UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
AMARILLO DIVISION

AMERICAN HEALTH CARE ASSOCIATION *et al.*,

Plaintiffs,

v.

XAVIER BECERRA *et al.*,

Defendants.

No. 2:24-cv-00114-Z-BR (lead)
No. 2:24-cv-171-Z (consolidated)

PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

Pursuant to Federal Rule of Civil Procedure 56 and Local Rule 56.3, and consistent with this Court's scheduling order and consolidation order, Dkt.47[1]; Dkt.52, Plaintiffs hereby move for summary judgment on all counts of their respective complaints. *See* Dkt.26 (amended complaint of American Health Care Association, LeadingAge, Texas Health Care Association, Arbrook Plaza, Booker Hospital District, and Harbor Lakes Nursing & Rehabilitation Center); No. 2:24-cv-171, Dkt.1 (complaint of the State of Texas).

This motion is accompanied by a supporting memorandum of law, which sets forth the argument and authorities on which Plaintiffs rely and contains the matters required by Local Rule 56.3.

[1] All docket citations are to the lead case, No. 2:24-cv-114, unless otherwise noted.

Respectfully submitted,

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October 18, 2024

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MEMORANDUM IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

For more than half a century, Congress has resisted efforts to impose one-size-fits-all staffing requirements on the more than 97% of nursing homes across the nation that participate in Medicare and Medicaid. And for good reason, as nursing homes come in all different shapes and sizes, serve patients with a wide variety of needs, and face very different challenges in recruiting and maintaining high-quality staff. Yet the Centers for Medicare and Medicaid Services ("CMS") has now decided it knows better. After acknowledging for decades that there is no single optimal level or mix of staffing for all facilities, CMS has now abruptly reversed course and arbitrarily imposed a set of rigid and impracticable minimum staffing requirements with which virtually every nursing home will be forced to comply. *See* Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting, 89 Fed. Reg. 40876 (May 10, 2024) ("Final Rule"). These onerous new requirements exceed CMS's statutory authority, represent a baffling and unexplained departure from the agency's longstanding position, and create impossible-to-meet standards that will harm thousands of nursing homes and the vulnerable Americans they serve. The Final Rule cannot stand.

Congress has explicitly and repeatedly addressed the question of staffing levels for nursing homes that participate in Medicare or Medicaid, and it has long taken the same approach: While a nursing home "must provide 24-hour licensed nursing services which are sufficient to meet the nursing needs of its residents," Congress has not dictated specific mixes of staff or provider-to-resident ratios other than to require that each facility "must use the services of a registered professional nurse [("RN")] for at least 8 consecutive hours a day, 7 days a week." 42 U.S.C. §1396r(b)(4)(C)(i); *accord id.* §1395i-3(b)(4)(C)(i).

The Final Rule brazenly overrides both of those statutory requirements. It explicitly "revises" the RN requirement, by tripling it—replacing Congress' directive to employ an RN for

8 consecutive hours, 7 days a week, with CMS's own directive to have an RN "onsite *24 hours per day*, for 7 days a week." 89 Fed. Reg. at 40898, 40997 (emphasis added). The Final Rule likewise departs from the more general staffing requirement, replacing the flexible qualitative standard Congress chose with three rigid quantitative requirements. Instead of following Congress' decision to require nursing services "sufficient to meet the nursing needs" of a given facility's residents, 42 U.S.C. §1396r(b)(4)(C)(i), the Final Rule demands that every facility across the nation—regardless of its residents' actual needs—provide (i) total nurse staffing of at least 3.48 hours per resident day ("HPRD"), including (ii) RN staffing of at least 0.55 HPRD and (iii) nurse aide ("NA") staffing of at least 2.45 HPRD. 89 Fed. Reg. at 40877.

CMS has not even tried to claim that the statutory provisions in which Congress explicitly addressed staffing requirements empower the agency to enact these sweeping new mandates. Instead, CMS claims to have discovered authority to do so lurking in "various provisions" of the Medicare and Medicaid Acts that enable the agency to promulgate requirements promoting resident health and safety. *Id.* at 40879, 40890-91. But that argument runs headlong into basic principles of administrative law, as generic rulemaking provisions do not empower agencies to "revise" legislative enactments and promote their own policy *du jour* over the policy choices that Congress enacted into federal law.

The major questions doctrine confirms that CMS lacks the sweeping statutory authority it claims. As the Fifth Circuit recently held, the major questions doctrine applies when an agency "claims the power to resolve a matter of great political significance." *Mayfield v. U.S. Dep't of Lab.*, 2024 WL 4142760, at *2 (5th Cir. Sept. 11, 2024). That describes this case to a T: Nationwide nursing-home-staffing requirements have been a hotly debated political issue for more than half a century, and Congress has directly addressed that issue by setting its own statutory

standards—and by conspicuously and repeatedly declining to enact the type of rigid requirements CMS now seeks to impose. Moreover, the major questions doctrine is "independently trigger[ed]" when "[an] agency 'seeks to … require billions of dollars in spending by private persons or entities,'" as the Final Rule unquestionably does. *Id.* Even by CMS's own low-ball estimate, nursing homes will need to spend *more than $40 billion* over the next decade to comply with the new staffing requirements. CMS therefore must identify clear congressional authorization for its onerous new mandates—which CMS comes nowhere close to doing.

