APPENDIX

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Appendix A

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 20-1799

NORTHPORT HEALTH SERVICES OF ARKANSAS, LLC, doing business as Springdale Health and Rehabilitation Center, et al.,

Plaintiffs-Appellants,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, XAVIER BECERRA,[1] in his official capacity as Secretary of the U.S. Department of Health & Human Services; CENTERS FOR MEDICARE & MEDICAID SERVICES; CHIQUITA BROOKS-LASURE,[2] in her official capacity as the Administrator of the Centers of Medicare & Medicaid Services,

Defendants-Appellees.

Submitted: January 15, 2021
Filed: October 1, 2021

Before SMITH, Chief Judge, KELLY and ERICKSON, Circuit Judges.

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[1] Xavier Becerra is automatically substituted pursuant to Federal Rule of Appellate Procedure 43(c)(2).

[2] Chiquita Brooks-LaSure is automatically substituted pursuant to Federal Rule of Appellate Procedure 43(c)(2).

OPINION

KELLY, Circuit Judge.

Northport Health Services of Arkansas, LLC, and other similarly situated long-term care (LTC) facilities (collectively, Northport) appeal the decision of the district court[3] granting summary judgment in favor of the U.S. Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS, and collectively, the government). Northport argues that a regulation promulgated by CMS through notice and comment rulemaking is unlawful and should be set aside for violating the Administrative Procedure Act (APA), 5 U.S.C. § 706, the Federal Arbitration Act (FAA), 9 U.S.C. § 1 *et seq.*, and the Regulatory Flexibility Act (RFA), 5 U.S.C. § 601 *et seq.* Having jurisdiction under 28 U.S.C. § 1291, we affirm.

I. Background

A. *Factual and Regulatory Background*

The federal government subsidizes eligible individuals' health care through two large programs: Medicare and Medicaid. Medicare, the second largest federal program, spends approximately $800 billion annually "to provide health insurance to nearly 60 million aged or disabled Americans." *Azar v. Allina Health Servs.*, 139 S. Ct. 1804, 1808 (2019); *see* NHE Fact Sheet, Ctrs. for Medicare & Medicaid Servs.,

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[3] The Honorable Timothy L. Brooks, United States District Judge for the Western District of Arkansas.

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet (last modified Dec. 16, 2020). "Medicaid is a cooperative federal-state program through which the Federal Government provides [approximately $600 billion in] financial assistance to States so that they may furnish medical care to needy individuals." *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502 (1990); *see* NHE Fact Sheet, *supra*. The Secretary of HHS administers both programs through CMS, a sub-agency of HHS. To provide services to Medicare- and Medicaid-covered individuals, medical providers must enter into provider agreements that establish treatment standards and set reimbursement rates for available services. *See* 42 U.S.C. §§ 1395cc, 1396a.

Medicare and Medicaid provide coverage for long-term residents of nursing homes, commonly referred to as LTC facilities. Participating LTC facilities must comply with the requirements set forth in 42 U.S.C. § 1395i-3 (Medicare) and 42 U.S.C. § 1396r (Medicaid), as well as the regulations promulgated thereunder, *see* 42 C.F.R. §§ 483.1-.95. The plaintiffs in this matter are "dually-certified" LTC facilities, meaning they provide long-term care under both the Medicare and Medicaid programs.

In 2015, CMS initiated notice and comment rulemaking to comprehensively revise the requirements for LTC facilities to participate in the Medicare and Medicaid programs. *See* Reform of Requirements for Long-Term Care Facilities, 80 Fed. Reg. 42,168, 42,168-69 (proposed July 16, 2015). The regulatory reforms were intended to "improve the

quality of life, care, and services in LTC facilities, optimize resident safety, reflect current professional standards, and improve the flow of the regulations" in light of "evidence-based research . . . [that] enhanced [CMS's] knowledge about resident safety, health outcomes, individual choice, and quality assurance and performance improvement." *Id.* at 42,169. In that vein, CMS noted the potential benefits of alternative dispute resolution, including arbitration, but also expressed its concern that LTC facilities' "superior bargaining power could result in a resident feeling coerced into signing the agreement," that residents might be waiving the right to judicial relief without full understanding, and that the prevalence of pre-dispute arbitration agreements "could be detrimental to residents' health and safety." *Id.* at 42,211. CMS therefore proposed certain limitations on LTC facilities' use of arbitration agreements, including requirements that the facilities explain such agreements to residents in a form, manner, and language that they understand and that they not treat arbitration agreements as a "condition of admission, readmission, or the continuation of [one's] residence at the facility." *Id.* In addition, reflecting a more general concern regarding the use of such agreements by LTC facilities, CMS stated it was considering and soliciting comments on "whether binding arbitration agreements should be prohibited" in the case of nursing home residents. *Id.*

On October 4, 2016, after an extended comment period, CMS published the final version of the rule (Original Rule) in the Federal Register. *See* Reform of Requirements for Long-Term Care Facilities, 81 Fed. Reg. 68,688 (Oct. 4, 2016). In a shift from the proposed

rule, the final rule prohibited LTC facilities from entering into pre-dispute, binding arbitration agreements with residents or their representatives. *See id.* at 68,690. CMS clarified further that, "[a]fter a dispute arises, the resident and the LTC facility may voluntarily enter into a binding arbitration agreement if both parties agree and comply with the relevant requirements" of the final rule. *Id.* at 68,800.

Several weeks later, before the Original Rule was to take effect on November 28, 2016, *see id.* at 68,688, a group of Mississippi nursing homes sued to preliminarily and permanently enjoin enforcement of the rule's arbitration provision. *See Am. Health Care Ass'n v. Burwell*, 217 F. Supp. 3d 921, 926 (N.D. Miss. 2016). Similar to this case, the nursing homes claimed that the rule's blanket prohibition of LTC facilities' use of pre-dispute arbitration agreements violated the APA, the FAA, and the RFA. *See id.* at 929-42. Finding that the nursing homes were likely to prevail, the district court granted a nationwide preliminary injunction of the challenged provision of the Original Rule. *See id.* at 946.

Rather than appeal the district court's decision, CMS initiated another round of notice and comment rulemaking several months later to revise the enjoined portion of the Original Rule. CMS proposed removing the requirement that precluded LTC facilities from entering into pre-dispute, binding arbitration agreements, reasoning that, "[u]pon reconsideration, [it] believe[d] that 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." Revision of Requirements for Long-Term Care Facilities: Arbitration Agreements, 82 Fed. Reg. 26,649, 26,650-51 (proposed June 8, 2017). CMS nevertheless acknowledged some concerns about the use of arbitration agreements in LTC facilities and proposed strengthening some requirements "to ensure the transparency of arbitration agreements in LTC facilities" and to strike the "best policy balance." *Id.* at 26,651.

After the comments period concluded, CMS published the final version of the rule (Revised Rule) in the Federal Register, to go into effect on September 16, 2019. *See* Revision of Requirements for Long-Term Care Facilities: Arbitration Agreements, 84 Fed. Reg. 34,718, 34,718 (July 18, 2019) (codified at 42 C.F.R. § 483.70(n)). It provided:

> (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.

Id. at 34,735-36 (quoting proposed 42 C.F.R. § 483.70(n)).

B. *Procedural History*

On September 4, 2019, Northport filed this lawsuit challenging multiple aspects of the Revised Rule: (i) the requirement that a binding arbitration agreement not be made a condition for the admission to, or the continuation of care in, an LTC facility, 42 C.F.R. § 843.70(n)(1); (ii) the requirement that residents be granted a right to rescind a binding arbitration agreement within 30 days of signing, *id.* § 843.70(n)(3); (iii) the requirement that any arbitration agreement (a) be explained to the resident so he or she understands it and (b) explicitly state that signing it is not a condition of admission to the LTC facility, *id.* § 843.70(n)(2)(i)-(ii), (4); and (iv) the requirement that the LTC facility retain copies of the signed arbitration agreement and any final arbitration decisions for five years, *id.* § 843.70(n)(6).

Northport moved to preliminarily enjoin the enforcement of the Revised Rule or, in the alternative, to stay enforcement pending judicial review. While that motion was pending, the parties agreed to stay enforcement of the Revised Rule until the district court ruled on the merits of the case, and they cross-moved for summary judgment based on the administrative record.

On April 7, 2020, the district court denied Northport's motion for summary judgment and granted the government's motion for summary judgment, upholding the Revised Rule. The court reasoned that the rule (i) did not violate the FAA, 9 U.S.C. § 2; (ii) was a permissible exercise of HHS's statutory authority under the Medicare and Medicaid statutes; (iii) was not "arbitrary and capricious" under the APA, 5 U.S.C. § 706(2)(A); and (iv) was promulgated in compliance with the RFA, 5 U.S.C. § 605(b). Northport now appeals, and we have granted a stay of the Revised Rule's enforcement pending resolution of this appeal.

II. Discussion

Northport revives its four challenges to the Revised Rule on appeal. "We review de novo a district court's decision on whether an agency action violates the APA." *Simmons v. Smith*, 888 F.3d 994, 998 (8th Cir. 2018) (quoting *Friends of the Norbeck v. U.S. Forest Serv.*, 661 F.3d 969, 975 (8th Cir. 2011)); *see also* 5 U.S.C. § 706 ("[T]he reviewing court shall decide all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of the terms of an agency action."). We may set aside agency action under the APA if it is

"arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law"; "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right"; or "without observance of procedure required by law." 5 U.S.C. § 706(2)(A), (C)-(D).

A. *Conflict with the Federal Arbitration Act*

Northport first argues that the Revised Rule violates the FAA and is therefore "not in accordance with law," *id.* § 706(2)(A), because it subjects arbitration agreements to "disfavored treatment." Enacted in 1925 "in response to widespread judicial hostility to arbitration agreements," *AT&T Mobility LLC v. Concepcion*, 563 U.S. 333, 339 (2011), the FAA provides that the terms of a written arbitration agreement "shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract." 9 U.S.C. § 2. As described by the Supreme Court, this provision "establishes an equal-treatment principle," requiring "courts to place arbitration agreements 'on equal footing with all other contracts.'" *Kindred Nursing Ctrs. Ltd. P'ship v. Clark*, 137 S. Ct. 1421, 1424, 1426 (2017) (quoting *DIRECTV, Inc. v. Imburgia*, 577 U.S. 47, 48 (2015)).

Northport argues that the Revised Rule contravenes the equal-treatment principle because it "singles out" arbitration agreements, including by regulating LTC facilities' ability to enter into them with residents. For example, Northport reasons that prohibiting LTC facilities from requiring residents to sign arbitration agreements as a condition for admission, 53 C.F.R. § 483.70(n)(1), "restricts the use

of arbitration agreements" and violates the FAA. We disagree. Such a construction of the FAA ignores the statute's plain language and interpreting precedent and would significantly expand the scope of the FAA to manufacture a conflict with the Revised Rule where none exists. Simply put, the Revised Rule does not come up against the FAA because it does not limit or frustrate the enforceability of valid arbitration agreements.

As noted above, the "savings clause" of the FAA "permits arbitration agreements to be declared *unenforceable* 'upon such grounds as exist at law or in equity for the revocation of any contract.'" *Concepcion*, 563 U.S. at 339 (emphasis added) (quoting 9 U.S.C. § 2). That is, an agreement to arbitrate a dispute may "be *invalidated* by 'generally applicable contract defenses, such as fraud, duress, or unconscionability,' but not by defenses that apply only to arbitration or that derive their meaning from the fact that an agreement to arbitrate is at issue." *Id.* (emphasis added) (quoting *Doctor's Assocs., Inc. v. Casarotto*, 517 U.S. 681, 687 (1996)). Thus, in *AT&T Mobility LLC v. Concepcion*, the Supreme Court held that a California rule that treated class-action waivers in arbitration agreements as per se unconscionable was preempted by the FAA. *See id.* at 340, 352. Although unconscionability typically is a "generally applicable contract defense," the Court reasoned that California was applying the doctrine discriminately to arbitration agreements by finding class-action waivers particularly unconscionable when included therein. *See id.* at 341-44, 346-48. And under the FAA, California courts could not avoid *enforcing* arbitration agreements, including their class-action waivers,

"according to their terms." *Id.* at 344 (quoting *Volt Info. Scis., Inc. v. Bd. of Trs. of Leland Stanford Junior Univ.*, 489 U.S. 468, 478 (1989)).

In our reading, the Supreme Court has never applied the FAA to prohibit a federal agency from generally regulating the use of arbitration agreements as CMS does here. Rather, it has construed the FAA simply to limit the circumstances in which arbitration agreements, once entered into, can be rendered invalid or unenforceable. So, for example, in *Kindred Nursing Centers Ltd. Partnership v. Clark*, the Court held that the FAA preempted a Kentucky rule that would have rendered invalid (and thereby unenforceable) arbitration agreements entered into by a principal's legal representative if the governing power of attorney did not specifically state that the representative was entitled to enter into arbitration agreements on the principal's behalf. *See* 137 S. Ct. at 1425-27; *see also id.* at 1428 ("A rule selectively finding arbitration contracts invalid because improperly formed fares no better under the Act than a rule selectively refusing to enforce those agreements once properly made."). Likewise, in *Preston v. Ferrer*, the Court held that the FAA preempted a California rule that required exhaustion of state administrative remedies before arbitration, despite the fact that the parties had "agree[d] to arbitrate all questions arising under [the] contract." 552 U.S. 346, 359 (2008). Because requiring parties to initially refer their disputes to a state administrative body would frustrate the benefits of utilizing arbitration in the first instance, *see id.* at 357-58 ("A prime objective of an agreement to arbitrate is to achieve streamlined proceedings and expeditious results." (cleaned up)), the rule effectively

rendered valid arbitration agreements unenforceable and violated the FAA. *See id.* at 359. And in *Epic Systems Corp. v. Lewis*, the Supreme Court considered whether the National Labor Relations Act (NLRA) rendered certain agreements requiring individualized (as opposed to classwide) arbitration *unenforceable*. *See* 138 S. Ct. 1612, 1620 (2018); *see also id.* at 1622 (discussing the contract *defenses* that are preempted by the FAA: "defenses that target arbitration by name or by more subtle methods, such as by interfering with fundamental attributes of arbitration" (cleaned up)). Assuming the NLRA rendered class and collective action waivers in arbitration agreements illegal, the Court concluded that such a rule would violate the FAA because it would operate as a defense applicable to arbitration agreements only. *See id.* at 1622-23.

