as a result of coercion, misrepresentation, fraud, duress, or otherwise was unconscionable. One commenter noted that state courts have often found that requiring the resident to sign one of these agreements as a condition of admission was unconscionable. Some commenters were concerned that LTC facilities would have less incentive to provide quality care or improve their care to their residents, or perhaps, even worse, view these agreements as “get out of jail free cards.”

Response: We note that until the 2016 final rule was issued, there were no LTC

facility requirements regarding arbitration. LTC facilities were allowed to use these agreements and still maintained that right until the effective date of that rule. This rule was never enforced due to litigation. This final rule would allow the use of arbitration agreements as long as LTC facilities comply with the requirements finalized in this rule. We believe that residents and their families will have their rights protected and that there will be transparency in the arbitration process under this final rule. We believe that concerns about a link between the use of arbitration agreements and quality of care can be alleviated by ensuring that surveyors have access to key documents relating to the arbitration, including arbitral decisions. By prohibiting secrecy, surveyors can review the facts giving rise to the arbitration and keep those issues in mind when conducting the survey to, among other things, determine whether the LTC facility has taken steps to prevent similar problems from arising. In order to avoid secrecy problems, under these regulations Medicare-participating LTC facilities must retain copies of the signed arbitration agreements and the arbitrator's final decision for each dispute settled through arbitration. In addition, as discussed below, the LTC facility requirements are enforced through a survey process, including both routine surveys and complaint surveys. When surveyors are investigating a complaint that refers to issues related to the arbitration agreements and/or arbitrator's final decisions, surveyors will be directed to collect the relevant information (for example, the admissions packet, arbitration agreement, and record of arbitrator's hearing).

After finalization of the regulation, we will monitor trends of compliance and take any actions warranted based on these trends. Failure to comply with these requirements can result in sanctions, up to and including being de-certified from the Medicare program. Hence, these agreements are neither a “get out of jail free card” nor an incentive to provide substandard care or not improve the care they provide to their residents. Concerning the commenters' concerns that allowing these agreements to be used as a condition of admission would affect the fundamental concept that contracts must be entered into voluntarily and with consent, we share their concerns about individuals being coerced into signing one of these agreements, especially if they believe the resident will not receive the care he or she needs

if the agreement is not signed. As discussed above, we have modified the proposed rule to resolve these concerns by precluding LTC facilities from requiring an arbitration agreement as a condition of admission to, or as a requirement to continue receiving care at, the facility. The facility must also inform the resident or his or her representative of these rights and ensure that this language is in the agreement.

Comment: Some commenters were concerned about current residents in LTC facilities being coerced into signing pre-dispute, binding arbitration agreements. These commenters pointed out that when current residents are approached with these agreements, even if signing the agreement is presented as voluntary, they might feel pressured to sign it for fear of not being allowed to stay at the facility.

Response: This final rule makes clear that a resident must be informed, and the arbitration agreement must state, that signing an arbitration agreement is not a condition of admission nor is it necessary to remain at the facility. In addition, the agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. Thus, if a LTC facility complies with the rule, we believe residents should not feel that they have no choice in signing the arbitration agreement. In addition, a facility that transferred or discharged a resident for failure to sign an arbitration agreement (whether pre- or post-dispute) would risk termination from the Medicare and Medicaid programs. Under current regulations, residents cannot be transferred or discharged from a LTC facility due to their decision not to sign an arbitration agreement. Section 483.15(c), formerly § 483.12(a)(2), “Transfer and discharge”, sets forth the permissible reasons a LTC facility can transfer or discharge a resident. For a current resident, the permissible reasons a facility may transfer or discharge a resident are: (1) It is necessary for the resident's welfare and the resident's needs cannot be met in their facility; (2) the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (3) the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (4) the health of individuals in the facility would otherwise be endangered; (5) the resident failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility; and, (6) the facility ceases to operate. Failure to sign an agreement for binding

arbitration is not a permissible reason. If a LTC facility attempted to transfer or discharge a resident after either the resident or his or her representative refused to sign the agreement, they could be in violation of § 483.15(c) and CMS could take action, including citing the facility for a deficiency. Thus, we believe that residents are still protected from being transferred or discharged because of a refusal to sign an arbitration agreement. *See Binding Arbitration in Nursing Homes, Survey and Certification Letter dated January 9, 2003 (S&C-03-10)* (available at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/Survey-Certification/GenInfo/Downloads/SCletter03-10.pdf>).

Regarding current residents that have already signed arbitration agreements, we note that CMS does not have the power to annul valid contracts. Current arbitration agreements that are valid under the applicable state or other relevant jurisdiction's laws are still valid. We do believe that it would be good policy and we would encourage LTC facilities to offer current residents who have signed arbitration agreements the opportunity to rescind those agreements and proceed with a new agreement that conforms to these regulations. However, these provisions are only effective prospectively.

