THE VERIFICATION LAYER

PRE-CLOSE DILIGENCE FRAMEWORK

AI Liability Exposure in Senior Living Acquisitions

Inherited agent risk and recoverable denied revenue, and the twelve questions that surface both before you sign.

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STANDING	Unsolicited. No charge, no obligation, no access to your systems required.

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Summary

Every senior living business you buy already has artificial intelligence inside it. The seller bought it, the seller did not document it, and at close it becomes yours. This is not a technology question. It is a diligence question, and today it is not being asked.

Two exposures sit in every target. They point in opposite directions and only one of them is a cost.

The first is inherited liability. Systems that score fall risk, draft clinical notes, code assessments, optimise rosters and screen enquiries are already running in these buildings. In almost every case the facility cannot reconstruct, after the fact, what the system saw, what it recommended, who reviewed it and whether the human agreed. When a state surveyor, a plaintiff's attorney or a carrier asks that question, the absence of an answer is the finding.

The second is recoverable revenue, and it is the larger number. Medicare Advantage denials of skilled nursing and post-acute stays have risen sharply on the back of automated review. Denials are overturned on appeal at very high rates, and are appealed at very low ones. A facility that can evidence the care it delivered wins those appeals. A facility that cannot, writes the revenue off. That gap is visible in the target's own numbers before you close, and it is priceable.

> **RECOMMENDATION**
>
> Add the twelve questions in Section 05 to the standard acquisition checklist. They cost nothing to ask, they are answerable by any competent administrator, and the pattern of answers tells you whether you are buying a clean business, a discount, or a problem. Section 06 sets out what an acceptable answer looks like.

02

Where the agents already sit

The senior living operating model is unusually exposed because it combines healthcare, hospitality and property management in one building, and because labour is the dominant cost line. That combination has made it a heavy adopter of automation, usually purchased department by department rather than as a strategy. The result is a stack that no single person in the business owns.

The following are the surfaces where automated decisioning is now routine in the sector. In a target of any size, assume several are present until proven otherwise.

Revenue cycle and claims

Coding support, claim scrubbing, denial prediction and appeal drafting. Directly touches what is submitted to Medicare and Medicaid.

Assessment and clinical coding

Tools that draft or suggest MDS coding. Because assessment data drives both payment and the CMS Five Star quality measures, an error here is simultaneously a billing exposure and a rating exposure.

Staffing and scheduling

Acuity-based rostering and shift optimisation. Vendors market labour cost reductions in the region of ten to fifteen percent. Where state ratio requirements apply, the optimiser is making a compliance-relevant decision.

Fall detection and remote monitoring

Computer vision and sensor-based detection layered over a rounding model. The liability question is not whether it works. It is what happens evidentially when it does not fire.

Ambient clinical documentation

Systems that listen, draft and populate the resident record. The drafted note becomes the legal record of care.

Enquiry handling and family communication

Lead qualification, move-in nurturing and automated family updates. This is the surface most likely to trigger state AI disclosure requirements, and the one least likely to have been reviewed by anybody.

A recurring finding across the sector is that these systems sit on data spread across an electronic health record, a customer relationship system and a scheduling platform that were never built to talk to each other. That fragmentation is the reason the evidence trail does not exist. It is also the reason the problem is invisible in a standard data room.

03

The revenue case: denials you are already losing

This is the section to read if only one section gets read.

A Senate investigation led by Senator Richard Blumenthal, published in October 2024, found that one major Medicare Advantage insurer’s denial rate for post-acute care rose from 10.9 percent in 2020 to 22.7 percent in 2022, with skilled nursing denials climbing roughly ninefold across the period in which automated review was expanded.

The litigation now running against that practice is instructive for a buyer. In the class action in the District of Minnesota concerning the nH Predict tool, a federal magistrate judge granted broad discovery in March 2026, ordering production across most categories the plaintiffs sought, including material going to whether the tool was designed to override the clinical judgement of treating physicians. The insurer disputes the characterisation and maintains the tool does not make coverage determinations. The relevant point for an acquirer is narrower and is not in dispute: how an automated decision was reached is now discoverable, and courts are willing to compel it.

Plaintiffs in those proceedings put the overturn rate on appealed denials at roughly nine in ten, and the share of denials that are ever appealed at a fraction of one percent. Whatever the final adjudication, the operational asymmetry is the business fact. Denials are cheap to issue and expensive to contest, and the party that keeps better records wins the contest.

> **WHAT THIS MEANS AT THE DEAL TABLE**
>
> Under-appealed denials are revenue the seller has already given up on. If the target is not appealing, and the reason is that its documentation will not support an appeal, then you are looking at both a price adjustment and a post-close recovery programme. Questions 07 through 10 in Section 05 are designed to surface exactly this, from records the target already holds.

04

The liability case: what transfers at close

Regulatory exposure is fragmented and follows the resident

There is no single federal standard. State obligations generally apply based on where the resident is located rather than where the company is headquartered, which means a multi-state roll-up inherits a different obligation set with each acquisition. As at August 2026 the material regimes include the following. Effective dates in this area have moved repeatedly and should be confirmed with counsel at the time of each deal.