The Revised Rule, in comparison to the rules challenged in the above cases, does not invalidate or render unenforceable any arbitration agreement. *See* 84 Fed. Reg. at 34,718 ("This final rule does not purport to regulate the enforcement of any arbitration agreement . . . ."); *id.* at 34,729 ("CMS does not have the power to annul valid contracts."); *see also id.* at 34,732 ("This rule in no way would prohibit two willing and informed parties from entering voluntarily into an arbitration agreement."). Instead, it establishes the conditions for receipt of federal funding through the Medicare and Medicaid programs. *See id.* at 34,733 (noting that LTC facilities may enter into arbitration agreements "so long as they comply with the requirements" finalized in the Revised Rule). So, for example, if an LTC facility entered into an arbitration agreement with a resident without complying with the Revised Rule by requiring the resident to sign as a

condition of admission to the facility, *see* 42 C.F.R. § 483.70(n)(1), the arbitration agreement would nonetheless be enforceable, absent a showing of "generally applicable contract defenses, such as fraud, duress, or unconscionability," *Concepcion*, 563 U.S. at 339; *see* 9 U.S.C. § 2. CMS would simply enforce the regulation through a combination of administrative remedies, including denial of payment and civil monetary penalties. *See* 42 C.F.R. § 488.406; 84 Fed. Reg. at 34,733.

In summary, Northport expansively argues that the FAA established "a liberal federal policy favoring arbitration agreements," *Moses H. Cone Mem'l Hosp. v. Mercury Constr. Corp.*, 460 U.S. 1, 24 (1983), that is frustrated by the Revised Rule's regulation of nursing homes' use of arbitration agreements.[4] However, "courts do not apply federal policies; they apply federal statutes, and the FAA speaks only to the validity, irrevocability and enforceability of arbitration agreements." *Cal. Ass'n of Priv. Postsecondary Schs. v. DeVos*, 436 F. Supp. 3d 333, 344 (D.D.C. 2020), *vacated as moot*, No. 20-5080, 2020 WL 9171125 (D.C. Cir. Oct. 14, 2020). Because the Revised Rule does not, in words or effect, render arbitration agreements

[4] Northport largely ignores the extent to which the Revised Rule *favors* arbitration as "an appropriate forum to resolve disputes." 84 Fed. Reg. at 34,729; *see also id.* at 34,732 ("We acknowledge the[] 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.").

entered into in violation thereof invalid or unenforceable, it does not conflict with the FAA.[5]

B. *HHS's Statutory Authority Under the Medicare and Medicaid Statutes*

Next, Northport argues that the Revised Rule should be set aside because it exceeds HHS's statutory authority under the Medicare and Medicaid statutes to promulgate regulations (i.e., that it is ultra vires). *See* 5 U.S.C. § 706(2)(C); *see also U.S. ex rel. O'Keefe v.*

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[5] Because we find no conflict between the FAA and the Revised Rule, we need not address Northport's argument that Congress has not evinced a "clear and manifest" intention to empower CMS to promulgate rules overriding the FAA. *See Epic Sys.*, 138 S. Ct. at 1624 ("A party seeking to suggest that two statutes cannot be harmonized, and that one displaces the other, bears the heavy burden of showing a clearly expressed congressional intention that such a result should follow." (cleaned up)). Such an intention is unnecessary where there is "no conflict at all." *Id.* at 1625. Nor do we address Northport's argument that the Revised Rule engages in "economic dragooning," leaving LTC facilities "no real option but to acquiesce" to its regulations of arbitration agreements. *Nat'l Fed. of Indep. Bus. v. Sebelius*, 567 U.S. 519, 582 (2012) (plurality opinion). For one, a plurality of the Supreme Court used that language to describe the federal government's limited constitutional authority under the Spending Clause to regulate the states, *see id.* at 575-85, not a federal agency's ability to regulate LTC facilities' use of federal funding, as in this case. Indeed, it is irrelevant for the purposes of the FAA whether LTC facilities—private businesses that voluntarily participate in the Medicare and Medicaid programs, *see Minn. Ass'n of Health Care Facilities, Inc. v. Minn. Dep't of Pub. Health*, 742 F.2d 442, 446 (8th Cir. 1984); *Livingston Care Ctr., Inc. v. United States*, 934 F.2d 719, 720-21 (6th Cir. 1991)—must comply with the Revised Rule as the price of admission to obtain federal funding. The Revised Rule's regulations do not affect the validity or enforceability of LTC facilities' arbitration agreements, and they therefore do not conflict with the FAA.

McDonnell Douglas Corp., 132 F.3d 1252, 1257 (8th Cir. 1998) ("An agency's promulgation of rules without valid statutory authority implicates core notions of the separation of powers, and we are required by Congress to set these regulations aside."). We review such a claim using the familiar *Chevron* framework. *See Iowa League of Cities v. E.P.A.*, 711 F.3d 844, 876 (8th Cir. 2013). "Under that framework, we ask whether the statute is ambiguous and, if so, whether the agency's interpretation is reasonable." *King v. Burwell*, 576 U.S. 473, 485 (2015) (citing *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 842-43 (1984)). The two-step *Chevron* framework "is premised on the theory that a statute's ambiguity constitutes an implicit delegation from Congress to the agency to fill in the statutory gaps." *Id.* (quoting *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 159 (2000)).

The government relied on three sections of the Medicare and Medicaid statutes as the bases for its statutory authority to promulgate the Revised Rule. *See* 84 Fed. Reg. at 34,718, 34,725.

> It is the duty and responsibility of the Secretary to assure that requirements which govern the provision of care in [participating LTC facilities], and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.
>
> 42 U.S.C. §§ 1395i-3(f)(1), 1396r(f)(1).
>
> A [participating LTC facility] must meet such other requirements relating to the health, safety, and well-being of residents or relating

> to the physical facilities thereof as the Secretary may find necessary.
>
> *Id.* § 1395i-3(d)(4)(B); *cf. id.* § 1396r(d)(4)(B).
>
> A [participating LTC facility] must protect and promote the rights of each resident, including . . . [a]ny other right established by the Secretary.
>
> *Id.* §§ 1395i-3(c)(1)(A)(xi), 1396r(c)(1)(A)(xi).[6]

To determine whether a statute is ambiguous, we start with its plain language. *See Ark. AFL-CIO v. F.C.C.*, 11 F.3d 1430, 1440 (8th Cir. 1993) (en banc). "If congressional intent is clearly discernable, the agency must act in accordance with that intent and the court need not defer to the agency's interpretation of its mandate." *Id.* Thus, we must determine whether Congress intended HHS to have the authority to regulate LTC facilities' use of arbitration agreements. *See Friends of the Boundary Waters Wilderness v. Bosworth*, 437 F.3d 815, 823 (8th Cir. 2006).

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[6] Northport argues that the government "disclaimed reliance" on this last pair of provisions because it was not cited in the section titled "Statutory Authority" of the Revised Rule. *See* 84 Fed. Reg. at 34,718; *see also Michigan v. E.P.A.*, 576 U.S. 743, 758 (2015) (noting "the foundational principle of administrative law that a court may uphold agency action only on the grounds that the agency invoked when it took the action"). However, the Revised Rule did cite these provisions as statutory authorities for promulgating the Original Rule, which was "designed to accomplish the same goals" as the Revised Rule, 84 Fed. Reg. at 34,725; *see also* 82 Fed. Reg. at 26,651 (claiming statutory authority to issue the Revised Rule under these three provisions), and we consider all three statutory bases proffered by the government, *see Union Pac. R.R. Co. v. Surface Transp. Bd.*, 863 F.3d 816, 824 (8th Cir. 2017).

Looking to the above statutory provisions, we conclude that the Medicare and Medicaid statutes are ambiguous as to whether HHS has the authority to regulate the use of arbitration agreements. The statutes are broadly worded to give HHS significant leeway in deciding how best to safeguard LTC residents' health and safety and protect their dignity and rights. For example, the statutes delegate authority to the Secretary to promulgate regulations ensuring the "provision of care" at LTC facilities is adequate to "protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys." 42 U.S.C. §§ 1395i-3(f)(1), 1396r(f)(1). More capaciously, the statutes confer authority to the Secretary to promulgate regulations "relating to the health, safety, and well-being of residents" as deemed "necessary." *Id.* § 1395i-3(d)(4)(B); *cf. id.* § 1396r(d)(4)(B). And most expansively, the Secretary is empowered to "protect and promote" the rights of residents he or she may deem important. *Id.* §§ 1395i-3(c)(1)(A)(xi), 1396r(c)(1)(A)(xi).

We disagree with Northport's arguments that the statutes are sufficiently unambiguous to conclude that Congress did not intend for HHS to have the authority to regulate the use of arbitration agreements. First, Northport contends that arbitration is not "meaningful[ly] connect[ed]" to residents' "healthy, safety, and well-being," *e.g.*, *id.* § 1395i-3(d)(4)(B), and falls outside HHS's wheelhouse—the "provision of care," *id.* §§ 1395i-3(f)(1), 1396r(f)(1). In effect, Northport implies that although HHS is empowered to regulate the terms of residents' medical, palliative, or residential care, HHS does not have the authority

to regulate the administrative side of LTC facilities. Looking to the "text and context" of the statute, *Union Pac. R.R. Co.*, 863 F.3d at 825, we reject such a narrow reading of HHS's authority. In addition to conferring the general responsibility to promulgate regulations governing the "provision of care . . . adequate to protect the health, safety, welfare, and rights of residents," 42 U.S.C. §§ 1395i-3(f)(1), 1396r(f)(1), Congress gave HHS the power to develop standards for the qualification of LTC facility administrators, id. §§ 1395i-3(f)(4), 1396r(f)(4), to establish criteria for the administration of LTC facilities, *id.* §§ 1395i-3(f)(5), 1396r(f)(5), and to specify data to be collected by LTC facilities, *id.* §§ 1395i-3(f)(6), 1396r(f)(6). These provisions, though not themselves the statutory bases of the Revised Rule, demonstrate that HHS is not restricted to regulating only matters concerning residents' standard of medical care.

Next, relying on the interpretive canon that expressing some items of a group excludes the omitted items, *see N.L.R.B. v. SW General, Inc.*, 137 S. Ct. 929, 940 (2017) (defining *expressio unius est exclusio alterius*), Northport argues that Congress did not intend HHS to regulate LTC facilities' ability to condition residents' admission on signing arbitration agreements. In Northport's view, by enacting express provisions governing LTC facilities' admissions practices without mentioning arbitration agreements, *see* 42 U.S.C. §§ 1395i-3(c)(5), 1396r(c)(5), Congress intentionally withheld authority from HHS to promulgate regulations on that issue. "But that canon [is] a feeble helper in an administrative setting," *Child.'s Hosp. Ass'n of Tex. v. Azar*, 933 F.3d 764, 770-71 (D.C. Cir. 2019) (cleaned up), particularly when, as

here, Northport points to no evidence suggesting that "Congress considered the unnamed possibility and meant to say no to it," *Barnhart v. Peabody Coal Co.*, 537 U.S. 149, 168 (2003). Moreover, Northport's argument would suggest that HHS lacks the authority to regulate admissions practices beyond that specified in the pertinent statutory provisions, a claim undermined by other HHS regulations that do just that. *See, e.g.*, 42 C.F.R. § 483.15(a)(2)(iii), (6).

Finally, Northport infers from the fact that HHS had not tried to promulgate regulations governing the use of arbitration agreements until 2016, when it published the Original Rule, that HHS had implicitly recognized it lacked the statutory authority to do so. Northport points to no authority suggesting that an agency's inaction defines the boundaries of that agency's statutory authority. Indeed, we do not draw comparable inferences from *legislative* inaction. *See Pension Benefit Guar. Corp. v. LTV Corp.*, 496 U.S. 633, 650 (1990) ("Congressional inaction lacks persuasive significance because several equally tenable inferences may be drawn from such inaction." (cleaned up)). But more directly, whether or not an agency has previously attempted to exercise statutory authority it may or may not have does not answer the question before us—whether the statute is ambiguous, thereby implicitly leaving a gap in the statute to be filled. *See Iowa League of Cities*, 711 F.3d at 877.

Having determined that the Medicare and Medicaid statutes are ambiguous, we look to whether the agency's interpretation "is based on a permissible construction of the statute[s]." *Andrade-Zamora v. Lynch*, 814 F.3d 945, 951 (8th Cir. 2016) (quoting *City*

of Arlington v. F.C.C., 569 U.S. 290, 296 (2013)); *see Ark. AFL-CIO*, 11 F.3d at 1441 (noting "the agency's construction of [a] statute must be reasonable"). An agency's reasonable interpretation of a statute is entitled to "substantial deference." *Bosworth*, 437 F.3d at 821. In conducting our analysis, we need not identify the interpretation we would have taken had the question been presented to us initially in a judicial proceeding, as "a court may not substitute its own construction of a statutory provision for a reasonable interpretation made by the administrator of an agency." *Simmons*, 888 F.3d at 998 (quoting *Chevron*, 467 U.S. at 844); *see also Unity Healthcare v. Azar*, 918 F.3d 571, 578 (8th Cir. 2019) ("[T]he question before us is not whether an agency interpretation represents the best interpretation of the statute, but whether it represents a reasonable one." (quoting *Smiley v. Citibank (S.D.), N.A.*, 517 U.S. 735, 744-45 (1996))). Rather, we will uphold the agency's interpretation "so long as we can reasonably conclude that the grants of authority in the statutory provisions cited by the government contemplate the issuance." *Iowa League of Cities*, 711 F.3d at 877 (cleaned up).