Comment: Many commenters contended that claims for abuse, neglect, and malpractice are not appropriate for arbitral resolution. Other commenters noted the types of claims commonly brought against LTC facilities such as pressure ulcers, broken bones, malnutrition, dehydration, asphyxiation (due to improper restraints), sexual assault and other criminal activities are also inappropriate matters for arbitration.

Response: From these comments, it is our understanding that the commenters believe that claims related to possible medical negligence or malpractice or claims that involved serious physical or emotional injury need to be resolved in a public forum where the circumstances surrounding the claim would result in a public record. They apparently believe that settling a dispute through judicial proceedings has a more important and positive effect on improving the quality of care for residents and holding the LTC facility responsible for poor care than if the dispute had been settled through arbitration. Certain claims, especially those related to a serious injury to a resident's physical and/or his or her emotional well-being, are especially disturbing. We understand that many individuals would prefer that these types of claims be treated

differently. However, we believe that either type of forum, arbitration or judicial proceedings, can be an appropriate forum to resolve disputes. We also believe that a fundamental requirement for arbitration would be that the arbitral forum has the expertise to handle the dispute presented by the parties. Thus, we do not believe it is appropriate to prohibit certain types of claims from being resolved in arbitration. This could lead to confusion and some grievances or concerns not being addressed appropriately. Some claims may not fit into a single, clearly designated category, such as when there are features of the dispute that could be put it into multiple categories. Resolving the dispute could result in some portions of the dispute being resolved through arbitration but others having to go into judicial proceedings. Some matters may also involve CMS enforcement surveys or audits. We would also note that notwithstanding the existence of an arbitration agreement, the LTC facility is obligated to comply with all requirements for participation. Specifically, there are requirements in our regulations for reporting abuse, neglect, misappropriation, and maltreatment (See § 483.12 Freedom from abuse, neglect and exploitation). The resolution of any dispute through arbitration or judicial proceedings would not interfere with the facility's responsibility to report abuse or negate our ability to take appropriate enforcement action. The relevant law enforcement entities could also take appropriate action against individuals. In addition, § 483.70(n)(5) of this final rule provides that the agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representatives of the Office of the State Long-Term Care Ombudsman. This provision ensures that residents also have the right to speak to officials about any concerns they have regarding their treatment. Finally, the recordkeeping requirements finalized in this rule will also allow us to learn how these types of claims are being treated and resolved through arbitration in LTC facilities.

Comment: Despite the oversight that results from surveys, ombudsmen, and other mechanisms, some commenters believed these are insufficient to protect residents from neglect, abuse, or other harm. One commenter, who had been a therapist and is now a LTC ombudsman,

indicated that abuse and disregard of residents' rights was widespread in LTC facilities. The commenter also indicated that when violations were identified and reported to his or her state's Department of Health, it was rare for a facility to be held accountable for its actions. Other commenters also noted that they saw or their loved ones had experienced abuse and/or neglect. Some commenters drew our attention to media reports about incidents of abuse, neglect, and even criminal offenses against in LTC facilities. Some commenters pointed to a recent CNN investigation on LTC facilities (aired on March 17, 2017) as evidence of the poor and negligent care residents were enduring in these facilities, available at <http://www.cnn.com/2017/03/17/health/nursing-home-sex-abuse/index.html>. That investigation found that more than 1,000 nursing homes have been cited for mishandling alleged cases of sexual abuse. Another commenter cited other articles that also indicated that elder abuse and elder abuse in nursing homes was a serious problem.

Response: Given the lack of hard social science data, we do not believe that removing the ban on pre-dispute, binding arbitration agreements will increase the occurrence of any of the serious incidents that the commenters and the media are describing. We believe that the requirements finalized in this rule, as well as the other LTC facility requirements, will work together to reduce, and hopefully, eliminate such incidents. For example, in this final rule the results of disputes settled through arbitration will no longer be private but subject to inspection by CMS or its designee (§ 483.70(n)(5)). Other current requirements, including the requirements to report instances of abuse, neglect, exploitation, and mistreatment as set forth in § 483.12(c), will also address these instances to ensure that facilities are reporting to the state and other appropriate entities. In addition, we will continue to monitor the care residents receive through our routine and complaint survey processes. Information on the Quality, Certification and Oversight Reports are available at: <https://qcor.cms.gov/main.jsp>. Nursing Home Compare data sets are available at: <https://data.medicare.gov/data/nursing-home-compare>.

D. Transparency

Comment: Regarding the proposal to retain the requirement that would bar any arbitration agreement from including any language that would prohibit or discourage a resident or anyone else from communicating with

federal, state, or local officials, one commenter noted that they were unaware of any resident being precluded from discussing any quality-of-care concerns with any government official. In addition, the inclusion of such a provision in the agreement could invalidate the agreement, or at least that provision, as being unconscionable. No arbitration agreement could limit the power of government regulators from taking action when there is a complaint. They also point out that there are ample protections for residents to communicate with government officials. For example, facilities must not prohibit or discourage residents from communicating with federal, state, or local officials; facilities must provide residents with written notice of how they can file a complaint with the State Survey Agency and information and contact information for filing grievances of any suspected violation of state or federal nursing facility regulations; and facilities must post information regarding the filing of complaints with the State Survey Agency in a form and a manner accessible and understandable to residents and their representatives (§ 483.10(k), (g)(4)(i)(D), (vi), and (g)(5), respectively). There is no justification for an arbitration-specific provision and its inclusion in the requirements. It demonstrates a suspicion about arbitration which is inconsistent with the federal policy embodied within the FAA and the proposed changes.