Even if Congress had delegated CMS the authority it claims, the Final Rule independently violates the Administrative Procedure Act ("APA") because it is arbitrary and capricious. It makes no sense to impose a blanket 24/7 RN requirement and rigid staffing ratios on thousands and thousands of nursing homes across the country, regardless of each particular facility's local conditions and unique circumstances. On the contrary, as CMS and its predecessor agencies repeatedly explained in a series of regulations spanning more than four decades, the indisputable fact that nursing homes care for a wide range of resident populations with greatly divergent needs renders a one-size-fits-all approach manifestly inappropriate. The Final Rule is an unjustified about-face from that longstanding agency position and upsets significant reliance interests.

Those problems are only exacerbated by the irrational and unattainable staffing levels that the Final Rule imposes. As CMS openly acknowledges, its new mandates "exceed the existing minimum staffing requirements in nearly all" of the 38 States (plus the District of Columbia) that have adopted such requirements and will require increased staffing "in more than 79 percent of nursing facilities nationwide." 89 Fed. Reg. at 40877. Still worse, CMS failed to adequately account for the ongoing nationwide shortage of RNs and NAs—a shortage that will be exacerbated by the artificial demand that the agency's mandate will produce nationwide, making compliance

practically impossible in many parts of the country.

Texas provides a striking case in point. The Final Rule estimates that nursing homes in Texas will need to hire about 2,579 additional RNs, representing an increase of *46.1%* over current staffing, as well as 7,887 additional NAs, for an increase of 28.4%. *See id.* at 40957, 40976-80. Texas simply does not have enough RNs and NAs to sustain these massive increases. Meanwhile, Texas *does* have a relatively high proportion of licensed vocational nurses ("LVNs")[1] working in nursing homes across the State—but the Final Rule largely ignores their important contributions to resident care. The Final Rule will also have a disproportionate impact on smaller, rural facilities across Texas, which will struggle to compete with larger, better-funded urban facilities vying to attract new hires from the limited pool of RNs and NAs. AR_00057772; AR_00057782; AR_00066200.

No one disputes that nursing homes need an adequate supply of well-trained staff. But imposing a nationwide, multi-billion-dollar, unfunded mandate at a time when nursing homes are already struggling with staffing shortages and financial constraints will only make the situation worse. If CMS's new standards are permitted to take effect, hundreds of nursing homes will likely be forced to downsize or close their doors entirely. That threatens to displace tens of thousands of nursing home residents from their current facilities, while forcing countless other seniors and family members to wait longer, search farther, and pay more for the care they need. The Final Rule thus promises to be a nightmare not only for owners and operators of nursing homes, but also for the vulnerable residents they serve, in direct derogation of CMS's statutory mandate.

[1] Most states use the term "licensed practical nurse" ("LPN"), but Texas and California use the term LVN. *See* 87 Fed. Reg. 22,720, 22,790 (Apr. 15, 2022). LPNs and LVNs generally have one to two years of postsecondary education, such as an associate's degree, whereas NAs generally have only a high school diploma and have completed a state certification program.

In short, the staffing requirements in the Final Rule fail basic principles of administrative law at every turn. This Court should grant Plaintiffs' motion for summary judgment, hold that the 24/7 RN requirement and all three HPRD requirements exceed CMS's statutory authority and are arbitrary and capricious in violation of the APA, and issue an order vacating those requirements. *See Franciscan All., Inc. v. Becerra*, 47 F.4th 368, 374-75 (5th Cir. 2022) ("Vacatur is the only statutorily prescribed remedy for a successful APA challenge to a regulation.").

BACKGROUND

I. Statutory And Regulatory Background

A. Overview of the Medicare and Medicaid Programs

In 1965, Congress created the Medicare and Medicaid programs through amendments to the Social Security Act. *See generally* Pub. L. No. 89-97, 79 Stat. 286 (July 30, 1965). Medicare is a federal program that provides health insurance to individuals 65 and older, as well as those with certain disabilities or conditions. *See* 42 U.S.C. §1395c. Medicaid is a joint federal-state program that provides health insurance to low-income individuals. *See id.* §§1396-1, 1396a. Nursing homes that wish to participate in Medicare must meet the statutory requirements for "skilled nursing facilities" set forth at 42 U.S.C. §1395i-3. Nursing homes that wish to participate in Medicaid must meet the largely parallel set of statutory requirements for "nursing facilities" set forth at 42 U.S.C. §1396r. Collectively, skilled nursing facilities and nursing facilities are referred to as "long-term care" ("LTC") facilities. *See, e.g.*, 87 Fed. Reg. 22720, 22790 (Apr. 15, 2022). CMS has promulgated a single set of consolidated Medicare and Medicaid regulations that apply to all LTC facilities that participate in either program, or both. *See* 42 C.F.R. § 483.1. More than

97% of nursing homes in the United States participate in at least one of the two programs.[2]