JURISDICTION	OBLIGATION	STATUS
Texas	HB 149 requires clear and conspicuous disclosure to patients where AI is used in their care, with limited emergency exceptions.	IN FORCE JAN 1, 2026
California	AB 3030 requires disclaimers on AI-generated clinical patient communications with a route to a human. SB 1120 bars medical necessity determinations based solely on automated tools. AB 489 bars systems	IN FORCE JAN 1, 2025 / JAN 1, 2026

JURISDICTION	OBLIGATION	STATUS
	implying licensed clinician status.	
Illinois	Prohibits AI from making independent therapeutic decisions. A bright line rather than a disclosure duty.	IN FORCE AUG 2025
Utah	Disclosure of generative AI use on request, and proactively in high-risk and regulated occupational settings.	IN FORCE
Colorado	The 2024 high-risk AI framework was delayed, then frozen by court order in April 2026, then repealed and replaced with a lighter disclosure-based regime.	PENDING JAN 1, 2027
Maryland and others	Human review requirements on automated utilisation review, following the California model. Arizona, Connecticut, Nebraska and Texas have comparable provisions enacted or in progress.	IN FORCE OCT 1, 2025

A federal executive order issued in June 2026 did not preempt these state regimes. Plan for fragmentation, not consolidation.

Litigation exposure

The discovery order described in Section 03 was made against a payer. The reasoning does not stop there. Where an automated system contributed to a decision that is later challenged, the design, deployment and override history of that system is fair ground for discovery. An operator holding no decision-level record is not protected by that absence. It simply has nothing to put in front of the court except staff recollection.

Insurance exposure

Professional and general liability underwriting in long-term care is already tight. Two questions matter and are rarely asked in diligence. Whether the target disclosed its AI deployment to its carrier at the last renewal, and whether the carrier would consider that deployment material. Non-disclosure of a material fact is a coverage argument the buyer inherits.

Contractual exposure

Vendor agreements in this sector generally place disclosure, human review and compliance obligations on the deploying facility rather than on the vendor. The facility carries the duty and frequently has not read the clause that says so. Check where the indemnity actually sits before assuming the vendor stands behind the tool.

05

The twelve questions

These belong in the standard checklist, asked of the administrator and the finance lead at every target. They require no technical expertise to ask and no system access to answer. The pattern of answers is the finding.

Inventory and control

01 List every system in the business that produces a recommendation, a score, a prediction or a draft of a clinical or billing record. Include anything a vendor markets as AI, automation or clinical decision support.

02 For each, who signed the contract and when, and does the agreement place disclosure and compliance obligations on the vendor or on the facility?

03 Which of these systems touch a resident record, a care plan, an assessment or a claim submitted to Medicare or Medicaid?

Evidence

04 For any AI-assisted or AI-drafted entry in a resident record, can the facility produce, eighteen months later, what the system saw, what it recommended, who reviewed it and whether the reviewer agreed or overrode it?

05 What is the written policy on human review of automated output in clinical and billing contexts, when was it last updated, and who signed it?

06 In which states does the business operate, which AI disclosure obligations apply in each, and what disclosure is currently given to residents and families?

Denied revenue

07 What are the Medicare Advantage denial rates for skilled nursing and post-acute stays over the last twenty four months, split by payer?

08 What share of those denials were appealed, and what was the overturn rate on appeal?

09 For denials that were not appealed, why not? Clinical judgement, administrative capacity, or documentation that would not support an appeal?

10 Has any payer used an automated or predictive tool in denying this facility's claims, and has the facility ever requested the basis of an automated denial in writing?

Incidents and cover

11 Has the facility received any survey citation, complaint or litigation demand in which an automated system, an alert that did not fire, or a documentation gap was a contributing factor?

12 What does the professional and general liability carrier know about the AI deployment, and was it disclosed at the last renewal?

06

What an acceptable answer looks like

A target does not need to be sophisticated to pass. It needs to be able to account for itself. The following is the standard worth holding at close, and the remediation list where it is not met.

- A live register of every automated system in the business, owned by a named person, rather than a list assembled once for the data room.
- A named human accountable for each system, identifiable in the record at the point of each decision, not merely in an org chart.
- Decision-level records retained for the applicable limitation period in the relevant state, not for the vendor default of ninety days.
- Disclosure language matched to each state of operation and actually in use at the point of resident and family contact.
- Vendor agreements reviewed for where the compliance duty and the indemnity sit.
- Written confirmation that the liability carrier has been told what is deployed.
- An appeals process that is capable of being run, evidenced by the appeal rate rather than by the policy document.

Where a target fails several of these, that is not automatically a reason to walk. It is a reason to price it, to condition it, and to fix it inside the first hundred days, which is where the margin sits in a roll-up anyway.

07

Scope, limits and what a systems review would add

This document is a desk review. It was prepared without access to any America Senior Living system, contract, facility or record, and without any engagement or fee. Nothing in it is legal advice, and no statement of state law here should be relied on without confirmation from counsel at the time of the transaction, because effective dates in this area have moved repeatedly during 2025 and 2026.

What a review with access would add, and what this cannot tell you, is the following. Which specific vendors are deployed across the portfolio and where their contractual liability actually falls. Whether the evidence the systems produce would survive contact with a surveyor or a discovery request. What the recoverable denied revenue actually totals across the portfolio rather than in principle. And whether the same gap is repeating across every target, which in a roll-up is the difference between a facility problem and a thesis problem.

That work is a matter of weeks, not months, and it is the work APIR does.

08

About

APIR Intelligence is the verification layer for AI agents. Cryptographically signed agent credentials, hash chained audit records and independent behavioural scoring, so that an organisation can evidence what an autonomous system actually did when a regulator, an insurer or a court asks.

The company was founded and built by Slav Ripa in Adelaide, South Australia. The platform is live. It is pre revenue.

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Sources for the regulatory and litigation positions cited in sections 03 and 04 include the October 2024 Senate report on Medicare Advantage post-acute denials, the March 2026 discovery order in the District of Minnesota class action concerning nH Predict, and published state legislative trackers current to August 2026. Effective dates should be reconfirmed at the time of each transaction.