Response: We disagree with the commenters. We believe that there does need to be an arbitration-specific requirement to ensure that there is no language in the LTC facility's arbitration agreement that could be interpreted as either discouraging or prohibiting not only the resident but anyone else from communicating with federal, state, or local officials. Comments we received contained anecdotal evidence of so-called 'gag-clauses' being common in arbitration agreements and that residents and family members were uncertain if they could talk to surveyors about a quality concern that was arbitrated. The requirements cited by the commenters only apply to residents, no one else. Since others in the LTC facility, including staff and other residents and visitors, may have important information surrounding the circumstances of a dispute between a resident and the LTC facility, it is important that the facility not be able to prevent or discourage anyone, such as family, friends, volunteers, other residents or staff, from communicating with any government officials, especially surveyors that need to

investigate the care being provided to residents. In addition, if an arbitration agreement contained such language, we believe that it is quite likely that the resident could interpret it as overriding the protections cited by the commenter, or at least result in confusion. Concerning the commenter's contention that, if a dispute arises, the resident has the opportunity to challenge the existence of the agreement, we do not believe that is sufficient. To vacate an award or decision procured through arbitration, courts are limited to certain causes, if proved. These limitations are set forth in 9 U.S.C. 10a and include, but are not limited to, the award was procured through corruption, fraud, or undue means; evident partiality or corruption in arbitrators, and misconduct by arbitrators such that the rights of any party were prejudiced. Among other things, this regulation ensures that arbitral decisions be available for surveyors. As we have explained, we have concluded that it is important for surveyors to be able to review these documents to determine compliance with requirements. Thus, this arbitration-specific requirement will ensure that the resident is not misled or confused about his or her right to communicate with federal, state, and local officials about the circumstances surrounding the dispute.

Comment: One commenter was concerned about the recordkeeping requirements mandating that a signed copy of the agreement and decision must be retained by the LTC facility for 5 years and be made available for inspection by CMS. They believe that this unjustifiably singles out arbitration and is unduly burdensome. They also noted that CMS had not provided any reason for the facility to retain the arbitration agreement for the 5 years after the dispute was resolved. If a dispute arises, the resident has the opportunity to challenge the existence of the agreement. The commenter stated that there was no reason to add this additional recordkeeping burden on facilities, and no justification for singling out arbitration agreements for this requirement. For example, CMS has not proposed that all settlement agreements be retained for 5 years.

Response: Unlike court decisions and settlement agreements, there are no public records when a dispute is settled through arbitration. These recordkeeping requirements are intended to ensure that CMS can fully evaluate quality of care complaints that are addressed in arbitration and assess the overall impact of these agreements on the safety and quality of care provided in LTC facilities. Many

commenters were concerned that these agreements have a negative effect on the care residents receive in these facilities. Some commenters, as noted previously, stated that pre-dispute, binding arbitration agreements would lead to a declining standard of care for residents. The requirement for facilities to retain these documents for CMS or its designee to review will assist CMS in determining to what extent quality of care issues are addressed in arbitration and in ensuring that quality of care concerns that are the subject of arbitration can be thoroughly investigated, if needed, in specific cases, or in aggregate.

Comment: Some commenters were dissatisfied with the transparency requirements we proposed. They believed that these requirements offered little, if any, value. The imbalance of power between the resident and the facility, as well as the stress a resident may experience during the admissions process, could exert pressure on the resident to sign a pre-dispute, binding arbitration agreement, even if the facility does not intend to pressure the resident. One commenter stated that the transparency provisions simply do not protect residents from the coercive nature of the process. We believe that the commenter is referring to the unequal bargaining power between the resident and the facility, especially concerning knowledge of and control of the arbitration process and resident's need for care. Other commenters stated that it was unlikely that a resident would delay signing the admissions contract in order to seek legal advice, since the predominant concern will be obtaining the care the resident needs. Two commenters discussed a cooling off or rescission period. One commenter, an organization that supports the overall health and well-being of seniors, children, and those with special needs, made some specific recommendations concerning the use of pre-dispute, binding arbitration agreements. One of those recommendations is that the agreement should include a rescission period. This would give residents and their representatives a chance to thoroughly read the agreement and reconsider whether they should agree to its terms. They would also have time to seek legal advice, if they chose to do so. If they change their minds regarding the agreement, they would then have time to rescind it. The other commenter, a major organization that represents nursing homes, noted that its own model agreement for arbitration agreements contained a provision for a 30-day rescission period. That

commenter noted that many nursing homes already include safeguards in their contracting process, including a provision for a 30-day rescission process, so that a resident and his or her representative has a meaningful opportunity to reconsider whether he or she wants to settle any disputes with the LTC facility through arbitration. Therefore, we are adding a requirement that the agreement must allow the resident or his or her representative to rescind the agreement within 30 calendar days of signing it at § 483.70(n)(3).