Reviewing the provisions of the Revised Rule, we conclude that they are reasonable interpretations of the Medicare and Medicaid statutes. As noted by CMS, the Revised Rule reflects the agency's belief that "arbitration has both advantages and disadvantages" and permits LTC facilities "to ask their residents to sign arbitration agreements so long as they comply with the [Revised Rule's] requirements." 84 Fed. Reg. at 34,732-33. Generally, these requirements ensure that residents who enter into arbitration agreements with LTC facilities do so knowingly and voluntarily,

without the specter that the facility will deny care should they refuse. For example, LTC facilities may not require a resident to sign an arbitration agreement either as a condition of admission or as a requirement to continue receiving care. *See* 42 C.F.R. § 483.70(n)(1); *see also id.* § 483.70(n)(4). LTC facilities must explain the function of the arbitration agreement before a resident signs it, and they must afford residents the right to rescind the agreement within 30 days of signing it. *See id.* § 483.70(n)(2)(i), (3). And to assist CMS in monitoring the efficacy of arbitration in resolving disputes between residents and LTC facilities, the Revised Rule requires LTC facilities to keep for five years the applicable arbitration agreement and the arbitrator's final decision if ever a dispute is resolved. *See id.* § 483.70(n)(6).

In our view, it is reasonable for CMS to conclude that regulating the use of arbitration agreements in LTC facilities furthers the health, safety, and well-being of residents, particularly during the critical stage when a resident is first admitted to a facility. *See* 42 U.S.C. § 1395i-3(d)(4)(B), (f)(1); *id.* § 1396r(d)(4)(B), (f)(1). We can appreciate how conditioning care on entering into a binding arbitration agreement may frustrate residents' access to treatment or jeopardize their health and well-being. *See* 84 Fed. Reg. at 34,726 (noting that the Revised Rule "holds the [LTC] facility accountable by ensuring that [it] cannot coerce or apply unreasonable pressure on a resident . . . by implying the resident would not receive the care he or she needs without signing the agreement"); *see also id.* at 32,727 (noting that "residents are frequently admitted during a time of stress and often after a

decline in their health or directly from the hospital . . . mak[ing] it extremely difficult for LTC residents . . . to make an informed decision about arbitration"). Likewise, we think the Revised Rule is a reasonable exercise of CMS's authority to protect residents' rights. *See* 42 U.S.C. §§ 1395i-3(c)(1)(A)(xi), 1396r(c)(1)(A)(xi).

In summary, the Revised Rule "represents a reasonable accommodation of manifestly competing interests and is entitled to deference." Chevron, 467 U.S. at 865. We affirm the district court's conclusion that it is not ultra vires.

C. *Northport's Challenge to the Rule as Arbitrary and Capricious*

Next, Northport argues that the Revised Rule should be set aside because it is "arbitrary, capricious, [and] an abuse of discretion." *See* 5 U.S.C. § 706(2)(A). When promulgating a rule, an agency "must examine the relevant data and articulate a satisfactory explanation for its action including a 'rational connection between the facts found and the choice made.'" *Motor Vehicles Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983) (quoting *Burlington Truck Lines v. United States*, 371 U.S. 156, 168 (1962)). "Normally, an agency rule would be arbitrary and capricious if the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *Id.*; *see also F.C.C. v. Fox Television Stations, Inc.*, 556 U.S. 502,

536 (2009) (Kennedy, J., concurring in the judgment) ("The question in each case is whether the agency's reasons for the change, when viewed in light of the data available to it, and when informed by the experience and expertise of the agency, suffice to demonstrate that the new policy rests upon principles that are rational, neutral, and in accord with the agency's proper understanding of its authority."). Our scope of review is narrow, and we are "not to substitute [our] judgment for that of the agency." *State Farm*, 463 U.S. at 43. Although "[w]e may not supply a reasoned basis for the agency's action that the agency itself has not given," *id.* (quoting *SEC v. Chenery Corp.*, 332 U.S. 194, 196 (1947)), we will "uphold a decision of less than ideal clarity if the agency's path may reasonably be discerned," *id.* (quoting *Bowman Transp., Inc. v. Ark.-Best Freight Sys., Inc.*, 419 U.S. 281, 286 (1974)).

Northport raises two arguments as to why the Revised Rule is arbitrary and capricious. First, it suggests that the rule was "based on sheer speculation" because CMS relied principally on anecdotal evidence rather than quantitative social science evidence to support the rule. *See, e.g.*, 84 Fed. Reg. at 34,722, 34,726 (noting that CMS believed the Revised Rule was "the best way to strike a balance" between "a great deal of anecdotal evidence and reportage" critical of LTC facilities' use of arbitration agreements and the "lack of statistical data" showing "that arbitration agreements necessarily have a negative effect on quality of care"). But "[t]he APA imposes no general obligation on agencies to produce empirical evidence," *Stilwell v. Office of Thrift Supervision*, 569 F.3d 514, 519 (D.C. Cir. 2009), and

CMS was entitled to justify the rule using the available anecdotal evidence so long as it provided a rational, reasoned explanation for doing so. *See id.*; *see also Sacora v. Thomas*, 628 F.3d 1059, 1069 (9th Cir. 2010) (noting that although "[i]t may have been preferable for the [agency] to support its conclusions with empirical research," "it was reasonable for the [agency] to rely on its experience, even without having quantified it in the form of a study").

Having reviewed the regulatory record of both the Original Rule and the Revised Rule, we are satisfied that the evidence CMS relied upon is sufficient to support the Revised Rule. *See* 84 Fed. Reg. at 34,722 (noting that CMS relied on the evidence and comments gathered during the Original Rule's rulemaking process to justify the Revised Rule). For example, CMS took into consideration commenters' stated beliefs that arbitration agreements in some instances permitted LTC facilities "to avoid responsibility for providing poor or substandard care to their residents," jeopardizing residents' health and safety. 81 Fed. Reg. at 68,793; *see also id.* (noting that some commenters "had personally witnessed resident neglect and attributed it to facilities believing that they were immune to any legal consequences for their mistreatment because of the likelihood that they would prevail in binding arbitration"). Furthermore, CMS conducted a review of academic literature and court opinions, which "provided evidence that pre-dispute arbitration agreements were detrimental to the health and safety of LTC facility residents." *Id.* (noting various evidence-based critiques of LTC facilities' use of arbitration agreements, including "the unequal bargaining power between the resident and

the LTC facilities; inadequate explanations of the arbitration agreement; the inappropriateness of presenting the agreement upon admission, an extremely stressful time for the residents and their families; negative incentives on staffing and care as a result of not having the threat of a substantial jury verdict for sub-standard care; and the unfairness of the arbitration process for the resident"). Although these observations were not supported by statistical data that quantified their aggregate effect, they were sufficient to justify CMS "implement[ing] a regulation that accommodates arbitration while also protecting LTC facility residents from unfairly coerced agreements." 84 Fed. Reg. at 34,726. Likewise, it was not arbitrary or capricious for CMS to have adopted a rule recognizing the importance of amassing data going forward to continue monitoring the propriety of the rule, *see id.* at 34,723 ("[T]he 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."), as agencies are empowered to "adopt prophylactic rules to prevent potential problems before they arise," *see Stilwell*, 569 F.3d at 519.

Second, Northport argues that CMS did not adequately explain the rule's alleged departure from the agency's historical support for the use of arbitration agreements by LTC facilities. Northport relies on two documents that supposedly reflect HHS and CMS's prior policy toward arbitration agreements: a January 2003 memorandum from Steven Pelovitz, the former Director of the Survey and Certification Group of CMS, Dist. Ct. Dkt. 25-5 at 2-3

(the Pelovitz Memo), and a July 2008 letter from Michael Leavitt, the former Secretary of HHS, to the House Judiciary Committee, Dist. Ct. Dkt. 24-25 at 691-93 (the Leavitt Letter). In the Pelovitz Memo, CMS set forth its policy regarding LTC facilities that conditioned residents' admission to or ability to remain in an LTC facility on their signing of a pre-dispute, binding arbitration agreement. Noting that the agency's "primary focus should be on the quality of care actually received by nursing home residents that may be compromised by such agreements," CMS declared that it would enforce existing federal regulations to prevent LTC facilities from discharging, transferring, or retaliating against current residents who refused to enter into binding arbitration agreements. Dist. Ct. Dkt. 25-2 at 2-3. And in the Leavitt Letter, HHS articulated its general support for pre-dispute arbitration agreements as "an excellent way for patients and providers to control costs, resolve disputes, and speed resolution of conflicts." Dist. Ct. Dkt. 24-25 at 691. The agency noted its opposition to legislation that would "deprive patients and providers of the opportunity to agree voluntarily to resolve their disputes through arbitration," *id.*, and suggested along similar lines as the Pelovitz Memo that existing regulations "provide[d] ample safeguards to ensure that nursing home residents are protected from harm," *id.* at 692.

To the extent the Revised Rule departs from these prior policies,[7] we find that CMS has provided a

[7] Although Northport argues that the Revised Rule departs from CMS's historical position on arbitration agreements by being *more* restrictive of the use of arbitration agreements, the

sufficiently reasonable explanation for doing so. When an agency reverses its prior policy, "it need not demonstrate . . . that the reasons for the new policy are *better* than the reasons for the old one." *Fox Television*, 556 U.S. at 515. "[I]t suffices that the new policy is permissible under the statute, that there are good reasons for it, and that the agency *believes* it to be better, which the conscious change of course adequately indicates." *Id.* At the outset, we note that the Revised Rule is generally in harmony with the Pelovitz Memo and the Leavitt Letter. Indeed, the rule appreciates the advantages of arbitration and expressly permits LTC facilities and their residents to enter into arbitration agreements transparently and voluntarily. *See* 84 Fed. Reg. at 34,722. But even if the Revised Rule changed direction slightly by deciding that existing federal and state regulations are insufficient to protect residents' quality of care vis-á-vis arbitration agreements, CMS has provided a rational justification for that change. As noted above, CMS relied on evidence suggesting that LTC facilities' use of arbitration agreements had a larger impact on residents' health and safety than had previously been realized. CMS noted comments "rais[ing] a number of concerns that convinced us that [existing federal and state] protections are limited and do not protect the unique needs of Medicare and Medicaid beneficiaries." *Id.* at 34,720 (noting that "state laws

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Revised Rule is in fact *less* restrictive than CMS's immediately preceding policy: the Original Rule's per se ban on pre-dispute, binding arbitration agreements. *See* 84 Fed. Reg. at 34,719, 34,722 (noting that the "overwhelming majority of commenters" opposed the Revised Rule because it "revers[ed] course" on the Original Rule).

differ . . . offer[ing] varying levels of protection" and that residents may not be financially capable of challenging unconscionable arbitration agreements in court, requiring CMS to step in to further safeguard residents). Relatedly, CMS determined that the five-year recordkeeping requirement was necessary to "evaluate quality of care complaints . . . and assess the overall impact of these agreements on the safety and quality of care provided in LTC facilities." *Id.* at 34,730.

Finally, Northport argues that the change of policy was arbitrary and capricious because it did not consider LTC facilities' "substantial reliance interests" on CMS's historical arbitration agreement policy. *See Fox Television*, 556 U.S. at 515 (noting that an agency may need to provide greater explanation "when its prior policy has engendered serious reliance interests that must be taken into account"). Specifically, it argues that LTC facilities have "built their economic and pricing models in reliance on the prior policy" and that the Revised Rule will require LTC facilities to henceforth allocate more money to cover their dispute resolution costs. To begin, we echo the district court's reasonable skepticism of Northport's claimed reliance interests. Under the Revised Rule, existing arbitration agreements will continue to be enforceable, and LTC facilities can still enter into arbitration agreements with their residents and obtain federal funding so long as they comport with the rule's requirements. Therefore, the availability of arbitration and any associated cost savings are largely unaffected by the Revised Rule, and LTC facilities can continue to rely on historical economic models. But even setting that aside, we find

that CMS reasonably explained the departure from CMS's prior policy in spite of those reliance interests. *See Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2126 (2016) (noting that an agency need only provide "a reasoned explanation . . . for disregarding facts and circumstances that underlay or were engendered by the prior policy" (quoting *Fox Television*, 556 U.S. at 515-16)). As noted above, the Revised Rule continues to recognize the advantage of permitting LTC facilities to rely on arbitration as a fast and economic means to resolve disputes with residents. *See* 84 Fed. Reg. at 34,722. But CMS also explained that the cost-efficiency and expediency of arbitration had to be counter-balanced by the need to protect residents by ensuring that they enter into arbitration agreements voluntarily and in a transparent way. *See id.*

We conclude that the Revised Rule reflects CMS's reasoned judgment in light of competing considerations, *see State Farm*, 463 U.S. at 43, and we affirm the district court's conclusion that the Revised Rule is not arbitrary or capricious.

D. *Compliance with the Regulatory Flexibility Act*

Finally, Northport argues that the promulgation of the Revised Rule violated the RFA. Enacted in 1980 as a "response to the complaints of small business about the burdens of federal regulation," *see* Paul R. Verkuil, *A Critical Guide to the Regulatory Flexibility Act*, 1982 Duke L.J. 213, 226 (1982), the RFA requires an agency undergoing informal rulemaking to prepare and publish a regulatory flexibility analysis that details, among other things, the rule's "significant

economic impact on small entities" and the steps the agency has taken to minimize that impact. *See* 5 U.S.C. § 604; *see also id.* § 601(6) (defining "small entities" to include small businesses, certain non-profit organizations, and small governmental jurisdictions). However, an agency may forego the regulatory flexibility analysis "if the head of the agency certifies that the rule will not, if promulgated, have a significant impact on a substantial number of small entities." *Id.* § 605(b). And central to this appeal, the certification must be published in the Federal Register "along with a statement providing the factual basis for such certification." *Id.* In reviewing a party's claim that an agency violated the "[p]urely procedural" requirements of the RFA, *Nat'l Tel. Coop. Ass'n v. F.C.C.*, 563 F.3d 536, 540 (D.C. Cir. 2009), we consider whether the agency made a "reasonable, good-faith effort to carry out the RFA's mandate." *Zero Zone, Inc. v. U.S. Dep't of Energy*, 832 F.3d 654, 683 (7th Cir. 2016) (cleaned up) (quoting *U.S. Cellular Corp. v. F.C.C.*, 254 F.3d 78, 88 (D.C. Cir. 2001)); *see Alenco Commcn's, Inc. v. F.C.C.*, 201 F.3d 608, 625 (5th Cir. 2000)); *Associated Fisheries of Maine, Inc. v. Daley*, 127 F.3d 104, 114 (1st Cir. 1997); *see also* 5 U.S.C. § 611(a)(1) (permitting judicial review of a claim that an agency failed to comply with the requirements of, among other provisions of the RFA, 5 U.S.C. § 605(b)).

