LEGAL ISSUES
By Alan C. Horowitz, Esq., RN

Arbitration Agreements: Are They Enforceable?

Few issues regarding skilled nursing facilities are as controversial as pre-dispute, binding arbitration agreements. Moreover, even fewer issues have been litigated as much as binding arbitration agreements. The Federal Arbitration Act (FAA), enacted by Congress almost a century ago in 1925, facilitates dispute resolution by having a neutral and objective third party render a decision on the disputed issue that “shall be valid, irrevocable, and enforceable” (9 U.S.C. §§ 1–16). Neither a judge nor jury is involved with an arbitration, which allows the parties to resolve their disputes in a fair, efficient, and cost-effective manner without the considerable expense and protracted time that litigation requires.

In enacting the FAA, Congress sought “to reverse the longstanding judicial hostility to arbitration agreements ... and to place arbitration agreements upon the same footing as other contracts” (Gilmer v. Interstate/Johnson Lane Corp., 500 U.S. 20, 24 (1991)). In 2019, the U.S. Supreme Court unanimously upheld the arbitration agreement in Henry Schein, Inc. v. Archer & White Sales, Inc. (592 U.S. [2021]), noting the trend of federal courts to defer to arbitration agreements. The Court stated, “Under the [Federal Arbitration] Act, arbitration is a matter of contract, and courts must enforce arbitration contracts according to their terms” (citing Rent-A-Center, West, Inc. v. Jackson, 561 U.S. 63, 67 (2010)).

Although arbitration agreements are legal contracts, as with most things the devil is in the details. There are times when arbitration agreements have been and will be struck down by courts. Additionally, in long-term care, if an arbitration agreement between a resident and a nursing facility is unenforceable or otherwise flawed, it will likely give rise to a deficiency and enforcement action from the Centers for Medicare & Medicaid Services (CMS).

Binding, pre-dispute arbitration agreements are contractual agreements that are made before any problems arise. In long-term care, these have been used and continue to be used when a facility offers a resident the opportunity to elect to arbitrate rather than litigate any potential future disputes. Some resident advocacy groups view pre-dispute arbitration agreements as one-sided and coercive arrangements that deprive residents of their right to sue a nursing facility. Even the New York Times Editorial Board concurred with various advocacy groups in calling for a ban on pre-dispute arbitration agreements, wrongly claiming they deny residents justice (New York Times, Nov. 7, 2015, https://nyti.ms/35qfNyN). Not surprisingly, the trial lawyers lobby has pushed hard for a ban on arbitration agreements in long-term care for the obvious reason: they make tens of millions of dollars in “nursing home negligence” cases.

Apparent in agreement with those who opposed pre-dispute, binding arbitration agreements, in 2016 the Obama administration promulgated a federal regulation that prohibited pre-dispute arbitration agreements in long-term care. Our story begins with that prohibition.

Background

On October 4, 2016, CMS published a final rule (“Reform of the Requirements for Long-Term Care Facilities,” henceforth the “Final Rule”) that amended the regulation at 42 C.F.R. § 483.70(n) such that it prohibited nursing facilities from entering into pre-dispute, binding arbitration agreements with any individual residents or their representative (Fed Reg 2016:81:68688–68872). In response to the Final Rule, the American Health Care Association (AHCA) and a number of nursing homes filed a complaint in U.S. District Court seeking both preliminary and permanent injunctions, which would preclude CMS from enforcing its newly amended regulation. The district court agreed with AHCA and issued a preliminary injunction, meaning that CMS could not enforce its anti-arbitration regulation.

Two months after CMS issued the Final Rule, on December 9, 2016, it directed all state survey agencies not to cite a deficiency based on the Final Rule’s prohibition on pre-dispute, binding arbitration agreements. (Given the court’s injunction, it had no choice.) Then, on June 8, 2017, CMS published another proposed rule regarding arbitration agreements. CMS received more than 1,000 comments regarding its proposed rule, which revised its prior regulation. Based in part on the analysis by CMS of these public comments and the legal impact of the FAA, on July 18, 2019, CMS (again) published a Final Rule concerning arbitration agreements: the blanket prohibition was gone. However, some important elements remained, as we will discuss next.

The Final Rule (Really, We Mean It This Time)

The new and improved Final Rule dealing with arbitration agreements, which became effective on September 16, 2019, is governed by the regulation at 42 C.F.R. § 483.70(n) (see https://www.law.cornell.edu/cfr/text/42/483.70). It requires facilities to comply with the following:

• Facilities must not require a resident or his/her representative to sign an arbitration agreement as a condition of admission or as a requirement to remain in the facility, and the agreement must state this point.

• The agreement must be explained to the resident or his/her representative in a manner understood and acknowledged by the resident or representative.

• The agreement requires both the resident and facility to agree to a venue and neutral arbitrator in the event of an arbitration.

• Either the resident or his/her representative may rescind the agreement within 30 calendar days from its execution.

• The agreement must not attempt to prohibit or discourage the resident or his/her representative from communicating with any local, state, or federal officials, including the state’s Long Term Care Ombudsman or surveyors.

• A copy of the signed arbitration agreement and an arbitrator’s decision must be retained for five years after the dispute has been resolved, both of which must be available to CMS or its designees (such as surveyors).

Recommendations

Nursing facilities should develop and implement appropriate policies and procedures regarding pre-dispute, binding arbitration agreements, to be revised as necessary. All staff involved with the admissions process, and especially arbitration agreements, should be educated regarding a facility’s policies and procedures. State laws may impose additional requirements on arbitration agreements. Therefore, a facility’s arbitration agreement should be carefully reviewed to ensure that it fully complies with all applicable federal regulations as well as state laws.

Conclusion

The revised regulation’s requirements, as noted previously, are not “best practices” — they are minimum requirements. Moreover, they are fair. As the Supreme Court observed, “Arbitration is an alternative means of dispute resolution.” Residents or their representatives should never be coerced into signing an arbitration agreement. Rather, they should be free to choose arbitration over litigation so long as it is done knowingly and without any undue influence. Respecting a competent resident’s (or legal representative’s) choice to have a pre-dispute arbitration agreement falls under the rubric of resident’s rights and should be honored.

Mr. Horowitz is Of Counsel at Arnall Golden Gregory LLP. His practice involves regulatory compliance concerning skilled nursing facilities, hospices, and home health agencies. Prior to joining the firm, he served as Assistant Regional Counsel at the U.S. Department of Health and Human Services and represented the Centers for Medicare & Medicaid Services. Mr. Horowitz also has extensive experience as health care provider.

PALTC Season
Continued from previous page

community in which I could continue to develop.

Each of these steps continued my journey, leading me to the roles of medical director and PALTC specialist, and eventually to becoming this year’s Society president. To sustain our workforce, we need to both invest in paths like mine and build innovative new routes to careers in long-term care.

We are in a season of unprecedented interest in nursing home care, and I am grateful to have the privilege of working with the incredibly intelligent and compassionate leaders of the Society. They inspire me, and together our work is making a real difference in people’s lives. As I think about the next year, I am excited to see how many steps we will take toward achieving our mission.

Dr. Gillespie is president of AMDA—The Society for Post-Acute and Long-Term Care. She lives in Rochester, New York, where she is associate professor of medicine at the University of Rochester School of Medicine and Dentistry.