Response: We acknowledge that, despite the requirements in this rule that would prohibit a LTC facility to have a resident sign an arbitration agreement as a condition of admission, some residents or their representatives might feel pressure to sign these agreements. We agree with the commenter who suggested that a rescission period would provide residents time to get beyond the admissions process and consider whether they want to be bound by the arbitration agreement. It will also give them time to obtain legal advice, if they chose to do so. Therefore, we are adding a requirement that the agreement must allow the resident or his or her representative to rescind the agreement within 30 calendar days of signing it at § 483.70(n)(3).

Comment: Some commenters stated that the transparency provisions do not overcome the fundamental problem with pre-dispute, binding arbitration agreements, which is the lack of an informed agreement. The decision to sign a binding arbitration agreement can never be informed unless both parties are fully aware of the circumstances surrounding the dispute and the consequences of agreeing to settle the dispute through arbitration. This can only happen after the circumstances that resulted in the dispute have already occurred.

Response: We agree that, when a pre-dispute, binding arbitration agreement is signed neither the resident nor the LTC facility are aware of the circumstances surrounding any future dispute between them. However, by signing one of these agreements, the parties are not settling a dispute but deciding the forum in which any future disputes would be settled. We believe that the requirements finalized in this rule provide the transparency necessary for residents to understand the ramifications of signing an arbitration agreement.

Comment: Some commenters believed that posting a notice was not only unhelpful but also confusing. One

commenter noted that so many items must already be posted that any notice on arbitration would likely not stand out.

Response: We agree with the commenters. Posting a notice would not likely serve any purpose other than to require more paperwork. Thus, we are not finalizing the requirement that LTC facilities post a notice concerning their policy on arbitration agreements.

Comment: We received mixed comments on the fairness of arbitral forums. Some commenters expressed concerns that in some situations arbitrators had awarded the resident or his or her family much less compensation than would have been expected if the dispute had been resolved through a formal judicial proceeding or had found that the LTC facility was not responsible for an injury to a resident when it was likely that a judge or jury would have. Some commenters pointed to specific instances of residents or their families receiving little to no compensation. Other commenters stated that residents and their families did as well or better with disputes settled through arbitration than they would have through formal judicial proceedings. Other commenters stated that residents, especially those that are in facilities for an extended length of time, are vulnerable. As discussed above, about half of LTC facility residents have been diagnosed with Alzheimer's disease or another form of dementia. This situation only amplifies the disadvantages of arbitration. In addition, some commenters were concerned about arbitrator bias in favor of the facility. They were particularly concerned that a facility's ongoing need for arbitrators in subsequent cases could result in arbitrators issuing decisions favorable to the facility in order to receive future arbitral business from that facility.

Response: We understand that there are concerns about the fairness of the arbitral forum. Although no one can guarantee that every arbitrator will be neutral and fair in all arbitrations, comments we received caused us to conclude that arbitrators generally review the evidence submitted to them and make rational decisions based upon that evidence. While most state laws limit the circumstances upon which an arbitrator's decision can be challenged in court,² we believe that state laws regarding unconscionability or cohesion contracts offer some protection to residents from an arbitrator's decision if such a decision suggests bias towards the LTC facility. In addition, we are

retaining the requirements that the facility must ensure that the arbitration agreement provides for the selection of a neutral arbitrator agreed upon by both parties and for the selection of a venue that is convenient to both parties. We are also finalizing the requirement at § 483.70(n)(5), which requires that when a facility resolves a dispute with a resident through arbitration, the facility must retain a copy of the signed arbitration agreement and the arbitrator's final decision for 5 years after the resolution of that dispute and make it available for inspection upon request from CMS or its designee. This requirement will enable us to determine how arbitration is being used by nursing homes and how residents are being treated in these arbitral forums. We believe that improving the transparency surrounding arbitration in nursing homes should also encourage facilities and arbitrators to treat residents fairly, if they are not currently doing so.

Comment: Some commenters disagreed with our proposal to require that the agreement be in plain language, be explained in a form and manner the resident understands, and that the facility receive an acknowledgement from the resident that he or she understands the agreement. They contended that these requirements did not eliminate or address what they saw as the fundamental problem: That a resident's decision to sign a pre-dispute, binding arbitration agreement could never be informed or voluntary without in-context knowledge of what is at stake. Some commenters asserted that the plain language requirement was useless, arguing that where pre-dispute, binding arbitration agreements are allowed as a condition of admission, it simply meant that it would be clear to the resident that he or she had no choice. Other commenters believed that the requirements for "plain language" were so vague and unclear that they would generate confusion. They also contended that the proposed rule would not support meaningful decision making by residents and its implementation would decrease residents' health, safety, and well-being. These commenters stated that the only way for the decision to sign an arbitration agreement to be voluntary and informed is if the resident was asked to sign it after the dispute has arisen. Many residents enter LTC facilities because they lack the ability to manage their day-to-day affairs. About half of LTC residents have been diagnosed with Alzheimer's disease or another form of dementia. The commenters are concerned that failure to explain the arbitration agreement to

² See 9 U.S. Code 10(a).

residents in a way that they understand the issue, could result in residents unwittingly signing an agreement to arbitrate with little understanding of the consequences of their action.