The parties agree that the Secretary of HHS certified that the Revised Rule would not have a significant economic impact on a substantial number of small entities. *See* 84 Fed. Reg. at 34,734. But Northport argues that CMS failed to provide the requisite factual basis for that certification. At first

blush, it appears that Northport is correct; CMS seemingly did not provide any evidence or reasoning to support the certification, let alone make a "reasonable, good-faith effort" to do so. In publishing the final Revised Rule, CMS provided the following, cursory explanation of its decision to certify:

> 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 government jurisdictions. Most hospitals and most other providers and suppliers [subject to the Revised Rule] 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. . . . 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.

Id. Considered alone, this paragraph falls short of other certifications that have passed muster. *See, e.g.*, *Carpenter, Chartered v. Sec'y of Veterans Affs.*, 343 F.3d 1347, 1356-57 (Fed. Cir. 2003) (upholding § 605(b) certification that clarified that the rule would not affect small businesses because it "would affect only the processing of claims by VA" (cleaned up)); *Sw. Penn. Growth All. v. Browner*, 121 F.3d 106, 123 (3d Cir. 1997) (upholding § 605(b) certification that explained that the rule "d[id] not affect any existing requirements applicable to small entities nor d[id] it impose new requirements").

In response, CMS argues that the required factual basis was provided in the prefatory statement to the agency's RFA certification. *See* 84 Fed. Reg. at 34,733-34. There, the agency noted that the Revised Rule "will increase transparency in LTC facilities that cho[o]se to use arbitration while, at the same time, allowing facilities to use arbitral forums as a means of resolving disputes." *Id.* at 34,734. It also explained the Revised Rule's "Overall Impact," noting that it will "ensure[] 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." *Id.* We struggle to see how these statements provide a factual basis for certifying that the rule will not have a significant economic impact on a substantial number of small entities. Although they might describe the Revised Rule's intended effects, these statements do not even purport to consider which entities the rule will affect or to what degree.

CMS also argues that the required factual basis for the RFA certification was provided earlier in the rulemaking process. In the Original Rule, which covered significantly more than LTC facilities' use of arbitration agreements, CMS estimated that the rule in its entirety would impact less than one percent of LTC facilities' annual revenues, an insignificant economic impact. *See* 81 Fed. Reg. at 68,846. Similarly, in the notice of proposed rulemaking of the Revised Rule, CMS noted that one of its proposals (ultimately amended for the final rule) would not impose significant costs or burdens on LTC facilities because it required what was already a standard business practice. *See* 82 Fed. Reg. at 26,652 ("We are proposing that LTC facilities post a notice regarding

the use of arbitration agreements in an area that is visible to residents and visitors. . . . We believe that notices concerning facility practices are periodically developed, reviewed, and updated as a standard business practice. We also believe that facilities that are already using arbitration agreements post some type of notice. Thus, there is no burden associated with the posting of this notice.").

Yet CMS has not provided any convincing authority to suggest that an agency may satisfy its requirements under § 605(b) by relying on factual bases sprinkled throughout the Federal Register. Indeed, the plain language of the statute suggests that the certification and corresponding factual basis should be supplied by the agency in tandem. *See* 5 U.S.C. § 605(b) ("If the head of the agency makes a certification . . . , the agency shall publish such certification in the Federal Register. . . *along with* a statement providing the factual basis for such certification." (emphasis added)). And the cases cited by CMS do not establish that we may consider the "entire administrative record," expansively defined to include the record of a precedent rule, to determine that CMS satisfied its procedural obligations under the RFA.

For example, CMS relies upon *Michigan v. Thomas* to argue that we must analyze Northport's RFA claim in "the context of [CMS's] overall rulemaking analysis." 805 F.2d 176, 188 (6th Cir. 1986). But in *Thomas*, the Environmental Protection Agency (EPA) expressly cited in its challenged rule a previous notice that categorically certified that rules of that type (i.e., approvals of State Implementation

Plans) would not affect small entities because they stood only to approve state regulations already in place. *Id.* at 187-88; *see also Council for Urological Interests v. Burwell*, 790 F.3d 212, 227 (D.C. Cir. 2015) (upholding certification as sufficient where HHS expressly incorporated the rule's preamble into its RFA analysis). Similarly, CMS relies upon *Carpenter, Chartered v. Secretary of Veterans Affairs* to argue we must assess compliance with the RFA "in view of the record as a whole," including the administrative record of the Original Rule. 343 F.3d at 1357. But there, the Federal Circuit found that the Department of Veterans Affairs (DVA) satisfied § 605(b) because it expressly noted, when certifying that a regulatory flexibility analysis was unwarranted, that the rule would "affect only the processing of claims." *See id.* at 1356 (quoting 67 Fed. Reg. at 36,104). Moreover, the court looked to the record as a whole *not* to find whether the DVA provided a factual basis at all but rather to assess whether the DVA's certification was reasonable in light of the factual basis it provided. *See id.* at 1357. *California Farm Bureau Federation v. U.S. E.P.A.* is similarly not on point. 72 F. App'x 540 (9th Cir. 2003). There, although the court mentioned in passing that the EPA's certification "was supported by [the] EPA's earlier impact analysis," it more importantly noted that the EPA provided a factual basis along with its certification that the rule would not have a significant economic impact on a substantial number of small entities. *Id.* at 541 (noting that the "EPA reasoned that few agricultural operations that qualify as a small business for purposes of the Act will also qualify as a major source of pollution," the subject of the challenged regulation).

Thus, looking to the Revised Rule and the certification provided therein, we conclude that CMS failed to comply with the procedural requirements of the RFA. However, we conclude that such an error is harmless. *See Env't Def. Ctr. v. U.S. E.P.A.*, 344 F.3d 832, 879 (9th Cir. 2003); *cf. Nat'l Mining Ass'n v. Mine Safety & Health Admin.*, 512 F.3d 696, 701 (D.C. Cir. 2008) (finding that the agency did not need to certify under § 605(b) that an alternative method of compliance did not create a significant economic burden on small businesses because the agency had already determined that the *primary* method of compliance did not). "Failure to comply with the RFA may be, but does not have to be, grounds for overturning a rule." *Cement Kiln Recycling Coalition v. E.P.A.*, 255 F.3d 855, 868 (D.C. Cir. 2001) (cleaned up). In granting relief for a violation of the RFA, we may take corrective actions, including "remanding the rule to the agency" to conduct a regulatory flexibility analysis under § 604(a) or to properly certify that such an analysis is unwarranted under § 605(b). 5 U.S.C. § 611(a)(4)(A). But such a remedy is unnecessary because, as a factual matter, the Revised Rule unquestionably has less of an economic impact than the Original Rule had.

Recall that the Original Rule entirely prohibited LTC facilities from entering into pre-dispute, binding arbitration agreements with residents. *See* 81 Fed. Reg. at 68,690. In promulgating the Original Rule and pursuant to the RFA, CMS certified that the entire rule—encompassing not only the arbitration prohibition but also regulations impacting, among other things, resident rights, nursing services, food and nutrition services, and infection control—would

not result in a significant economic impact to LTC facilities, costing them less than one percent of their annual revenue. *See* 81 Fed. Reg. at 68,846; *see also id.* at 68,844 tbl.5 (breaking out by category the estimated costs to LTC facilities attributable to the Original Rule's regulations). In contrast, the Revised Rule *permits* LTC facilities to enter into arbitration agreements with residents so long as they meet the rule's other requirements, allowing facilities to reduce their overall costs by using arbitration as a means of dispute resolution. *See* 84 Fed. Reg. at 34,733-34. Accordingly, the Revised Rule *lessens* whatever financial burden was placed on LTC facilities by the Original Rule, an obvious factual basis for CMS's certification that the rule will not have a significant economic impact on a substantial number of small entities. *See* 5 U.S.C. § 605(b).

Therefore, although CMS failed to provide a factual basis in support of its § 605(b) certification in the Revised Rule, we conclude that failing to do so was harmless error.

III. Conclusion

For the foregoing reasons, we affirm the district court's grant of summary judgment in favor of HHS and CMS.

Appendix B

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 20-1799

NORTHPORT HEALTH SERVICES OF ARKANSAS, LLC, doing business as Springdale Health and Rehabilitation Center, et al.,

Plaintiffs-Appellants,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants-Appellees.

Filed: Dec. 14, 2021

ORDER

The petition for rehearing en banc is denied. The petition for rehearing by the panel is also denied.

December 14, 2021

Order Entered at the Direction of the Court:

Clerk, U.S. Court of Appeals, Eighth Circuit.

/s/ Michael E. Gans

Appendix C

UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF ARKANSAS

No. 5:19-cv-5168

NORTHPORT HEALTH SERVICES OF ARKANSAS, LLC, doing business as Springdale Health and Rehabilitation Center, et al.,

Plaintiffs,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

Filed: Apr. 7, 2020

MEMORANDUM OPINION AND ORDER

Before the Court are the Plaintiffs' Motion for Summary Judgment (Doc. 26) and Memorandum Brief in Support (Doc. 27) and Defendants' Cross-Motion for Summary Judgment and Response to Plaintiffs' Motion (Doc. 28) and a Memorandum Brief in Support (Doc. 29). Plaintiffs filed a Reply to Defendants' Cross-Motion and Response (Doc. 36), and Defendants filed a Reply brief (Doc. 42), so the matter has now been

fully briefed and is ripe for decision.[1] For the reasons given below, the Plaintiffs' Motion for Summary Judgment (Doc. 26) is **DENIED** and the Defendants' Cross-Motion for Summary Judgment (Doc. 28) is **GRANTED**.

I. BACKGROUND

The federal government subsidizes medical care for eligible individuals, including the elderly, people with disabilities, and families with limited income. These subsidies are distributed through two programs: the federal Medicare program and Medicaid, which is a federal-state partnership. The Secretary of Health and Human Services ("Secretary") administers both programs through the Centers for Medicare & Medicaid Services ("CMS"), an agency within the Department of Health and Human Services ("HHS"). Medicare and Medicaid were created as amendments to the Social Security Act, and the governing statutes for each program are found at 42 U.S.C. § 1395 *et seq.*, and 42 U.S.C. § 1396 *et seq.*, respectively. Medical providers may request to enter into a provider agreement with CMS, in the case of Medicare, and with the state administrator for Medicaid. The provider agreements place myriad requirements on participating providers, including,

[1] Defendants also filed the administrative record associated with the rulemaking at issue here. (Doc. 24). Additionally, the Court received an Amicus Brief in Opposition to Plaintiffs' Motion for Summary Judgment and In Support of the Government's Motion (Doc. 39) filed on behalf of National Consumer Voice for Quality Long-term Care, American Association for Justice, Arkansas Trial Lawyers Association, and Justice in Aging.

but not limited to, establishing standards for treatment and setting reimbursement rates for services provided to eligible participants. *See* 42 U.S.C. §§ 1395cc & 1396a. *See also* 42 C.F.R. § 489. Funds are disbursed by CMS or the administering state agency directly to the facility providing care. If a participating provider violates the terms of the provider agreement, the provider can be denied reimbursement, subject to civil penalties, or even excluded from further participation in the Medicare and Medicaid programs. *See* 42 C.F.R. § 488.406.

The Medicare and Medicaid programs both provide coverage for care in long-term care, or "LTC," facilities. Participating LTC facilities must meet the program requirements laid out at 42 U.S.C. § 1395i-3 (Medicare) and 42 U.S.C. § 1396r (Medicaid).[2] The Plaintiffs in this case are "dually certified" facilities, providing long-term care under both the Medicare and Medicaid programs. In 2015, the federal government spent almost 30 billion dollars on payments to skilled nursing facilities, and payments to nursing facilities under Medicaid topped $50 billion. Reform of Requirements for Long-Term Care Facilities, 81 Fed. Reg. 68688, 68690 (Oct. 4, 2016).

In July 2015, CMS solicited public comments on a comprehensive evaluation and restructuring of the

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[2] The Medicare statute refers to "skilled nursing facilities," and the Medicaid statute refers to "nursing facilities." Despite this difference in terminology, the requirements placed on these facilities by each statute are materially identical, and the Court will use the term "facility," "LTC facility," or "nursing home" to refer to both skilled nursing facilities under the Medicare statute and nursing facilities under the Medicaid statute.

consolidated Medicare and Medicaid requirements for LTC facilities to ensure that the requirements reflect enhanced "knowledge about resident safety, health outcomes, individual choice, and quality assurance and performance improvement." Reform of Requirements for Long-Term Care Facilities, 80 Fed. Reg. 42168, 42169 (proposed July 16, 2015). Among the changes on which CMS sought comment were new restrictions on the use of pre-dispute binding arbitration agreements between facilities and their patients. CMS indicated its concern that "the increasing prevalence of these agreements could be detrimental to residents' health and safety and may create barriers for surveyors and other responsible parties to obtain information related to serious quality of care issues." *Id.* at 42211. Therefore, CMS suggested placing several conditions and requirements on a facility's use of pre-dispute binding arbitration agreements. For example, CMS proposed requiring the facility to "explain the agreement to the resident in a form, manner and language that he or she understands and have the resident acknowledge that he or she understands the agreement." *Id.* CMS also proposed stipulating that an agreement to arbitrate "will not be considered to have been entered into voluntarily by the resident if the facility makes it a condition of admission, readmission, or the continuation of his or her residence at the facility," and that it therefore "should be a separate agreement" and "should not be contained within any other agreement or paperwork addressing any other issues." *Id.* In addition to proposing these and other conditions, CMS noted that it was "also aware that there are concerns that these agreements should be

prohibited in the case of nursing home residents. Therefore, we are also soliciting comments on whether binding arbitration agreements should be prohibited." *Id.*

As the 60-day comment period drew to a close, CMS agreed to extend the comment period by another thirty days in response to requests for more time to respond and in recognition of the "scope and complexity" of the proposals on which the agency had sought comment. Reform of Requirements for Long-Term Care Facilities, 80 Fed. Reg. 55284, 55284-85 (Sept. 15, 2015). The extended comment period closed on October 14, 2015. On October 4, 2016, CMS published notice of the final rule in the Federal Register. The final rule prohibited the use of pre-dispute arbitration agreements by LTC facilities receiving Medicare and Medicaid funding. Residents and facilities could still agree to arbitrate once a dispute arose, but the facility could not enter into a general agreement to arbitrate any dispute with a resident or resident's family before the dispute arose. Reform of Requirements, 81 Fed. Reg. at 68690.