B. Historical Federal Regulation of Nursing Home Staffing

For more than half a century, Congress—not CMS or its predecessors—has taken the lead in setting staffing requirements for nursing homes that participate in the Medicare and Medicaid programs. And by and large, it has eschewed a one-size-fits-all approach. In 1972, Congress amended the Social Security Act to require all "skilled nursing facilities" ("SNFs") participating in either or both programs to "provide[] 24-hour nursing service which is sufficient to meet nursing needs in accordance with the [facility's patient care] policies." 42 U.S.C. §1395x(j)(6) (1976) (Medicare); *see id.* §1396a(a)(28) (1976) (requiring state Medicaid plans to define "skilled nursing facility" by reference to the Medicare definition). But it did not dictate how facilities must meet that standard other than to require them to have "at least one registered professional nurse employed full time." *Id.* And with respect to SNFs in rural areas that met enumerated conditions, Congress empowered the Secretary to waive even those requirements "[t]o the extent" they "require that any skilled nursing facility engage the services of a registered professional nurse for more than 40 hours a week." Pub. L. No. 92-603, §267, 86 Stat. 1329, 1450 (Oct. 30, 1972).

In 1973, the Social Security Administration ("SSA") proposed regulations that mirrored Congress' decisions on nursing home staffing requirements. *See* 38 Fed. Reg. 18620 (July 12, 1973) (SNFs). Just like the statute, these proposed regulations required SNFs to provide "24-hour nursing service which is sufficient to meet nursing needs in accordance with the [facility's patient care] policies," but did not dictate how a facility must go about doing so other than to require at least one "qualified registered nurse employed full-time"—i.e., "during the day tour of duty 5 days

[2] *See* Nat'l Ctr. for Health Stats., U.S. Dep't of Health & Human Servs., *Post-acute and Long-term Care Providers and Services Users in the United States, 2017-2018*, at 9-10 (2022) (stating that 97.8% of nursing facilities are certified under Medicare and 95.4% are certified under Medicaid).

a week." *Id.* at 18625. During the notice-and-comment period, the agency received comments urging it to deviate from Congress' approach and require all nursing homes to maintain "a specific ratio of nursing staff to patients." 39 Fed. Reg. 2238, 2239 (Jan. 17, 1974). The agency considered and expressly rejected that one-size-fits-all approach, explaining that "the variation from facility to facility in the composition of its nursing staff, physical layout, patient needs[,] and the services necessary to meet those needs precludes setting such a figure." *Id.* The agency also expressed concern that "[a] minimum ratio could result in all facilities striving only to reach that minimum and could result in other facilities hiring unneeded staff to satisfy an arbitrary ratio." *Id.*

In 1980, HHS took over the administration of Medicare and Medicaid. It promptly "propos[ed] a general revision" of the regulations governing SNF participation in Medicare and Medicaid. *See* 45 Fed. Reg. 47368, 47368 (July 14, 1980). Consistent with SSA's approach in the 1974 rulemaking, HHS declined to propose "any nursing staff ratios or minimum number of nursing hours per patient per day." *Id.* at 47371. Instead, it proposed "retain[ing] the language in the existing regulations," which closely tracked the governing statutes. *Id.*; *see also id.* at 47378 (requiring "24-hour nursing service with a sufficient number of qualified nursing personnel to meet the total nursing needs of the patient," as well as "a registered nurse full-time, 7 days a week on the day shift"). At the same time, HHS acknowledged that "[s]ome States ha[d] chosen to employ [quantitative staffing] standards," invited them to share their experiences, and announced its intention "to undertake a study on this subject." *Id.* at 47371-72.

As HHS later acknowledged, the agency's proposed overhaul of the SNF regulations in 1980 was "surrounded by controversy" and "met with strong opposition from a variety of sources." 52 Fed. Reg. 38582, 38583 (Oct. 16, 1987). That included Congress, which responded by adopting legislation expressly prohibiting HHS from using any appropriated funds to finalize the proposed

rule "prior to [its] receipt of revised cost estimates" and a "General Accounting Office evaluation of the[ir] impact." Pub. L. No. 96-536, §119, 94 Stat. 3166, 3172 (Dec. 16, 1980). The proposed rule was never finalized, but HHS nevertheless followed through on its plan to explore the possibility of minimum staffing standards, commissioning a multi-year study by the Institute of Medicine. *See* 52 Fed. Reg. at 38583.

That study ratified the agency's (and Congress') longstanding decision not to impose a one-size-fits-all staffing standard on America's nursing homes. *See* Inst. of Med., *Improving the Quality of Care in Nursing Homes* 101-03 (1986), https://archive.ph/KFNCi ("Institute of Medicine Study"). The study emphasized the importance of recruiting, retaining, and supporting adequate numbers of nursing staff but concluded that "prescribing simple staffing ratios clearly is inappropriate." *Id.* at 102. It reached this conclusion in part because of "the complexities of case mix"—that is, individuals within a single facility have "widely differing needs," and some facilities have a much "larger proportion of heavy-care residents" than other facilities. *Id.* at 102-03. The study noted the possibility of "prescribing sophisticated staffing standards" that would account for such complexities—e.g., by using "algorithms … to estimate amounts of nursing time needed by residents that are based on functional assessment scores and requirements for special care needs"—but found that this was not feasible at the time. *Id.* at 102.