Response: After considering these comments, we agree with the commenters that the requirement for “plain language” is vague and could result in confusion. Therefore, we are not finalizing that proposed change to the requirements. As discussed above, we are also not finalizing the proposed change that would have allowed these agreements to be used as a condition of admission. However, we are retaining the requirement at § 483.70(n)(2)(i) and (ii) that the facility must ensure that the agreement be explained to the resident and his or her representative in a form and manner that he or she understand, including in a language the resident understands and the resident or his or her representative acknowledges that he or she understands the agreement. We believe these requirements are essential to ensure transparency in the arbitration process.

Comment: Some commenters were concerned about removing some of the specific requirements concerning arbitration or the arbitration agreement. For example, the proposed removal of the requirement that another individual could only sign for the resident if that individual had no interest in the facility and was authorized by state law to sign for the resident, could result in a person who is affiliated with the facility or has some type of interest in the facility signing for the resident. This would remove a critical protection for residents that may lack decision-making capacity. Others expressed concern about the possibility that residents and potential residents could have a family member, friend, or other personal contact affiliated with the facility.

Response: In drafting and entering into an arbitration agreement with its residents, LTC facilities must still comply with state law governing the rights of an individual to represent or legally bind a resident through a power of attorney or similar instrument. We are confident that state law would protect the rights of residents if someone signs one of these agreements without having the appropriate authority.

E. Costs

Comment: Some commenters pointed out the different advantages and disadvantages of arbitration. Some stated that arbitration results in faster, more flexible, less costly, and less adversarial resolution of disputes than litigation. One commenter quoted the

2016 final rule, “arbitration agreements are, in fact, advantageous to both providers and beneficiaries because they allow for the expeditious resolution of claims without the costs and expense of litigation” (82 FR 26651). One commenter cited an article that showed that in the context of labor-management disputes the costs of arbitration were less for lower-income employees (Elizabeth Hill, *Due Process at Low Cost: An Empirical Study of Employment Arbitration Under the Auspices of the American Arbitration Association*, 18 Ohio St. J on Disp. Resol. 777, 802 (2003)). They also pointed out that other advantages of arbitration included not needing an attorney, not having to show up at court since arbitration could be accomplished over the telephone or, perhaps, just submitting documents to the arbitrator. In addition, the commenter noted that reductions in funding to both federal and state courts could also lengthen the time needed to resolve a dispute through judicial proceedings. The commenter noted that arbitration proceedings do not have similar backlogs and can resolve disputes much faster.

However, there were also commenters pointed out that there were disadvantages. Some pointed out that arbitration could be more costly, especially for the resident. While LTC facilities may pay the costs for arbitration, this is not always the case. Since arbitration is a private process, there are costs for the venue, discovery, and the arbitrator. These costs can amount to thousands of dollars. It may also not result in a much faster or less adversarial resolution than litigation. In addition, some commenters contended that if arbitrators apply the applicable law incorrectly or make mistakes concerning what the appropriate law is for a particular claim and that state law generally limits the reasons for challenging the arbitrator’s decision.

Privacy was another area in which commenters differed. Many commenters believed the secrecy of the arbitration process could be a disadvantage because LTC facilities could prevent disclosure of instances of poor or substandard care. However, another commenter, a non-profit provider, pointed out that some residents may not want to settle disputes in a court, especially disputes that involve physical or emotional injuries. Due to the relationship between non-profits and their residents, the residents may also prefer a less adversarial forum in which to settle disputes. Hence, judicial proceedings might not be preferable for all disputes.

Response: We agree with the commenters that arbitration has both

advantages and disadvantages. Nonetheless, despite these claimed advantages and disadvantages, arbitration is an accepted form of dispute resolution and the FAA expresses a favorable view of arbitration. In addition, we agree that judicial proceedings may not be a preferable way for resolving all disputes. There are substantial hurdles to get a dispute into court. The resident must find an attorney willing to take the case. The attorney will generally decide to take a case based upon the potential damages and the difficulty of the case. If the attorney believes the case will be difficult to prove or that the damages are not adequate to justify the time and expense of judicial proceedings, he or she may not take the case. Cases of this nature would appear, therefore, to be good candidates for arbitration. Of course, there are also disadvantages to arbitration. It is not always faster or less expensive. In some cases, the costs associated with settling a dispute through arbitration could exceed those if the dispute was settled through judicial proceedings, especially for the resident or his or her representative. As commenters noted, settling a dispute in arbitration may not be faster. In addition, the losing party has limitations on contesting an arbitrator’s decision in court. We acknowledge these advantages and disadvantages to arbitration and believe that the requirements in this final rule provide the transparency and opportunity for the resident and his or her representative to evaluate those advantages and disadvantages and make a choice that is best for them. This rule in no way would prohibit two willing and informed parties from entering voluntarily into an arbitration agreement.