A few weeks later, the American Health Care Association and a number of nursing homes sought a preliminary injunction against the rule in the United States District Court for the Northern District of Mississippi. On November 7, 2016, the court granted a nationwide preliminary injunction, stopping the rule from going into effect. *See Am. Health Care Ass'n v. Burwell*, 217 F. Supp. 3d 921 (N.D. Miss. 2016).

Rather than appealing the preliminary injunction or pursuing the litigation in the district court, CMS went back to the drawing board. Inviting comments on

a revision of the 2016 final rule in June 2017, CMS indicated that "further analysis is warranted before any rule takes effect." Revision of Requirements for Long-Term Care Facilities: Arbitration Agreements, 82 Fed. Reg. 26649, 26650 (proposed June 8, 2017). CMS proposed to withdraw its ban on pre-dispute arbitration agreements and instead place various conditions on their use, similar to the conditions CMS had first proposed in 2015. For example, the agency proposed requiring that any agreement be explained to the resident in language he or she understands and that the resident acknowledge such understanding; that residents not be prohibited or discouraged from communicating with any federal, state, or local official; and that the facility save a copy of the agreement and arbitrator's final decision for five years, subject to inspection by CMS. *Id.* at 26653. CMS suggested that the new proposal "will achieve a better balance between the advantages and disadvantages of pre-dispute arbitration for residents and their providers." *Id.* at 26650.

After another comment period, on July 18, 2019, CMS promulgated the Final Rule that the Plaintiffs challenge here, which went into effect on September 16, 2019. In its final form, the Rule adds the following language regarding binding arbitration agreements to the regulations governing the administration of LTC facilities:

> (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.

Revision of Requirements for Long-Term Care Facilities: Arbitration Agreements, 84 Fed. Reg. 34718, 34735-36 (July 18, 2019) (codified at 42 C.F.R. § 483.70(n)).

On September 4, 2019, Plaintiffs filed a Complaint and Motion for Preliminary Injunction in this Court. (Docs. 2 & 4). Subsequently, the parties

filed a Joint Motion for Scheduling Order in which the Government agreed that it would stay enforcement of the Rule as to Plaintiffs and associated entities to allow the Court to rule on cross-motions for summary judgment the parties would file. (Doc. 16). That motion was granted by the Court. (Doc. 23). Ultimately, the Government agreed to extend the stay of enforcement as to Plaintiffs until April 17, 2020.[3] (Doc. 43).

Plaintiffs claim to be harmed by four elements of the Final Rule in particular: (1) the requirement that an agreement to arbitrate not be made a condition for admission to the facility (42 C.F.R. § 483.70(n)(1)); (2) the requirement that the agreement be explained in language the resident or her representative understands (§ 483.70(n)(2)(i)); (3) the 30-day right of rescission for residents who sign pre-dispute arbitration agreements (§ 483.70(n)(3)); and (4) the 5-year retention requirement (§ 483.70(n)(6)). Plaintiffs challenge these elements of the Final Rule under the Administrative Procedures Act ("APA"), which allows a party harmed by an agency action to seek judicial review of that action. 5 U.S.C. § 702. Upon review, the court must set aside agency action that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law; . . . in excess of statutory jurisdiction, authority, or limitations; [or] without observance of procedure required by law." 5 U.S.C. § 706(2)(A), (C) & (D). The First Amended Complaint raises five claims under the APA. (Doc. 25). First, Plaintiffs assert that the Final Rule is "not in

[3] While the Government agreed to extend the stay, it did not concede that the public interest or any other factor favored delaying the implementation of the Final Rule.

accordance with law" because it violates the Federal Arbitration Act ("FAA"). In Claims Two and Three, Plaintiffs argue that the Rule violates the APA because it exceeds CMS's authority under the Medicare and Medicaid statutes. Claim Four asserts that the Rule is arbitrary and capricious because there is a lack of empirical evidence to support the position taken by the agency and it is an unreasoned departure from CMS's past positions on the issue of binding arbitration. Finally, Plaintiffs assert that CMS has also violated the Regulatory Flexibility Act ("RFA") by failing to acknowledge and analyze fully the economic impact of the Final Rule. Plaintiffs therefore ask the Court to strike down the Rule.

For its part, the Government asserts that the Final Rule is not in conflict with the FAA or that if it is, CMS nevertheless has the authority to promulgate the Rule as a condition on the receipt of federal funding. The Government further argues that the Rule is within the scope of its authority and is adequately supported by the record. Finally, the Government asserts that it complied with the requirements of the RFA. Therefore, the Government asks the Court to uphold CMS's rulemaking on all grounds.

II. DISCUSSION

A. The Rule Does Not Violate the Federal Arbitration Act

Plaintiffs' first argument is that the Rule violates the FAA and therefore must be set aside under the APA as "not in accordance with law." 5 U.S.C. § 706(2)(A). The FAA provides, in relevant part, that "[a] written provision . . . to settle by arbitration a

controversy thereafter arising out of such contract or transaction . . . shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract." 9 U.S.C. § 2. Plaintiffs argue that because the Rule imposes special requirements on the formation of enforceable arbitration agreements that do not apply to any other kind of contract, it violates the FAA, which requires the equal treatment of arbitration agreements and any other contract.

The Government also moves for summary judgment on this point, arguing that the Final Rule does not violate the FAA. The Government attempts to distinguish between "legal rules," which are "wielded to preclude or invalidate an agreement to arbitrate," and "procedural rules" that "form no legal barrier to the creation or enforcement of arbitration contracts." (Doc. 29, p. 24). The Government argues that the FAA "has no bearing" on the Final Rule at issue here because the Rule does not prevent nursing homes from forming binding arbitration agreements or undermine the enforceability of any arbitration agreement that is already in place. (Doc. 29, p. 15). Requirements about what a nursing home "must and must not do when attempting to persuade patients to arbitrate," the Government argues, are "no legal impediment to enforcement of any arbitration agreement residents and nursing homes ultimately sign." *Id.*

In its Reply brief, the Government is even more explicit: While "violating the Rule can carry consequences for a nursing home's ability to participate in Medicare and Medicaid, a nursing home

can still enforce any agreement it enters into in violation of the procedures that the Rule sets out." (Doc. 42, p. 10). Rather, "any violation of the Rule is an issue between the nursing home and CMS, which conditions its payments to the nursing home on that home following applicable guidelines." *Id.* at 11. In other words, a participating nursing home may choose to enter into a pre-dispute binding arbitration agreement without complying with the procedural requirements laid out in the Final Rule, and if a resident were to sue the nursing home, the facility could seek to compel arbitration pursuant to the agreement and expect a court to enforce the agreement. At the same time, however, the nursing home would be exposing itself to the possibility of corrective action by CMS for a violation of the facility's participation agreement. But, as the Government points out, a nursing home "could rationally choose to accept a fine as the price for negotiating an agreement the way it wants." *Id.*

CMS also made this argument regarding the Final Rule's validity in the administrative record. In proposing and finalizing the Rule, CMS asserted that the Rule "does not purport to regulate the enforceability of any arbitration agreement, and does not pose any conflict with the language of the FAA." Revision of Requirements, 82 Fed. Reg. at 26651. *See also* Revision of Requirements, 84 Fed. Reg. at 34718. In discussing the conditions on the use of pre-dispute arbitration agreements the agency proposed back in 2015, which are substantially similar to those in the Final Rule challenged here, the agency stated that the "regulations are not meant to limit or provide standards for courts to use in determining if an

arbitration agreement should be enforced in, for example, a motion to compel arbitration." Reform of Requirements, 81 Fed. Reg. at 68799.

The Court recognizes that, generally, the distinction that the Government tries to draw between "legal" rules that declare arbitration agreements invalid and "procedural" rules, which simply place requirements on the formation of such agreements, could not save the Final Rule from conflict with the FAA. The cases on which the Plaintiffs rely, particularly *Doctor's Associates, Inc. v. Casarotto*, 517 U.S. 681 (1996), and *Kindred Nursing Centers Limited Partnership v. Clark*, 137 S. Ct. 1421 (2017), make clear that "[a] rule selectively finding arbitration contracts invalid because improperly formed fares no better under the Act than a rule selectively refusing to enforce those agreements once properly made." *Kindred Nursing*, 137 S. Ct. at 1428.

In *Casarotto*, for example, the Supreme Court considered the following Montana state law: "Notice that a contract is subject to arbitration . . . shall be typed in underlined capital letters on the first page of the contract; and unless such notice is displayed thereon, the contract may not be subject to arbitration." 517 U.S. at 684. The Montana Supreme Court upheld the state law, holding that the first-page requirement was a procedural issue that "did not undermine the goals and policies of the FAA, for the notice requirement did not preclude arbitration agreements altogether; it simply prescribed 'that before arbitration agreements are enforceable, they be entered knowingly.'" *Id.* at 685 (quoting the state supreme court decision, *Casarotto v. Lombardi*, 886

P.2d 931, 939 (Mont. 1994)). The Supreme Court reversed. It held that the FAA preempted the state notice requirement because, in enforcing the procedural rule, a court "would not enforce the arbitration clause in the contract between [the parties]; instead Montana's first-page notice requirement would invalidate the clause." *Id.* at 688.

Similarly, in *Kindred Nursing*, the plaintiffs argued that there is a "distinction between contract formation and contract enforcement," and the Kentucky Supreme Court's "clear-statement rule," requiring that a power-of-attorney expressly include the power to waive the right to a jury trial, should be upheld because it dealt only with formation. 137 S. Ct. at 1428. The Supreme Court rejected this argument, however, holding, as quoted above, that "[a] rule selectively finding arbitration contracts invalid because improperly formed fares no better under the Act than a rule selectively refusing to enforce those agreements once properly made." *Id.*

Thus, if the failure to comply with the procedural requirements in the Final Rule were a basis for holding an agreement to arbitrate invalid and unenforceable, the Rule would indeed conflict with the FAA. Here, in contrast, the Final Rule places requirements on the use of arbitration agreements that do not undermine the validity or enforceability of the agreement when it comes before a court. Instead, the Rule only establishes conditions of the facility's receipt of federal subsidies. Imagine, for example, that a nursing home participating in the Medicare and Medicaid programs had a resident sign an agreement to arbitrate without having "explained [it] in a form

and manner that he or she understands" and without having received the resident's "acknowledge[ment] that he or she understands that agreement," in violation of 42 C.F.R. §§ 483.70(n)(2)(i) & (ii). If the nursing home subsequently sought to enforce the agreement in court, the nursing home's violation of the Final Rule would *not* prevent enforcement. Since failure to comply with the Rule's requirements does not prevent the enforcement of arbitration agreements between an LTC facility and a resident, the Court finds no conflict with the FAA.

A district court in the District of Columbia recently reached a similar conclusion in *California Association of Private Postsecondary Schools v. Devos*, 2020 WL 516455 (D.D.C. Jan. 31, 2020) [hereinafter *CAPPS*]. There, the plaintiffs challenged a final rule promulgated by the Department of Education ("DOE") requiring that schools whose students receive funding from the Federal Direct Loan program "not enter into a predispute agreement to arbitrate a borrower defense claim, or rely in any way on a predispute arbitration agreement with respect to any aspect of a borrower defense claim." *Id.* at *5 (quoting 34 C.F.R. § 685.300(f)(1)(i)). In determining that the rule did not conflict with the FAA, the court noted that "[i]nstitutions of higher education remain free to seek and to invoke predispute . . . arbitration agreements, and, when confronted with any such agreement that is otherwise enforceable, courts must—and will—enforce the agreement." *Id.* at *8. DOE's rule, the court noted, "does not provide a basis for a student to resist a motion to compel arbitration" nor "to stay a judicial proceeding pending arbitration." *Id.* The court concluded that since "the regulations do not purport to

invalidate or to render unenforceable any arbitration agreement," the plaintiff's argument invoking *Kindred Nursing* was unpersuasive. *Id.* "[T]o the extent CAPPS suggests that *Kindred Nursing* holds—or even implies—that agencies may not dissuade program participants from entering into arbitration agreements that relate to the federal programs they administer, that contention bears no relation to what the Supreme Court considered or held." *Id.* at *9.

B. The Rule is a Valid Condition on Federal Funds

Plaintiffs argue that the mere fact of *disfavoring* arbitration by placing additional requirements on the formation of arbitration agreements that do not apply to other contracts is a violation of the FAA. Pursuant to the Court's ruling in *Epic Systems Corp. v. Lewis*, 138 S. Ct. 1612 (2018), Plaintiffs argue HHS cannot be permitted to promulgate the Final Rule without explicit authorization from Congress, which it lacks.