In October 1987, HHS again recognized the pitfalls of one-size-fits-all staffing mandates in a proposed rule stemming from the results of the Institute of Medicine study. *See* 52 Fed. Reg. at 38586. At the time, Congress had defined "intermediate care facilities" ("ICFs") as a class of institutions serving individuals who "require care and services (above the level of room and board)" but "do not require the degree of care and treatment which a hospital or [SNF] is designed to provide." 42 U.S.C. §1396d(c) (1982). Although the Institute of Medicine study recommended

extending the SNF requirement of 24-hour nursing services to ICFs, HHS was hesitant to do so. HHS explained that it "wish[ed] to provide maximum flexibility for staffing and to avoid requiring 24 hour nurse staffing if there are cases in which the needs of the residents can be met through the use of other personnel." 52 Fed. Reg. at 38586. HHS also expressed "concern[] that some facilities would have difficulty in recruiting the nurses necessary to meet the requirement and d[id] not wish to create a situation in which needed nursing home beds are unavailable to program beneficiaries because facilities cannot meet staffing requirements." *Id.* Despite these qualms, HHS issued a proposed rule that contemplated extending the existing SNF staffing requirements to ICFs, such that both types of facilities "would be required to have a sufficient number of licensed nurses and other personnel on a 24 hour a day basis, including a registered nurse on duty on the day shift at least 8 hours a day, 7 days a week." *Id.*

Once again, Congress stepped in. In December 1987—less than three months after HHS issued the proposed rule—Congress enacted extensive revisions to the statutory requirements for nursing homes participating in Medicare and Medicaid. *See* Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, 101 Stat. 1330 (Dec. 22, 1987) ("OBRA '87")). With respect to Medicaid, Congress replaced the two-level framework of SNFs and ICFs with a single definition of "nursing facilities" ("NFs"), while retaining the term "SNF" in the Medicare context.[3] *See id.* §4211(a), 101 Stat. at 1330-183 to -203. Congress then imposed substantively identical staffing requirements on both SNFs and NFs (collectively known as LTC facilities), requiring each such facility to "provide 24-hour licensed nursing service which is sufficient to meet [the] nursing needs of its residents," but beyond that specifying only that each facility must "employ the services of a

[3] OBRA '87 redefined "intermediate care facilities" as institutions for individuals with intellectual disabilities. *See* Pub. L. No. 100-203, §4201(e), (h), 101 Stat. at 1330-204 to -205 (Dec. 22, 1987).

registered professional nurse at least during the day tour of duty (of at least 8 hours a day) 7 days a week." *Id.* §4201(a), 101 Stat. at 1330-163 (SNF requirement); *accord id.* §4211(a), 101 Stat. at 1330-186 (NF requirement). Notably, lawmakers *voted down* proposed legislation that would have imposed a 24/7 RN requirement. *See* 133 Cong. Rec. 28,998 (Oct. 22, 1987).

Not content with leaving matters to the agency's discretion, Congress also enacted detailed rules for when the Secretary may waive the staffing requirements for SNFs, and slightly different rules for when a State may waive the staffing requirements for NFs. *Compare id.* §4201(a), 101 Stat. at 1330-163, *with id.* §4211(a), 101 Stat. at 1330-186. Congress made both types of waivers subject to annual review and renewal. *See id.*; *accord id.* §4201(a), 101 Stat. at 1330-163. And Congress revisited the waiver issue less than three years later, amending both provisions to provide that, when a waiver is granted, notice must be given to facility residents, members of their immediate families, and relevant state authorities. *See* Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, §§4008(h), 4801(a), 104 Stat. 1388, 1388-49, 1388-211 (Nov. 5, 1990) ("OBRA '90").

Further underscoring its intent to keep control over nursing home staffing requirements, Congress instructed the Secretary to "conduct a study and report to Congress no later than January 1, 1992, on the appropriateness of establishing minimum caregiver to resident ratios and minimum supervisor to caregiver ratios for [LTC facilities]," and to "include in such study recommendations regarding appropriate minimum ratios." OBRA '90 §4801(e)(17), 104 Stat. at 1388-218 to -219. HHS failed to comply with Congress' instructions, however, until 2002—ten years after the statutory deadline. When the Secretary finally sent Congress a responsive letter, he reported that the study "d[id] not provide enough information to address the question posed by Congress

regarding the appropriateness of establishing minimum ratios."[4] The Secretary's letter went on to express "serious reservations about the reliability of staffing data at the nursing home level and with the feasibility of establishing staff ratios to improve quality given the variety of quality measures used and the perpetual shifting of such measures." Thompson Letter at 1. The Secretary also observed that the study "d[id] not fully address important related issues," including "the reality of current nursing shortages." *Id.* In light of the Secretary's report, Congress declined to impose any minimum caregiver-to-resident or supervisor-to-caregiver ratios, and instead left the existing statutory staffing requirements undisturbed.

C. Statutory Staffing Requirements for Nursing Homes

The statutory staffing requirements for nursing homes have remained substantively unchanged since 1990. They provide, in relevant part, that each facility must (1) "provide 24-hour licensed nursing services which are sufficient to meet the nursing needs of its residents"; and (2) "use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week." 42 U.S.C. §1396r(b)(4)(C)(i); *accord id.* §1395i-3(b)(4)(C)(i).