Comment: Some commenters stated that prohibiting arbitration agreements would lead to more litigation and higher legal costs. These higher legal costs would result from increased insurance premiums and jury verdicts that would likely be higher than awards given in arbitration. One commenter cited a declaration from the AHCA litigation, that indicated that the insurer for Mississippi LTC facilities was likely to increase premiums if these arbitration agreements were not enforceable (*citing* Decl. of Suzanne Meyer at para. 14, *Am. Health Care Ass’n v. Burwell*, 217 F. Supp. 3d 921 (N.D. Miss. 2016) (No. 3:16-cv-00233), Dkt. No. 20-3). These higher legal costs could result in fewer resources for resident care and improving the quality of care for all residents. It would also increase the cost

of care, which would affect residents who are self-pay, their insurance companies, and government programs, especially Medicare and Medicaid.

Response: As discussed above, we are removing the prohibition on pre-dispute, binding arbitration agreements. Facilities are allowed to ask their residents to sign arbitration agreements so long as they comply with the requirements we are finalizing in this rule. This should address the commenters' concerns.

Comment: One commenter was concerned about higher costs to the facility as a result of the prohibition on pre-dispute, binding arbitration agreements. Since the amount of reimbursement from the Medicare and Medicaid programs is fixed, LTC facilities cannot raise their rates for residents whose care is paid for by those programs. Hence, LTC facilities could only cover higher costs by increasing the costs of care to residents who are paying for their care themselves and/or reduce the amount of resources that go to resident care. This could result in less care to all of the residents. Government programs could even face increased costs due to increased injuries or complications that result from poorer care.

Response: At this point, the evidence on the financial effects of prohibiting arbitration or allowing unfettered arbitration is anecdotal. However, the commenters tend to agree that when a claim is settled through arbitration, facilities save money. The resident advocacy groups contend that residents lose more often and, when they win, receive smaller awards than they would likely have had in judicial proceedings. LTC facilities assert that this same set of facts results in a positive financial impact because arbitration reduces their costs and ensures that more of their money can be spent on providing quality care to the residents. As discussed above, we are removing the prohibition on pre-dispute, binding arbitration agreements and permitting LTC facilities to enter into arbitration agreements if they comply with the requirements that are being finalized in this rule. We believe that the finalized requirements address these commenters' concern to a large extent.

Comment: Another commenter stated that arbitration prevents the government from seeking reimbursement for the costs of the resident's care related to any negligence by the LTC facility. Arbitration is not a public process and the government would not be made aware of any award by the arbitrator to a resident. Without notice, the government could not seek to recover

any part of the cost of care to the resident as a result of any negligence or substandard care provided on the part of the facility from that award.

Response: We note that CMS generally does not seek to recover its costs from any award of damages to a resident when services are negligently provided. Instead, we enforce our health and safety standards through Requirements of Participation, Conditions of Participation, Conditions for Coverage, and the authority to terminate a negligent provider. For LTC facilities, we can also impose civil monetary penalties.

IV. Provisions of the Final Regulations

In this final rule, we are adopting the provisions in the June 8, 2017 proposed rule, with the following changes:

- Revised § 483.70(n)(1) to specify that a facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue receiving care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue receiving care at, the facility.
- Removed § 483.70(n)(1)(i).
- Redesignated § 483.70(n)(1)(ii) and (iii) as § 483.70(n)(2)(i) and (ii).
- Revised the redesignated § 483.70(n)(2)(ii) to specify that the facility must ensure that the resident or his or her representative acknowledge that he or she understands the agreement.
- Added § 483.70(n)(2)(iii) to specify that the agreement provides for the selection of a neutral arbitrator agreed upon by both parties.
- Added § 483.70(n)(2)(iv) to specify that the agreement provides for the selection of a venue that is convenient to both parties.
- Redesignated § 483.70(n)(2) as § 483.70(n)(5).
- Redesignated § 483.70(n)(3) as § 483.70(n)(6).
- Added § 483.70(n)(3) to specify that the agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it.
- Revised § 483.70(n)(4) to state that an arbitration agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility.
- Revised redesignated § 483.70(n)(6) to read that when a facility and a

resident resolve a dispute through arbitration, a copy of the signed agreement for binding arbitration and the arbitrator's final decision must be retained by the facility for 5 years after resolution of that dispute and be available for inspection upon request by CMS or its designee.