The Government argues that even if there is a conflict between the FAA and the Final Rule, CMS has the authority to promulgate this regulation as a condition on the receipt of federal funds. The Rule should be upheld because it "imposes conditions only on entities that choose to accept federal funds—not on a universe of unwilling private parties." (Doc. 29, p. 28). In Reply, Plaintiffs argue that this is a false choice—without Medicare and Medicaid dollars, Plaintiffs and other nursing homes like them would go out of business because LTC facilities "typically serve a patient base that is predominantly part of these federal programs." (Doc. 36, p. 17). For example, Plaintiffs attach affidavits from administrators of two

Plaintiff LTC facilities attesting that Medicare and Medicaid funding pay for more than 70 percent of the residents at each facility. *See* Docs. 25-3 & 25-4 at ¶ 3. The "choice" between complying with the Final Rule or withdrawing from Medicare and Medicaid, Plaintiffs argue, therefore exceeds the federal government's authority and constitutes impermissible "'economic dragooning' that leaves participants in a federal program with 'no real option but to acquiesce' to the government's demands." (Doc. 36, p. 17 (quoting *NFIB v. Sebelius*, 567 U.S. 519, 582 (2012))).

1. *Epic Systems Is Inapposite in the Context of Federal Spending Power*

First, the Court finds that the facts of this case, which restrict only those parties who voluntarily choose to avail themselves of federal funding through the Medicaid and Medicare programs, are not governed by *Epic Systems*, and CMS did not need explicit authorization from Congress to implement the Final Rule. In *Epic Systems*, the Supreme Court considered an interpretation of the National Labor Relations Act ("NLRA") by the agency charged with administering the NLRA, the National Labor Relations Board ("NLRB") that would have rendered invalid and unenforceable a particular class of arbitration agreements. The Supreme Court held that the NLRB did not have the authority to interpret the NLRA "in a way that limits the work of [the FAA]. And on no account might we agree that Congress implicitly delegated to an agency authority to address the meaning of a second statute it does not administer." 138 S. Ct. at 1629. An agency may not "seek to diminish the second statute's scope in favor of a more

expansive interpretation of its own," *id.*, without Congress having made its intent to empower the agency in this way "clear and manifest." *Id.* at 1624.

Here, in contrast, the Final Rule does not purport to bar the use of arbitration agreements in the heath care industry generally but only to place conditions on the use of such agreements by voluntary participants in a federally funded program. CMS expressly disavows any intent to limit the enforceability of any arbitration agreement. *See, e.g.*, Revision of Requirements, 82 Fed. Reg. at 26651; Revision of Requirements, 84 Fed. Reg. at 34718. The Secretary's exercise of his statutory responsibility does not "limit the work" of the statutory language of the FAA. The FAA allows private parties to agree to arbitrate disputes that might arise between them in the future and to have those agreements enforced according to their terms, on equal footing with any other contract. But there is nothing in the text of the FAA that limits an agency's prerogative to place conditions on the receipt of federal funding in order to achieve the goals of the federal program, nor have the parties cited the Court to any precedent so holding. The Court declines to expand *Epic Systems* in this way.

The court in *CAPPS* reached a similar conclusion. The plaintiffs asserted that "*Epic Systems* stands for the proposition that 'federal Departments and agencies . . . may not, in the absence of explicit congressional authorization, invalidate or otherwise discriminate against arbitration agreements.'" 2020 WL 516455, at *9 (quoting Plaintiff's Motion for Summary Judgment at 16 (No. 17-cv-999), ECF No. 83-1). The court did not disagree with this summary of

the holding but pointed out that the plaintiff could identify "no support for its further contention that federal agencies lack authority to disfavor arbitration agreements in any respect. *Epic Systems* certainly does not support that sweeping proposition." 2020 WL 516455, at *9. Thus, the Court concludes that *Epic Systems* is inapposite and neither finds, nor is directed to, authority indicating that an agency must have explicit authorization from Congress to regulate the use of binding pre-dispute arbitration agreements by voluntary participants in a federal program it administers.

2. *The Final Rule Does Not Disfavor Arbitration and is Related to the Purposes of Medicare and Medicaid*

The federal government has broad authority to place conditions on the use of funds it distributes, even broader than its authority to impose direct restrictions, so long as those conditions are related to the goals of the program. *See, e.g.*, *South Dakota v. Dole*, 483 U.S. 203 (1987) ("[C]onditions on federal grants might be illegitimate if they are unrelated to the federal interest in particular national projects or programs." (internal quotation marks omitted)); *Van Wyhe v. Reisch*, 581 F.3d 639, 650 (8th Cir. 2009) ("[C]onditions on federal funds must be related to the federal interest in particular national projects or programs . . . ."). The Supreme Court has often repeated its conclusion that the FAA is "a congressional declaration of a liberal federal policy favoring arbitration agreements," *Moses H. Cone Mem'l Hosp. v. Mercury Constr. Corp.*, 460 U.S. 1, 24 (1983), but the Court has also made clear that the

government's refusal to provide funds for a particular activity, even one involving the exercise of a fundamental right, cannot be considered to infringe, interfere with, or penalize that right. *See Rust v. Sullivan*, 500 U.S. 173, 193 (1991). ("'[A] legislature's decision not to subsidize the exercise of a fundamental right does not infringe the right.' . . . 'A refusal to fund protected activity, without more, cannot be equated with the imposition of a 'penalty' on that activity.'") (quoting *Regan v. Taxation With Representation of Wash.*, 461 U.S. 540, 549 (1983) and *Harris v. McRae*, 448 U.S. 297, 317 n.19 (1980)). Thus, though the FAA protects an individual's right to have an arbitration agreement enforced on the same terms as any other contract, the government does not infringe upon that right or "disfavor" arbitration when it limits the use of such agreements to pursue the policy goals of a federally funded program. As the court concluded in *CAPPS*:

> There is, in short, a vast difference between an agency's use of its regulatory authority to impose stricter regulatory requirements on parties that opt to use arbitration in transactions *not* involving public funds and an agency requiring participants in a federal program to eschew predispute arbitration clauses in transactions involving the disbursement . . . of billions of dollars of taxpayer funds as a precondition to participation in that federal program.

CAPPS, 2020 WL 516455, at *12 (emphasis added).

The Court finds that the conditions in the Rule are reasonably related to the federal interest in the

Medicare and Medicaid programs. The federal government expends tens of billions of dollars annually to subsidize healthcare for eligible participants in order to ensure their access to healthcare services. *See* Reform of Requirements, 81 Fed. Reg. at 68690. CMS describes its substantial interest in the contractual relationship between the LTC facility and the resident as follows:

> Unlike traditional arms-length commercial contracts that are, for the most part, business arrangements between two private individuals, the Medicare and Medicaid programs have a significant interest in both the services being delivered as well as the well-being of the beneficiary. In many cases, Medicare and Medicaid are the sole payors for the services. That's why, for example, Congress has required that the Secretary create a wide assortment of rules and regulations relating to quality of care and the delivery of services in the LTC context.

Reform of Requirements, 81 Fed. Reg. at 68796.[4] The administrative record provides sufficient support for

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[4] Similar logic was central to the court's reasoning in upholding the regulation prohibiting reliance on pre-dispute arbitration agreements in *CAPPS*, observing that the DOE "is not acting as a disinterested regulator but as the administrator of a multi-billion-dollar program and as a participant in the transaction between the student borrowers and the schools they attend." 2020 WL 516455, at *10. The Court recognizes that, unlike the DOE in *CAPPS*, CMS does not necessarily face increased financial liability from the unrestricted use of arbitration agreements. But an LTC facility is able to contract with the resident because CMS has approved the facility's participation as

the relationship between the Final Rule and the provision of federally funded care in LTC facilities. The conditions on the use of pre-dispute arbitration agreements were put in place to "ensure that residents will not be forced to sign arbitration agreements to receive the care they need" and that a resident "is not placed in the position of deciding between signing an arbitration agreement or . . . not receiving the care at the facility that he or she needs." Revision of Requirements, 84 Fed. Reg, at 34724. The Final Rule was designed to accomplish the goal of "protecting resident's rights in matters concerning the arbitration process" by decoupling the process of seeking care in a facility that can meet the resident's medical needs from the agreement to arbitrate. *Id.* at 34725. CMS has observed that "many residents or their families usually do not have many LTC facilities to choose from" and determined that "no one should have to choose between receiving care and signing an arbitration agreement." *Id.* at 34728. The dispute requirements in 42 C.F.R. § 483.70(n)(1)-(3) ensure that a pre-dispute agreement to arbitrate is not a barrier for a resident to access care. The provisions allow prospective residents "to choose a LTC facility based upon what is best for the resident's health and safety" without having to forgo access to a judicial forum in exchange. *Id.* at 34735.

Similarly, the requirement that the facility retain copies of agreements and decisions by arbitrators where disputes were subject to arbitration helps hold

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a provider and will pay for the care provided to the resident. CMS therefore has an interest in ensuring the LTC facility does not leverage the resident's need for care to deprive her of other rights.

facilities accountable for the quality of care they provide. *Id.* at 34726. CMS determined 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." *Id.* at 34728. The regulations are reasonably related to achieving these goals, and CMS has the authority to impose them.

3. *The Final Rule Does Not Constitute Economic Dragooning*

The Court is not persuaded by Plaintiffs' attempt to invoke *NFIB v. Sebelius* to invalidate the Final Rule as a condition of federal funding. In *NFIB*, the Supreme Court struck down as overly coercive a section of the Affordable Care Act intended to incentivize each state to expand its Medicaid program by withdrawing all of its federal Medicaid funding if the state did not comply. The plurality's holding regarding the impermissible coerciveness of the condition, however, was based on the constitutional balance of power between the state and federal governments. A state's acquiescence to the federal government's conditions must be *voluntary* to ensure that "Spending Clause legislation does not undermine the status of the States as independent sovereigns in our federal system." 567 U.S. at 577. Where a state's decision not to comply with conditions placed on federal funding is so significant that it constitutes "economic dragooning that leaves the States with no real option but to acquiesce," *id.* at 582, the conditions must be struck down because the state's participation is no longer voluntary.

No part of the Court's decision in *NFIB* touched on the government's power to place conditions on private entities. In fact, Courts of Appeals have held time and time again that the participation of private entities in Medicare and Medicaid is always voluntary, and providers can avoid regulations to which they object by choosing not to participate in Medicare or Medicaid. "Nursing homes, unlike public utilities, have freedom to decide whether to remain in business and thus subject themselves voluntarily to the limits imposed" by the Medicaid program. *Minn. Ass'n of Health Care Facilities, Inc. v. Minn. Dep't of Pub. Health*, 742 F.2d 442, 446 (8th Cir. 1984) [hereinafter, *MAHCF*]. "It is, of course, only through voluntary participation in the state's Medicaid program that a nursing home falls within the purview" of a challenged regulation. *Id. See also Livingston Care Ctr., Inc. v. United States*, 934 F.2d 719, 720 (6th Cir. 1991) ("[P]articipation in the Medicare program is a voluntary undertaking."); *St. Francis Hosp. Ctr. v. Heckler*, 714 F.2d 872, 875 (7th Cir. 1983) (same).

This is true even where providers argued that choosing not to participate in the Medicare and Medicaid programs would cause them to earn less revenue and undermine their viability. "Despite the strong financial inducement to participate in Medicaid, a nursing home's decision to do so is nonetheless voluntary." *MAHCF*, 742 F.2d at 446. *See also Se. Ark. Hospice, Inc. v. Burwell*, 815 F.3d 448 (2016) (holding that hospice provider's voluntary participation in Medicare "forecloses the possibility that the statute could result in an imposed taking of private property which would give rise to the

constitutional right of just compensation" (quoting *MAHCF*, 742 F.2d at 446)); *St. Francis*, 714 F.2d at 875 ("Providers who opt not to participate are free to serve persons not covered by Medicare and those potential Medicare recipients who are willing to forego Medicare benefits for the services provided. As a practical matter, perhaps few of those persons eligible for Medicare would choose a non-participating hospital, but the fact that practicalities may in some cases dictate participation does not make participation involuntary."); *Cf. Livingston Care Ctr.*, 934 F.2d at 720-21 (affirming the dismissal of a nursing home's suit for wrongful termination after it was terminated from Medicare and was forced to declare bankruptcy, noting that "[j]ust as those who choose to serve individuals not covered by Medicare assume the risks of the private market, those who opt to participate in Medicare are not assured of revenues"). Having chosen to structure their private businesses to be heavily dependent on Medicare and Medicaid funding, Plaintiffs cannot now argue that dependence somehow shields them from CMS's efforts to protect the beneficiaries of those programs. Thus, Plaintiff's argument regarding the coercive nature of their "choice" does not undermine CMS's authority to implement the Final Rule.

In summary, the Court concludes that the Rule codified at 42 C.F.R. § 483.70(n) does not conflict with the FAA because it does not interfere with the validity or enforceability of any arbitration agreement. To the extent that the Final Rule places limitations on the use of arbitration agreements by LTC facilities, it cannot be said to disfavor such agreements. Rather, CMS has reasonably imposed these restrictions as

conditions by which an LTC facility must abide to receive federal dollars from the Medicare and Medicaid programs. The regulations are reasonably related to the policy goals of the Medicare and Medicaid programs and are therefore a permissible use of the Government's authority to place conditions on the use of federal funds.

C. The Rule is Within the Secretary's Statutory Authority

The Government cites two sections of the Medicare and Medicaid statutes as the basis for its statutory authority. *See* Revision of Requirements, 84 Fed. Reg. at 34718.

> It is the duty and responsibility of the Secretary to assure that requirements which govern the provision of care in [participating LTC facilities], and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.

42 U.S.C. §§ 1395i-3(f)(1) & 1396r(f)(1).

> A [participating LTC facility] must meet such other requirements relating to the health, safety, and well-being of residents or relating to the physical facilities thereof as the Secretary may find necessary.

42 U.S.C. §§ 1395i-3(d)(4)(B) & 1396r(d)(4)(B).[5]

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[5] The Court also notes that while the Government does not rely on this statutory authority in promulgating the Final Rule or in its briefs, the administrative record also refers to 42 U.S.C. §§ 1395i-3(c)(1)(A)(xi) & 1396r(c)(1)(A)(xi), which require that an

The Government argues that the Rule falls within the plain language of these authorizing provisions, protecting the health, safety, welfare, and rights of Medicare and Medicaid recipients. If it is ambiguous whether the statute encompasses the new regulations, the Government argues that CMS's interpretation of the extent of its authority is entitled to deference pursuant to *Chevron, U.S.A., Inc. v. Natural Resource Defense Council, Inc.*, 467 U.S. 837 (1984).