For Medicaid participants, the State in which they operate may waive *both* the requirement that a given facility "provide 24-hour licensed nursing services which are sufficient to meet the needs of its residents" *and* the requirement to use the services of an RN for at least 8 consecutive hours per day, 7 days a week, if:

> **(I)** the facility demonstrates to the satisfaction of the State that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel,
>
> **(II)** the State determines that a waiver of the requirement will not endanger the health or

[4] Letter from Tommy G. Thompson, Sec'y of Health & Human Servs., to J. Dennis Hastert, Speaker of the House of Representatives 1-2 (Mar. 19, 2002) ("Thompson Letter"), *reprinted in* Office of Asst. Sec'y for Plan. & Evaluation, Dep't of Health & Human Servs., *State Experiences with Minimum Nursing Staff Ratios for Nursing Facilities: Findings from Case Studies of Eight States* app. 1-2 (Nov. 2003), https://archive.ph/wip/KQWPt.

safety of individuals staying in the facility,

(III) the State finds that, for any such periods in which licensed nursing services are not available, a registered professional nurse or a physician is obligated to respond immediately to telephone calls from the facility,

(IV) the State agency granting a waiver of such requirements provides notice of the waiver to the State long-term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and the mentally retarded, and

(V) the nursing facility that is granted such a waiver by a State notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.

Id. §1396r(b)(4)(C)(ii). But "[i]f the Secretary determines that a State has shown a clear pattern and practice of allowing waivers in the absence of diligent efforts by facilities to meet the staffing requirements, the Secretary shall assume and exercise the authority of the State to grant waivers." *Id.* §1396r(b)(4)(C)(iii).

For Medicare participants (i.e., SNFs), the Secretary may waive the requirement to use the services of an RN for at least 8 consecutive hours per day, 7 days a week, if the Secretary finds that:

(I) the facility is located in a rural area and the supply of skilled nursing facility services in such area is not sufficient to meet the needs of individuals residing therein,

(II) the facility has one full-time registered professional nurse who is regularly on duty at such facility 40 hours a week,

(III) the facility either has only patients whose physicians have indicated (through physicians' orders or admission notes) that each such patient does not require the services of a registered nurse or a physician for a 48-hour period, or has made arrangements for a registered professional nurse or a physician to spend such time at such facility as may be indicated as necessary by the physician to provide necessary skilled nursing services on days when the regular full-time registered professional nurse is not on duty,

(IV) the Secretary provides notice of the waiver to the State long-term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and the mentally retarded, and

> **(V)** the facility that is granted such a waiver notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.

Id. §1395i-3(b)(4)(C)(ii).

Shortly after Congress enacted these statutory standards (through OBRA '87 and OBRA '90), HHS promulgated consolidated Medicare and Medicaid regulations that respect Congress' judgment by essentially parroting the statutory text. *See* 56 Fed. Reg. 48826, 48874 (Sept. 26, 1991); *see also* 54 Fed. Reg. 5316 (Feb. 2, 1989). And for more than 30 years, CMS faithfully administered the staffing standards established by Congress. *See* 42 C.F.R. §483.35(a)-(b) (2016). Indeed, as recently as 2016, CMS expressly rejected "many comment[s]" urging it to deviate from those standards by "establish[ing] and requir[ing] minimum staffing levels and requir[ing] a registered nurse to be in the LTC facility 24 hours a day, 7 days a week." 81 Fed. Reg. 68688, 68754 (Oct. 4, 2016). While CMS claimed (without explanation) that it had the statutory authority to impose its own standards and suggested that it might do so in a future rulemaking, it reiterated its longstanding view that "a 'one size fits all' approach" to nursing home staffing is inappropriate. *Id.* at 68755.

In doing so, CMS emphasized its "concerns about [imposing] mandatory ratios" or requiring "a 24/7 RN presence." *Id.* at 68756; *see id.* at 68754-56, 68758. For example, CMS felt it was unable to "determin[e] a 'right' number for any staffing ratio," *id.* at 68576, because "LTC facilities are varied in their structure and in their resident populations," *id.* at 68758; *see also* 80 Fed. Reg. 42168, 42201 (July 16, 2015) (emphasizing the importance of "taking acuity levels into account"). CMS instead opined that the "focus" of its regulations "should be on the skill sets and specific competencies of assigned staff to provide the nursing care a resident needs rather than a static number of staff or hours of nursing care." 80 Fed. Reg. at 42201; *accord id.* at 42200 ("A

focus on numbers of nurses fails to address the influence of other staffing factors (for example, turnover and agency staff use), training and experience of staff, and care organization and management."). CMS also cautioned "that establishing a specific number of staff or hours of nursing care could result in staffing to that number rather than to the needs of the resident population." *Id.* at 42201. Finally, CMS expressed concern that requiring 24/7 RN presence in every facility "could negatively impact the development of innovative care options, particular[ly] in smaller, more home-like settings," and that "geographic disparity in supply could make such a mandate particularly challenging in some rural and underserved areas." 81 Fed. Reg. at 68755.