V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 30-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Omnibus Budget Reconciliation Act of 1987 Waiver

Ordinarily, we are required to estimate the public reporting burden for information collection requirements for this regulation in accordance with chapter 35 of title 44, United States Code. However, sections 4204(b) and 4214(d) of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) (Pub. L. 100–204) provide for a waiver of the PRA requirements for this regulation. Thus, we have not provided an estimate for any paperwork burden related to these revisions and additions.

VI. Regulatory Impact Statement

A. Statement of Need

The district court's decision in granting the preliminary injunction against enforcement of the prohibition on pre-dispute, arbitration agreements indicated that CMS would at a minimum face some substantial legal hurdles from pursuing the arbitration policy set forth in the 2016 final rule. We have reviewed the provisions and determined that the arbitration requirements should be revised. We believe that the protections for residents that we have finalized in this rule strike a better balance of competing policy

concerns. The revisions to these requirements in the 2017 final rule will increase transparency in LTC facilities that chose to use arbitration while, at the same time, allowing facilities to use arbitral forums as a means of resolving disputes.

B. Overall Impact

The overall impact of this final rule is to provide transparency in the arbitration process in nursing homes to the residents, his or her family and representatives, and the government. It also ensures that no resident will be required to sign a pre-dispute, binding arbitration agreement as a condition for receiving the care he or she needs. In addition, by ensuring that the resident has the right to rescind the agreement within 30 calendar days of signing it, residents can get beyond the admissions process and have adequate time to consider the agreement and get legal advice.

We have examined the impact of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), the Congressional Review Act (5 U.S.C. 804(2)), and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A RIA must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year). This rule does not reach the economic threshold and thus is not considered a major rule.

The RFA requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of less than \$7.5 million to \$38.5 million in any 1 year. Individuals and states are not included in the definition

of a small entity. We are not preparing an analysis for the RFA because we have determined, and the Secretary certifies, that this final rule will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare an RIA if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area for Medicare payment regulations and has fewer than 100 beds. We are not preparing an analysis for section 1102(b) of the Act because we have determined, and the Secretary certifies, that this final rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. In 2019, the UMRA threshold is approximately \$154 million. This rule will have no consequential effect on state, local, or tribal governments or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has Federalism implications. Since this regulation does not impose any costs on state or local governments, the requirements of Executive Order 13132 are not applicable.

C. Cost to the Federal Government

We do not believe that these revisions would impose any additional costs.

D. Regulatory Review Costs

If regulations impose administrative costs on private entities, such as the time needed to read and interpret a final rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume that the number of commenters on the proposed rule is the number of reviewers who will thoroughly review the final rule. We acknowledge that this assumption may understate or overstate

the costs of reviewing this rule. It is possible or even likely that not all of those prior reviewers will extensively reread this rule, and may instead focus on changes to the regulatory text or only specific responses to comments. On the other hand, it is conceivable that there may be more than one individual reviewing the rule for some of the affected entities, or that many entities thoroughly reviewed the rule without commenting. For those reasons, we thought that the number of commenters on the proposed rule would be a fair estimate of the number of reviewers of this rule. We also recognize that different types of entities are in many cases affected by mutually exclusive sections of some final rules, or that some entities may not find it necessary to fully read each rule, and therefore for the purposes of our estimate we assume that each reviewer reads approximately 50 percent of the rule.

Using the wage information from the Bureau of Labor Statistics (BLS) for medical and health service managers (Code 11–9111), we estimate that the cost of reviewing this rule is \$107.38 per hour, including overhead and fringe benefits https://www.bls.gov/oes/2017/may/oes_nat.htm. Assuming an average reading speed, we estimate that it would take 0.65 hours for the staff to review half of this final rule. For each entity that reviewed the rule, the estimated cost is \$69.80 (0.65 hours × \$107.38). Therefore, we estimate that the total cost of reviewing this regulation is \$70,000 (\$69.80 × 1,020 reviewers).

E. Executive Order 13771

Executive Order 13771, titled Reducing Regulation and Controlling Regulatory Costs, was issued on January 30, 2017 and requires that the costs associated with significant new regulations “shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least two prior regulations.” OMB’s interim guidance, issued on April 5, 2017, <https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/memoranda/2017/M-17-21-OMB.pdf>, explains that for Fiscal Year 2017 the above requirements only apply to each new “significant regulatory action that imposes costs.” It has been determined that this final rule is an action that does not impose more than de minimis costs and thus is not a regulatory or deregulatory action for the purposes of Executive Order 13771.

F. Benefits of the Rule

With the exception of the requirement that facilities post notices of their

arbitration policies, the requirements finalized in this rule maintain the transparency requirements promulgated in the 2016 final rule. Specifically, this rule ensures that LTC facilities must make every effort to inform the resident of the nature and existence of any proposed arbitration agreement. The agreement must be explained to the resident in a form and manner he or she understands and the must resident acknowledge that he or she understands the agreement. Additionally, we are retaining the requirement that the agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials.