The bulk of Plaintiffs' opposition centers on the argument that, pursuant to *Epic Systems*, the Secretary must have explicit authorization from Congress to regulate the use of arbitration. That argument has already been addressed and rejected above. In the alternative, Plaintiffs argue that the statute grants the Secretary narrower authority than the Government believes: "Congress actually confined Defendants' authority to regulate to '*the provision of care'* provided '*in* skilled nursing facilities,' and did not authorize any regulation that might arguably promote the 'health, safety, welfare, and rights of residents.'" (Doc. 27, p. 30 (quoting 42 U.S.C. § 1395i-3(f)(1) with emphasis added)). Plaintiffs argue that a permissible restriction must be linked to "*how* long-term care providers administer care to residents," not a "condition precedent to the provision of care." *Id.* at pp. 30-31. Regulation of a facility's admissions policies,

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LTC facility "protect and promote the rights of each resident," including "[a]ny other right established by the Secretary." The Court agrees with CMS that with this statutory provision, "Congress has expressed an [sic] clear interest in protecting the rights of Medicare and Medicaid beneficiaries in LTC facilities." Reform of Requirements, 81 Fed. Reg. at 68796.

Plaintiffs argue, does not fall within the statutory language authorizing regulation.

The Supreme Court established the legal standard for judicial review of an agency's construction of the statute it administers in *Chevron*. First a court must consider "whether Congress has directly spoken to the precise question at issue," in which case Congress's command is controlling. *Id.* at 842. But where "the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute." *Id.* at 843. When Congress, through its silence, implicitly delegates authority to an agency, "a court may not substitute its own construction of a statutory provision for a reasonable interpretation made by the administrator of an agency." *Id.* at 844. Therefore, the Court "must decide (1) whether the statute unambiguously forbids the Agency's interpretation, and, if not, (2) whether the interpretation, for other reasons, exceeds the bounds of the permissible." *Barnhart v. Walton*, 535 U.S. 212 (2002).

The Court does not find any statutory language that would forbid CMS from enacting the Final Rule. On the contrary, the statutory language is broad. It does not just empower the Secretary to develop a solution to a particular problem; it is gives the Secretary the responsibility to identify areas where there is inadequate protection for the "health, safety, welfare, and rights" of Medicare and Medicaid recipients and to promulgate regulations governing the provision of care in LTC facilities to provide needed protection. 42 U.S.C. §§ 1395i-3(f)(1) &

1396r(f)(1). Sections 1395i-3(d)(4)(B) & 1396r(d)(4)(B) contain an even broader mandate to promulgate any regulations necessary for the "health, safety, and well-being" of residents. The Court reads this statutory language as granting discretion to the Secretary to make the regulations he finds necessary based on CMS's experience administering the Medicare and Medicaid programs, and the Court must defer to the agency's judgment so long as it is reasonable.

Plaintiffs do not cite the Court to any language that would forbid CMS's interpretation of the regulation. At most, Plaintiffs point to the fact that Congress has considered, but failed to enact, legislation banning the use of pre-dispute arbitration agreements as evidence that Congress would not wish CMS to regulate such agreements in this way. The Court notes that the regulations in the Final Rule do not rise to the level of the complete prohibition contemplated by proposed legislation. More to the point, however, "[c]ongressional inaction lacks persuasive significance because several equally tenable inferences may be drawn from such inaction. . . ." *Pension Benefit Guar. Corp. v. LTV Corp.*, 496 U.S. 633, 650 (1990) (analyzing agency action under *Chevron* and declining to conclude that Congress had expressed its position by considering, but not enacting, a provision relevant to the agency's rulemaking) (internal quotation marks omitted). Here, for example, the Court could just as easily conclude from Congress's inaction that it believed CMS had the authority to regulate the use of pre-dispute arbitration agreements and would do so if such regulation were necessary, so that there was no need for Congress to act. The ambiguity of

congressional inaction is further underscored in this case by the fact that CMS received multiple pieces of correspondence from members of Congress regarding its rulemaking on arbitration agreements, each taking a different position. *See* Reform of Requirements, 81 Fed. Reg. at 68790. Therefore, the Court concludes that at the first stage of the *Chevron* inquiry, there is no congressional command that forbids the agency's interpretation of its authority.

At the second step of the *Chevron* analysis, the Court finds that it was reasonable for CMS to determine that it had the authority to promulgate the Final Rule. The restrictions on the use of pre-dispute arbitration agreements are intended to protect the resident by preventing the nursing home from leveraging the resident's need to access care to achieve other goals not related to that resident's medical care. CMS observed that when arbitration agreements are included as part of the admissions process, they "are often made when the would-be resident is physically and possibly mentally impaired, and is encountering such a facility for the first time. In many cases, geographic and financial restrictions severely limit the choices available to an LTC resident." *Id.* at 68792. It was reasonable for the agency to conclude that preventing a facility from refusing to serve a resident in need of medical care who declined to enter into a pre-dispute arbitration agreement was necessary to protect the health, safety, welfare, and rights of residents.

Furthermore, the protections CMS has put in place are consistent with other existing statutory and regulatory protections for residents. For example, the

administrative record provides several examples of "rules mandating that suppliers of health care items and services forgo contractual and other commercial rights they might otherwise have with respect to Medicare and Medicaid patients," such as restrictions on marketing to program participants, a requirement to give written advance notice to residents of non-covered services, and a limitation on the right of the facility to pursue payment from a patient who could not have known the service would not be covered by Medicare. *Id.* at 68791. The Court agrees with CMS that these restrictions "evince a Congressional and administrative understanding that business arrangements with Medicare and Medicaid patients are not typical commercial contracts where both parties engage in arms-length bargaining." *Id.*

Additionally, section 483.15 of the Medicare and Medicaid regulations establishes other requirements for an LTC facility's admissions policy, including multiple regulations intended to ensure the facility is not leveraging the resident's need for care to accomplish other goals. Plaintiffs' argument that the language of the statute limits the Secretary's authority to regulate *how* care is provided is particularly unpersuasive in light of the regulations discussed here. For example, the regulations establish that a facility must not "request or require residents or potential residents to waive potential facility liability for losses of personal property" as a condition of admission. 42 C.F.R. § 483.15(a)(2)(iii). Nursing facilities participating in Medicaid also may not "charge, solicit, accept, or receive . . . any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in

the facility." § 438.15(a)(4). LTC facilities participating in Medicaid also cannot "condition the resident's admission or continued stay" at the facility on his or her willingness to purchase "additional services" not covered by the state's Medicaid plan. § 483.15(a)(4)(i). Nursing homes are also required to "disclose and provide to a resident or potential resident prior to time of admission, notice of special characteristics or service limitations of the facility." § 483.15(a)(6).

These regulations establish requirements for the facilities' admissions policies, which are conditions precedent to the resident's admission to the facility. The Final Rule similarly limits a facility's ability to leverage the resident's need for medical care to make other demands on the resident. CMS, recognizing that an agreement to arbitrate can be valuable to both parties if entered into knowingly and voluntarily, has reasonably chosen not to prohibit such agreements altogether, but to use regulations to protect the patient's health, safety, welfare, and rights by decoupling the resident's ability to receive care in a particular LTC facility from her decision whether or not to sign a pre-dispute arbitration agreement. Additionally, given CMS's conclusion that "the secrecy surrounding the arbitration process is a substantial concern" and that because of this secrecy, arbitration "could result in some facilities evading responsibility for substandard care," Reform of Requirements, 81 Fed. Reg. at 68797-98, the retention requirement found at § 483.70(n)(6) is a reasonable exercise of the Secretary's responsibility to ensure that CMS is able to enforce the program requirements.

For these reasons, the Court concludes that the Final Rule is a reasonable exercise of the authority delegated to the Secretary by the Medicare and Medicaid statutes and is entitled to deference under *Chevron*.

D. The Rulemaking Was Not Arbitrary and Capricious

Plaintiffs challenge the Rule as arbitrary, capricious, and an abuse of discretion on two separate grounds. The Court will address each in turn.

1. *Empirical Data Was Not Necessary*

First, Plaintiffs argue that the Government does not have the empirical data to support the Rule—in fact, one rationale for the Rule's retention requirement is to allow CMS to *collect* such data. *See* Revision of Requirements, 84 Fed. Reg. at 34728. The Government acknowledges that there is "little solid social science research" indicating the effect of binding pre-dispute arbitration on the quality of care received by residents. *Id.* at 34722. However, the Government argues that it is not obliged to rely on empirical evidence and has provided a sufficiently reasoned basis for the Final Rule.

The standard of review to determine if a change in regulation is arbitrary and capricious is the same as promulgation of a new rule. *Motor Vehicle Mfrs. Ass'n of U.S. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 41 (1983). The Supreme Court has described this standard as upholding a rule that is "rational, based on consideration of the relevant factors and within the scope of the authority delegated to the agency by the statute." *Id.* at 42. The scope of the court's review "is narrow and a court is not to

substitute its judgment for that of the agency. Nevertheless, the agency must examine the relevant data and articulate a satisfactory explanation for its action including a 'rational connection between the facts found and the choice made.'" *Id.* at 43 (quoting *Burlington Truck Lines v. United States*, 371 U.S. 156, 168 (1962)). The Court must rely only on the rationale that the agency offers without "supply[ing] a reasoned basis for the agency's action that the agency itself has not given." *Id.* (quoting *SEC v. Chenery Corp.*, 332 U.S. 194, 196 (1947)). However, the Court may "uphold a decision of less than ideal clarity if the agency's path may reasonably be discerned." *Id.* (quoting *Bowman Transp. Inc. v. Arkansas-Best Freight Sys., Inc.*, 419 U.S. 281, 286 (1974)).

To satisfy this standard, "it is highly desirable that the agency: independently amass the raw data; verify the accuracy of that data; apply that data to consider several alternative courses of action; and reach a result confirmed by the comments and submissions of interested parties." *Nat'l Ass'n of Regulatory Util. Comm'rs v. FCC*, 737 F.2d 1095, 1124 (D.C. Cir. 1984). However, the Courts of Appeals have recognized that it may not be possible for the agency to undertake all of these steps. Instead, the

> [n]otice and comment procedures are partially designed to overcome this problem. They permit parties to bring relevant information quickly to the agency's attention. A degree of agency reliance on these comments is not only permissible but often unavoidable. Thus, although an agency must consider and analyze the factual materials

> gathered during the informal rulemaking process, we have never held that an agency must conduct this analysis without relying on the comments submitted during the rulemaking.

Id. *See also Peck v. Thomas*, 697 F.3d 767, 775-76 (9th Cir. 2012) (holding that while analysis of statistical evidence would be *sufficient* for APA compliance, it was not *necessary* where the agency reasonably relied on its own experience); *Stilwell v. Office of Thrift Supervision*, 569 F.3d 514, 519 (D.C. Cir. 2009) ("The APA imposes no general obligation on agencies to produce empirical evidence.").

The Court finds that the agency has provided a sufficiently reasoned basis for the Final Rule. While empirical data might have helped the agency form its policy regarding the use of binding pre-dispute arbitration agreements in LTC facilities, CMS was not required to have such data. It was permitted to rely on the numerous comments received from a variety of parties and its review of court decisions and academic literature to guide it in formulating the Final Rule. In responding to the comments received when CMS first proposed the possibility of regulating the use of binding pre-dispute arbitration agreements, the agency noted that it "conducted a literature review and also reviewed court opinions involving arbitration in LTC facilities." Reform of Requirements, 81 Fed. Reg. at 68793. These materials "provided evidence that pre-dispute arbitration agreements were detrimental to the health and safety of LTC facility residents." *Id.* This "published research"—in conjunction with the public comments reviewed by the

agency—led CMS to conclude that it was important to regulate the use of these agreements. Reform of Requirements, 81 Fed. Reg. at 68793.

Furthermore, the fact that evidence was mostly anecdotal rather than statistical influenced the agency's ultimate decision. In determining the appropriate scope of the regulation, the Government tempered its initial decision to bar the use of pre-dispute arbitration entirely precisely because of the "lack of statistical data" and the need to "strike a balance between the stakeholders supporting arbitration and residents having a complete understanding of the consequences of entering into an arbitration agreement." Revision of Requirements, 84 Fed. Reg. at 34722. The agency also finalized a requirement that facilities retain a copy of the arbitration agreement and the arbitrator's final decision in any dispute resolved through arbitration to "allow [CMS] to learn how arbitration is being used by LTC facilities and how this is affecting the residents." *Id.* at 34723 (codified at 42 C.F.R. § 483.70(n)(6)). While Plaintiffs assert that this "puts the cart before the horse," (Doc. 27, p. 33), the Court notes that "agencies can, of course, adopt prophylactic rules to prevent potential problems before they arise. An agency need not suffer the flood before building the levee." *Stilwell*, 569 F.3d at 519. On the basis of the materials it reviewed, including the academic literature and public comments, CMS could reasonably conclude that it was necessary to place some limitations on the use of predispute binding arbitration agreements without prohibiting them completely and establish mechanisms to collect additional information to inform future rulemaking.

2. *The Change in Policy is Adequately Justified*

Second, Plaintiffs assert that the Final Rule is arbitrary and capricious because the agency has left unexplained its departure from prior policy, as laid out in a memorandum from Steven Pelovitz, Director of the Survey and Certification Group in January 2003 (the "Pelovitz Memo") and a letter from Michael Leavitt, Secretary of HHS at the time, to the House Judiciary Committee in 2008 (the "Leavitt Letter"). In response, the Government asserts that the Pelovitz Memo and the Leavitt Letter are general statements that are not in conflict with the Final Rule, which still recognizes that there can be benefits of arbitration and simply eliminates certain negotiating tactics by LTC facilities.