II. CMS Adopts New Minimum Staffing Requirements

A. The White House Orders CMS to Promulgate Minimum Staffing Regulations.

In February 2022, the Biden Administration announced its intention to "establish a minimum nursing home staffing requirement." AR_00073200; AR_00073202. But the Administration did not call upon Congress to revise the governing statutes to accomplish this objective—even though Congress has repeatedly considered and rejected that approach. The Administration instead tasked *CMS* with (1) "conduct[ing] a new research study to determine the level and type of staffing needed to ensure safe and quality care"; and (2) "issu[ing] proposed rules" by February 2023 setting forth its own "minimum standards for staffing adequacy that nursing homes must meet." AR_00073202.

Shortly thereafter, CMS commissioned a private firm, Abt Associates, to perform the staffing study. AR_00069983. The staffing study was not published, however, until June 2023, which was several months after the Administration's self-imposed deadline for issuing a proposed minimum staffing rule. *Compare id.*, *with* AR_00073202. And when it finally was released, the study did not support the Administration's desired conclusion. For example, one of its "key findings" was that, while recent literature indicates that higher staffing levels are generally

correlated with better outcomes, "it does not provide a clear evidence basis for setting a minimum staffing level." AR_00069993. And it concluded that there is "no obvious plateau at which quality and safety are maximized or 'cliff' below which quality and safety steeply decline." *Id.*

The study also cited a wealth of evidence and feedback confirming that it makes no sense to mandate staff-to-patient ratios without accounting for variations in resident acuity. *See, e.g.*, AR_00070006 ("Nursing homes with higher-acuity or more clinically complex residents can require a higher level of staffing to meet resident needs."); AR_00070021 ("Existing literature confirms the importance of resident acuity in determining staffing needs."); AR_00070030 ("Direct care respondents (RNs, LPNs, nurse aides) consistently noted that resident acuity was more important than the actual number of assigned residents in determining whether their assignments were reasonable."). That should have come as no surprise to CMS, as the agency and its predecessors repeatedly embraced that very reasoning in rejecting calls to impose staff-to-patient ratios from the early 1970s all the way through 2016. *See, e.g.*, 39 Fed. Reg. at 2239 (explaining that "variation" in "patient needs and the services necessary to meet those needs precludes setting" "a specific ratio of nursing staff to patients"); 80 Fed. Reg. at 42201 (emphasizing the importance of "taking acuity levels into account").

Moreover, the study explained that many stakeholders, from nursing home owners and operators to nursing staff interviewees, "emphasized that workforce shortages and current hiring challenges could present barriers to nursing home compliance with a new federal staffing requirement." AR_00070003; *see also, e.g.*, AR_00069994; AR_00069996; AR_00070023; AR_00070035-AR_00070036. But the study ultimately dodged the crucial question of whether—notwithstanding the national workforce shortage, uneven workforce distribution, and limited access to training and education programs—it would even be feasible to implement a nationwide

minimum staffing requirement, claiming that it "was not a workforce study." AR_00070003.

B. The Proposed Rule Draws Widespread Opposition.

Undeterred, CMS forged ahead with the Administration's demand. On September 6, 2023, CMS published a proposed rule announcing rigid and demanding new minimum staffing requirements for all LTC facilities that would exceed those imposed by any of the States that have minimum requirements of their own. *See* 88 Fed. Reg. 61352 (Sept. 6, 2023). In response, the American Health Care Association ("AHCA"), Texas Health Care Association ("THCA"), LeadingAge, and a host of other stakeholders submitted detailed comments urging CMS not to adopt its proposed rule. AR_00057751-AR_00057795; AR_00056958-AR_00056962; AR_00066193-AR_00066202. Among others, those opposed to the rule included:

- The American Hospital Association, which represents nearly 5,000 hospitals and health systems, 2,425 post-acute care members, and professional membership groups and affiliates, including the American Organization for Nursing Leadership. AR_00022863-AR_00022871.
- The National Rural Health Association, a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. AR_00033554-AR_00033561; *see also* AR_00067693-AR_00067694.
- Catholic Charities USA, a national organization whose members operate more than 3,500 charitable institutions across the country, including skilled nursing facilities, hospice care, and a variety of other services for the elderly; and the Catholic Health Association of the United States, which represents more than 2,200 Catholic health care sponsors, systems, hospitals, long-term care facilities and related organizations across the continuum of care. AR_00060015-AR_00060021.

- Lutheran Services in America, a network of about 300 Lutheran health and human services nonprofit organizations serving over 1,400 communities across the country. AR_00011374-AR_000113781.
- The Jewish Federations of North America, which is one of the largest networks of social service providers in the country, supporting 15 medical centers, 95 nursing homes, 140 Jewish family services agencies, and more than 30 group homes. AR_00057106-AR_00057110; *see also* AR_00067693-AR_00067694 (opposition to the Final Rule from Jewish Aging Services).
- The National Association of State Veterans Homes, an all-volunteer organization that is dedicated to promoting and enhancing the quality of care and life for veterans in more than 150 skilled nursing care programs across the country. AR_00043460-AR_00043462; *see also* AR_00067693-AR_00067694.
- Members of the Medicare Payment Advisory Commission ("MedPAC"), a nonpartisan independent legislative branch agency that provides Congress with analysis and policy advice on the Medicare program. *See* AR_00068969; AR00033170 & n.1; AR_00057772; AR_00057631 & n.16.