We believe that these transparency requirements address many stakeholder concerns regarding the fairness of arbitration in LTC facilities. These requirements also support the resident's right to make informed choices about important aspects of his or her healthcare and ensure that we can protect resident health and safety.

We have also finalized the requirement that, when a facility and a resident resolve a dispute through arbitration, a copy of the signed agreement for binding arbitration and the arbitrator's final decision must be retained by the facility for 5 years after the resolution of that dispute and also be available for inspection by CMS or its designee. This requirement will provide CMS an opportunity to gather data about the extent to which quality of care issues are addressed in arbitration, to ensure that quality of care concerns that are the subject of arbitration can be thoroughly investigated, if needed, in specific cases, or in aggregate, and the overall impact that arbitration may have on residents of LTC facilities. Based on the comments we received, we have also added a requirement that the agreement must explicitly grant the resident the right to rescind the agreement within 30 calendar days of signing it. This provides the resident approximately one month to adjust to the LTC facility, consider and understand the implications of the agreement, and, if he or she desires, seek legal advice about rescinding the agreement.

In addition, based on comments we received, we are not finalizing the proposal to allow facilities to use pre-dispute, binding arbitration agreements as a condition of admission to the facility. As discussed above, residents, their families, and caregivers consider various factors in choosing a LTC facility. We doubt that one of those potential factors, whether a nursing home requires signing a pre-dispute,

binding arbitration agreement as a condition of admission, is often a deciding factor for residents, caregivers, or representatives. This is especially important since the choice of nursing homes may be limited based on various factors. This requirement will enable residents, their families, and caregivers to choose a LTC facility based upon what is best for the resident's health and safety without having to be required to sign a pre-dispute, binding arbitration agreement. It will also ensure that no resident, his or her family, or caregiver will have to decide between signing this type of agreement and the resident receiving the care he or she needs.

G. Alternatives Considered

As discussed above, the district court granted a preliminary injunction against enforcement of the prohibition against pre-dispute, binding arbitration agreements. We considered removing all of the arbitration requirements and returning to the position in the previous requirements, that is, the requirements would be silent on arbitration. We also considered continuing to defend the 2016 regulation. While we do not agree with the district court's decision, it provided us the opportunity to explore other ways to balance the interests of LTC facilities that wish to arbitrate claims with the need to ensure that LTC residents have the ability to make an informed decision about whether or not to sign an arbitration agreement and resolve issues when necessary in the best and most reasonable way they see fit.

In light of the comments we received, we have determined that such a balance can be struck by removing the prohibition of pre-dispute, binding arbitration agreements while maintaining and modifying the transparency requirements promulgated in the 2016 regulation. The comments we received demonstrated that many LTC residents are not aware they have signed an arbitration agreement until after a dispute arises. We have concluded, therefore, that transparency is essential, and that CMS may properly exercise its statutory authority to ensure transparency under its statutory authority to promote the health and safety of LTC residents. Consequently, with the exception of posting notices and requiring "plain language," we have retained those requirements that provide for transparency. We are also not finalizing our proposal that would have allowed facilities to use pre-dispute, binding arbitration agreements as a condition of admission to, or a requirement to continue to receive care at, the facility for the reasons discussed

above. We believe the finalized requirements will provide sufficient transparency to protect residents' health and safety, including supporting their right to make informed decisions about their health care. These finalized requirements should also alleviate many of the residents and advocates' concerns about the arbitration process while also allowing LTC facilities to arbitrate claims should they so choose.

In accordance with the provisions of Executive Order 12866, this final rule was reviewed by the Office of Management and Budget.

List of Subject in 42 CFR Part 483

Grant programs—health, Health facilities, Health professions, Health records, Medicaid, Medicare, Nursing homes, Nutrition, Reporting and recordkeeping requirements, Safety.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as set forth below:

PART 483—REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES

■ 1. The authority citation for part 483 is revised to read as follows:

Authority: 42 U.S.C. 1302, 1320a-7, 1395i, 1395hh and 1396r.

■ 2. Section 483.70 is amended by revising paragraph (n) to read as follows:

§ 483.70 Administration.

* * * * *

(n) *Binding arbitration agreements.* If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section.

(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility.

(2) The facility must ensure that:

(i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands;

(ii) The resident or his or her representative acknowledges that he or she understands the agreement;

(iii) The agreement provides for the selection of a neutral arbitrator agreed upon by both parties; and

(iv) The agreement provides for the selection of a venue that is convenient to both parties.

(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it.

(4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility.

(5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representatives of the Office of the State Long-Term Care Ombudsman, in accordance with § 483.10(k).

(6) When the facility and a resident resolve a dispute through arbitration, a copy of the signed agreement for binding arbitration and the arbitrator's final decision must be retained by the facility for 5 years after the resolution of that dispute on and be available for

inspection upon request by CMS or its designee.

* * * * *

Dated: February 6, 2019.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: February 13, 2019.

Alex M. Azar II,

Secretary, Department of Health and Human Services.

Editorial Note: This document was received by the Office of the Federal Register on July 10, 2019.

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