"'When an agency changes its existing position, it 'need not always provide a more detailed justification than what would suffice for a new policy created on a blank slate.' But the agency must at least 'display awareness that it is changing position' and 'show that there are good reasons for the new policy.'" *Encino Motorcars, LLC v. Narvarro*, 136 S. Ct. 2117, 2125-26 (2016) (quoting *FCC v. Fox Television Stations*, 556 U.S. 502, 515 (2009)) (internal citation omitted). A more detailed justification of the change may be necessary if the prior policy "has engendered serious reliance interests." *Fox Television Studios*, 556 U.S. at 515.

For the most part, the Court agrees that there is not as much tension between the Final Rule and the Pelovitz Memo and Leavitt Letter as Plaintiffs suggest. The Final Rule does not "deprive patients and

providers of the opportunity to agree voluntarily to resolve their disputes through arbitration," which was then-Secretary Leavitt's concern about the Fairness in Nursing Home Arbitration Act. (Doc. 24-26, p. 705). Nor does the Final Rule undercut his observation that "[p]re-dispute arbitration agreements are an excellent way for patients and providers to control costs, resolve disputes, and speed resolution of conflicts." *Id.* Where both parties agree, subject to the requirements put in place by the Rule, future disputes can still be committed to the arbitrator for resolution. Nor does the Court read the Pelovitz Memo to take a pro-arbitration stance at odds with the Final Rule; rather, it states CMS's decision to leave the choice whether to enter into arbitration agreements to the facility and the resident or to state law and emphasizes that a resident's refusal to enter into such an agreement is not a valid ground for the facility to discharge the resident. *See* Doc. 24-26, pp. 703-04.

However, to the extent that the Court finds that there is more tension between these two policy statements and the Final Rule than the Government is willing to acknowledge, the Court finds that any change in policy is adequately supported by the administrative record. For example, both the Pelovitz Memo and the Leavitt Letter assert that the use of arbitration agreements does not interfere with CMS's ability to enforce its regulations and sanction facilities for inadequate quality of care. *See* Doc. 24-26, pp. 704 & 705. But in promulgating the Final Rule, CMS stated that the retention requirement was being put in place "to ensure that CMS can fully evaluate quality of care complaints that are addressed in arbitration." Revision of Requirements, 84 Fed. Reg. at 34730. To

the extent that this suggests CMS now believes that arbitration agreements may in fact impede its enforcement efforts, that change in position is justified by "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." *Id.*

Similarly, to the extent that CMS's policy no longer leaves the decision whether to arbitrate *entirely* to the facility and the resident but establishes some additional protections for the resident, the perceived need for those additional protections has been discussed at length above and is sufficient to "show that there are good reasons for the new policy." *Fox Television Stations*, 556 U.S. at 515. Additionally, CMS noted that the use of arbitration by LTC facilities had increased in recent years, citing articles that were published after the Pelovitz Memo and Leavitt Letter were put forward. *See* Reform of Requirements, 81 Fed. Reg. at 68794. Finally, to the Plaintiffs' assertion that CMS has not met the threshold requirement of recognizing that the Final Rule departs from prior policy, (Doc. 36, p. 28), the Court notes CMS's acknowledgment that it "reversed the existing policy through the adoption of the 2016 final rule." Revision of Requirements, 82 Fed. Reg. at 26650. Therefore, the Court can conclude that the agency has sufficiently justified the Final Rule, including providing an adequate basis for changing its policy.

Finally, the Court is unpersuaded by Plaintiffs' claims to have a serious reliance interest in the prior policy that CMS failed to acknowledge. *See* Doc. 27,

p. 33. First, the Final Rule has no effect on arbitration agreements that were formed before it went into effect. *See* Revision of Requirements, 84 Fed. Reg. at 34729. Second, Plaintiffs' claim to have "built their economic and pricing models" in reliance on the prior policy, (Doc. 27, p.33), rings hollow in light of their admission that most of their residents are covered by Medicare and Medicaid, *see* Docs. 25-3 & 25-4 at ¶ 3, for whom the rates are set by the agency, not the facility. Ultimately, as discussed at length in Section B.2, *supra*, Plaintiffs are only subject to conditions on their use of pre-dispute arbitration by virtue of their voluntary participation in Medicare and Medicaid. If the regulatory changes made by the Final Rule truly shift Plaintiffs' economic calculus, they are free to serve fewer residents covered by Medicaid and Medicare, or none at all.

E. Regulatory Flexibility Act

Finally, Plaintiffs argue that the Rule violates the APA by failing to comply with the Regulatory Flexibility Act ("RFA"). The RFA requires that "[w]hen an agency promulgates a final rule, . . . the agency shall prepare a final regulatory flexibility analysis" containing a variety of descriptions and assessments described in the statute. 5 U.S.C. § 604(a). However, such an analysis is not required where "the head of the agency certifies that the rule will not, if promulgated, have a significant economic impact on a substantial number of small entities." 5 U.S.C. § 605(b). If the agency head, in this case the Secretary of HHS, makes such a certification, it must be published in the Federal Register when the final rule is promulgated,

"along with a statement providing the factual basis for such certification." *Id.*

Judicial review of agency compliance with § 605(b) is governed by the APA. "Thus, if data in the regulatory flexibility analysis—or data anywhere else in the rulemaking record—demonstrates that the rule constitutes such an unreasonable assessment of social costs and benefits as to be arbitrary and capricious, the rule cannot stand." *Nat'l Telephone Co-op Ass'n v. F.C.C.*, 563 F.3d 536, 540-41 (D.C. Cir. 2009) (quoting *Thompson v. Clark*, 741 F.2d 401, 405 (D.C. Cir. 1984)). Under arbitrary-and-capricious review, the court's "review is narrow," and that is "particularly true with regard to an agency's predictive judgments about the likely economic effects of a rule." *Id.* at 541 (internal quotation marks omitted).

It is appropriate for the court to consider the entire administrative record in making this assessment, even if the rulemaking took place over multiple phases. *See Michigan v. Thomas*, 805 F.2d 176, 188 (6th Cir. 1986) (rejecting an RFA challenge where the agency approved a rule, saw the rule challenged in court, and sought voluntary remand to reconsider the rule, because the agency "performed its regulatory flexibility analysis in the context of its overall rulemaking analysis"); *Cal. Farm B. Fed'n v. EPA*, 72 F. App'x 540, 541 (9th Cir. 2003) (rejecting an RFA challenge in part because the Secretary's certification was supported by an "earlier impact analysis"); *Carpenter, Chartered v. Sec'y of Veterans Affairs*, 343 F.3d 1347, 1357 (Fed. Cir. 2003) (upholding the Secretary's certification as complying with the RFA "in view of the record as a whole"). *Cf.*

Nat'l Mining Ass'n v. Mine Safety & Health Admin., 512 F.3d 696, 701 (D.C. Cir. 2008) (holding that since the agency had found that a more widely-applicable requirement did not create a significant economic burden on small business, it was unnecessary for the agency to perform an analysis of a second rule that was simply an alternative to the first).

It is undisputed that the notice of the Final Rule in the Federal Register did contain the Secretary's certification that the Rule would not have a significant economic impact on a substantial number of small entities, *see* Revision of Requirements, 84 Fed. Reg. at 34734, but Plaintiffs assert that the CMS provided no factual basis for the Secretary's certification, that there was no assessment or explanation to support the Secretary's conclusion, and that the Final Rule does in fact have a significant economic impact on a substantial number of small entities. The Government responds that the RFA certification requirement is a purely procedural mandate that requires a reasonable, good faith effort by the agency to comply but does not permit Plaintiffs or the Court to challenge the outcome of the Secretary's determination. The Government argues that CMS provided an extensive factual basis for the Secretary's certification in promulgating the 2016 version of the rule. Since the Final Rule at issue here imposed fewer requirements on regulated parties, the Secretary could conclude that the analysis under the RFA would be unchanged, and therefore the procedural requirements were met.

The Court agrees with the Government. As discussed above, the Court finds it appropriate to take into account the entire administrative record in

evaluating whether the Secretary complied with the requirements of the RFA. In promulgating the first version of the rule in 2016, the Government analyzed the economic impact of the entire rule and determined that "[t]he annual impact on a nursing facility would be around $63,000 in year 1 and $55,000 in year 2 and thereafter . . . so the average impact on the facility is less than 1 percent of revenue" and less than the threshold of 3 to 5 percent that would constitute a significant economic impact. Reform of Requirements, 81 Fed. Reg. at 68846. This was the basis for the Secretary's certification in 2016. The 2016 rule entailed extensive changes to the regulations governing LTC facilities. In addition to the regulation barring the use of pre-dispute binding arbitration, the rule implemented changes to requirements for infection control and nutrition, notification and grievance procedures, and many others. *See id.* at 68847-72.

In promulgating the Final Rule in 2019, the Secretary again certified that the Rule would not have a significant economic impact on a substantial number of small entities. *See* Revision of Requirements, 84 Fed. Reg. at 34734. Though the Secretary did not state the factual basis for this certification in the paragraph where it was made, the Court can conclude from review of the record that the 2019 Final Rule had a much narrower economic impact on LTC facilities than the 2016 rule, which the Secretary had previously certified. Furthermore, comparing only the portion of the rule related to pre-dispute binding arbitration agreements, CMS made clear that its intention with the Final Rule was to *reduce* the costs to the LTC facilities while still protecting the rights of

residents. *See, e.g.*, Revision of Requirements, 82 Fed. Reg. at 26651 ("We believe this revised approach is consistent with the elimination of unnecessary and excessive costs to providers while enabling residents to make informed choices . . . .); Revision of Requirements, 84 Fed. Reg. at 34722 ("[C]ommenters 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."); *id*. at 34733 ("LTC facilities assert that . . . arbitration reduces their costs . . . . [W]e are removing the prohibition on pre-dispute binding arbitration agreements . . . .).

Plaintiffs challenge CMS's reliance on the 2016 rulemaking, arguing that the agency should not be able to use its reasoning from 2016 as a factual basis for the RFA certification in 2019. The Court is not persuaded by Plaintiffs' reliance on *North Carolina Fisheries Ass'n v. Daley*, 16 F. Supp. 2d 647 (E.D. Va. 1997). There, the plaintiffs challenged the RFA certification of the Secretary of Commerce in setting the quota for the number of summer flounder that could be caught by the fishing industry in North Carolina in that year. The Secretary certified that there would not be significant economic impact on a substantial number of small entities because the quota was the same as the previous year. The court held that the Secretary did not satisfy § 605(b) and was required to "make some showing that it has at least considered the potential effects of *this* quota, *this* year." *Id.* at 652 (emphasis in original). However, the fisheries management plan being implemented by the Commerce Department requires the National Marine

Fisheries Services to set a quota every year based on a variety of factors. Each year is a new undertaking specific to that year. *See id.* at 649-50. Here in contrast, the Final Rule is the culmination of a multi-year process that began when a version of the current Rule was initially proposed in 2015. Therefore, the Court concludes that the Secretary complied with the requirements of the RFA.

Further, the Court finds that, as described above, the record provides adequate support for the agency's position. Given the deferential standard of review, the Court is not permitted to "substitute its judgment for that of the agency." even if it disagrees with the agency's conclusion. *Motor Vehicle Mfrs. Ass'n*, 463 U.S. at 43. Plaintiffs have not alleged that the agency has relied on improper factors or "entirely failed to consider an important aspect of the problem." *Id.* The Court cannot conclude that the Secretary's certification is "so implausible that it could not be ascribed to a difference in view," *id.* at 43, and therefore cannot find the agency's RFA certification arbitrary and capricious.

III. Conclusion

For the reasons given above, Plaintiffs' Motion for Summary Judgment (Doc. 26) is **DENIED** and the Defendants' Cross-Motion for Summary Judgment (Doc. 28) is **GRANTED**. Accordingly, Plaintiffs' First Amended Complaint is **DISMISSED WITH PREJUDICE** and this case is terminated.

IT IS SO ORDERED on this [handwritten: 7th] day of April, 2020.

[handwritten: signature]
TIMOTHY L. BROOKS
UNITED STATES
DISTRICT JUDGE

Appendix D

RELEVANT STATUTES AND REGULATIONS

42 C.F.R. §483.70(n)

(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.

9 U.S.C. §2

A written provision in any maritime transaction or a contract evidencing a transaction involving commerce to settle by arbitration a controversy thereafter arising out of such contract or transaction, or the refusal to perform the whole or any part thereof, or an agreement in writing to submit to arbitration an

existing controversy arising out of such a contract, transaction, or refusal, shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract or as otherwise provided in chapter 4.

42 U.S.C. §1395i-3(f)(1)

(f) Responsibilities of Secretary relating to skilled nursing facility requirements

(1) General responsibility

It is the duty and responsibility of the Secretary to assure that requirements which govern the provision of care in skilled nursing facilities under this subchapter, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.

42 U.S.C. §1396r(f)(1)

(f) Responsibilities of Secretary relating to nursing facility requirements

(1) General responsibility

It is the duty and responsibility of the Secretary to assure that requirements which govern the provision of care in nursing facilities under State plans approved under this subchapter, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.

42 U.S.C. §1395i-3(d)(4)(B)

(d) Requirements relating to administration and other matters

* * *

(4) Miscellaneous

* * *

(B) Other

A skilled nursing facility must meet such other requirements relating to the health, safety, and well-being of residents or relating to the physical facilities thereof as the Secretary may find necessary.

42 U.S.C. §1396r(d)(4)(B)

(d) Requirements relating to administration and other matters

* * *

(4) Miscellaneous

* * *

(B) Other

A nursing facility must meet such other requirements relating to the health and safety of residents or relating to the physical facilities thereof as the Secretary may find necessary.

42 U.S.C. §1395i-3(c)(1)(A)(xi)

(c) Requirements relating to residents' rights

(1) General rights

(A) Specified rights

A skilled nursing facility must protect and promote the rights of each resident, including each of the following rights:

* * *

(xi) Other rights

Any other right established by the Secretary.

42 U.S.C. §1396r(c)(1)(A)(xi)

(c) Requirements relating to residents' rights

(1) General rights

(A) Specified rights

A nursing facility must protect and promote the rights of each resident, including each of the following rights:

* * *

(xi) Other rights

Any other right established by the Secretary.