These and other commenters repeatedly explained that CMS's effort to dictate precise minimum staffing ratios and mixes for all facilities exceeded its statutory authority, contravened Congress' considered decision to impose qualitative rather than quantitative staffing standards, failed to account for the widely varying circumstances and needs of the thousands of LTC facilities across the country, and threatened to force nursing homes to close their doors and deprive residents of much-needed care.

C. CMS Issues the Final Rule.

CMS nevertheless pressed forward, publishing the Final Rule in the Federal Register on May 10, 2024. The Final Rule imposes two mandatory minimum staffing requirements on nursing homes, the second of which includes three mandatory sub-parts.

24/7 RN Requirement. First, the Final Rule replaces the statutory requirement that nursing homes "use the services of [an RN] for at least 8 consecutive hours a day, 7 days a week," 42 U.S.C. §1396r(b)(4)(C)(i); *accord id.* §1395i-3(b)(4)(C)(i), with a new requirement to "have a registered nurse (RN) onsite 24 hours per day, for 7 days a week that is available to provide direct resident care," 89 Fed. Reg. at 40997. In other words, it triples the required hours per day of RN services, raising the bar from the 8 hours per day that Congress prescribed to 24 hours per day. The Final Rule also alters the scope of the requirement, mandating that facilities must not just "use the services" of an RN (including in administrative or supervisory roles, 42 U.S.C. §1396r(b)(4)(C)(i); *accord id.* §1395i-3(b)(4)(C)(i), but have an RN "onsite" and "available to provide direct resident care," 89 Fed. Reg. at 40997.

HPRD Requirements. Second, the Final Rule departs from the qualitative statutory requirement that nursing homes "provide 24-hour licensed nursing services which are sufficient to meet the nursing needs of its residents," 42 U.S.C. §1396r(b)(4)(C)(i); *accord id.* §1395i-3(b)(4)(C)(i), by instead imposing three rigid quantitative requirements:

- "The facility must meet or exceed a minimum of 3.48 hours per resident day for total nurse staffing," which must include—
- "[a] minimum of 0.55 hours per resident day for registered nurses"; and
- "[a] minimum of 2.45 hours per resident day for nurse aides."

89 Fed. Reg. at 40996.

The Final Rule also extends the statutory waiver for Medicaid participants (*see supra*

pp.11-12) to the new 24/7 RN requirement and the 0.55 RN HPRD requirement, but not to the 3.48 total nurse HPRD or 2.45 NA HPRD requirements. 89 Fed. Reg. at 40997-98. The Final Rule likewise extends the statutory waiver for Medicare participants (*see supra* pp.12-13) to the new 24/7 RN requirement, but not the HPRD requirements. 89 Fed. Reg. at 40997-98. Neither of these statutory waivers will provide any widespread relief from the Final Rule's rigid requirements; in fact, despite the long-running nationwide shortage of nursing staff, very few facilities have been able to obtain those waivers to date even as to the existing statutory requirements. *See, e.g.*, AR_00066198-AR_00066199; AR_ 00062828.

The Final Rule also creates a new regulatory "hardship exemption" that can be used to obtain a partial exemption from the new 24/7 RN requirement and an exemption from one or more of the HPRD requirements. *See* 89 Fed. Reg. at 40998. To qualify for a "hardship exemption," the facility must establish that it meets four criteria:

> (1) "The facility is located in an area where the supply of applicable healthcare staff (RN, nurse aide (NA), or total nurse staffing ...) is not sufficient to meet area needs as evidenced by a provider to population ratio for nursing workforce that is a minimum of 20 percent below the national average, as calculated by CMS";
>
> (2) "The facility demonstrates that it has been unable, despite diligent efforts, including offering at least prevailing wages, to recruit and retain appropriate personnel";
>
> (3) "The facility demonstrates through documentation the amount of financial resources that the facility expends on nurse staffing relative to revenue"; and
>
> (4) "The facility: (i) Posts, in a prominent location in the facility, and in a form and manner accessible and understandable to residents, and resident representatives, a notice of the facility's exemption status, the extent to which the facility does not meet the minimum staffing requirements, and the timeframe during which the exemption applies; and (ii) Provides to each resident or resident representative, and to each prospective resident or resident representative, a notice of the facility's exemption status, including the extent to which the facility does not meet the staffing requirements, the timeframe during which the exemption applies, and a statement reminding residents of their rights to contact advocacy and oversight entities ... ; and (iii) Sends a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.

Id. at 40998. Notably, the criteria that CMS chose to govern its newly-invented "hardship exemption" differ substantially from the statutory criteria that Congress has set for the statutory waiver scheme. *See supra* pp.11-13.

It also fails to provide facilities with any meaningful relief. As the Final Rule emphasizes, the "hardship exemption" will be "available only in limited circumstances," and only "after a facility is surveyed and determined to be out of compliance with the [HPRD] staffing requirement." 89 Fed. Reg. at 40877, 40902; *accord id.* at 40894, 40899. Even if it is obtained, moreover, the "hardship exemption" for the new 24/7 RN requirement is only a partial one, as it provides only "an exemption of 8 hours a day"; in other words, a facility that obtains such an exemption must still have an RN "onsite" and "available to provide direct resident care" for at least 16 hours per day, 7 days per week (twice the level that Congress has required by statute). *Id.* at 40997-98. In addition, any facility that receives a hardship exemption from the 24/7 RN requirement "must have a registered nurse, nurse practitioner, physician assistant, or physician available to respond immediately to telephone calls from the facility" whenever there is no RN onsite. *Id.* at 40997. And a facility may not obtain *any* "hardship exemption" if it has been designated a "Special Focus Facility," which indicates that CMS has "identified [it] as having substantially failed to meet" applicable requirements of Medicare or Medicaid, *see* 42 U.S.C. §§1395i-3(f)(8), 1396r(f)(10); has received a citation from CMS within the past 12 months related to staffing-related issues; or has "failed to submit Payroll Based Journal data in accordance with [42 C.F.R.] § 483.70(p)." 89 Fed. Reg. at 40998.

The Final Rule's policies are to be phased in over the next several years. *Id.* at 40913. Facilities in non-rural areas must implement the 24/7 RN and the 3.48 total nurse HPRD requirements within 2 years and the 0.55 RN and 2.45 NA HPRD requirements within 3 years. *Id.*

Rural facilities must implement the 24/7 RN and the 3.48 total nurse HPRD requirements within 3 years and the 0.55 RN and 2.45 NA HPRD requirements within 5 years. *Id.*

D. The Final Rule Threatens to Harm a Wide Array of Stakeholders, Including Plaintiffs and Their Constituents.

AHCA is the largest association representing nursing homes in the United States, with a membership of more than 14,000 care providers. AR_00057751. Its Texas affiliate, THCA, is the largest association of nursing homes in Texas. AR_00056958. Shortly after the Final Rule was published, AHCA and THCA, joined by three facilities operating in the Northern District of Texas, filed suit to challenge it. Dkt.1.[5] Their lawsuit was joined a few weeks later by LeadingAge—a membership organization of over 5,400 nonprofit aging service providers and other mission-driven organizations serving older adults, including approximately 2,100 long-term care facilities across the United States. Dkt.26 ¶15. The State of Texas subsequently filed its own lawsuit challenging the Final Rule, and the cases have since been consolidated. *See* No. 2:24-cv-171, Dkt.1; Dkt.52.[6]

As Plaintiffs detailed in their complaints and their comments to CMS, the Final Rule will impose significant burdens not only on the nursing homes that are parties to this action, but on thousands of nursing homes throughout Texas and elsewhere that are represented by AHCA, LeadingAge, and THCA. All told, CMS estimates that the Final Rule will cost nursing homes more than $5 billion per year (in 2021 dollars) after the phase-in period. 89 Fed. Reg. at 40970, tbl.22; *see id.* at 40949. Separate analyses by LeadingAge and CliftonLarsonAllen predict that the costs will be even higher—around $7 billion per year. *See id.* at 40950; AR_00066194. But even under CMS's unduly low estimate, nursing homes are in no position to cope with this massive

[5] All docket citations are to the lead case, No. 2:24-cv-114, unless otherwise noted.

[6] Per joint and unopposed motions granted by this Court, all parties have agreed that the case can be resolved on summary judgment based on the administrative record, without discovery. *See* Dkt.45 at 1-2; Dkt.47; Dkt.48 at 6; Dkt.52.

unfunded mandate. As AHCA explained in its comments on the proposed rule, "nearly 60 percent of [LTC] facilities have negative operating margins." AR_00057756. Compounding the problem, average Medicaid rates "cover approximately only 84% of the cost of care"—a substantial deficit, given that Medicaid "is the primary payer of long-term care." AR_00066194. For nursing homes that are already struggling to stay afloat, the Final Rule imposes additional costs that could force them to close their doors for good.

Those costs will fall on nursing homes across the nation. CMS estimates that more than 79% of the nursing homes in the United States—nearly *four out of every five*—will have to find additional staff to comply with the new minimum staffing requirements, which "exceed the existing minimum staffing requirements in nearly all States." 89 Fed. Reg. at 40877. On the national level, CMS projects that the Final Rule will require facilities to hire an additional 15,906 RNs to meet the 24/7 RN requirement and 0.55 RN HPRD requirement (a staffing increase of about 11.8%), plus an additional 77,611 NAs to meet the 2.45 NA HPRD requirement and 3.48 total nurse HPRD requirement (a staffing increase of about 17.2%). *See id.* at 40958, tbl.16; *id*. at 40977-80, tbls.25 & 26

These staffing increases will be practically impossible to attain, as nursing homes are already experiencing major challenges finding and retaining qualified nursing staff even without the massive artificial increase in demand that the Final Rule will create. *See, e.g.*, AR_00066194. Many of AHCA's and LeadingAge's member facilities have vacant nursing positions that have been sitting open for months due to a dearth of qualified candidates. AR_00057756; *see* AR_00066194; AR_00066196-AR_00066198. The long-term care workforce remains about 125,000 workers below its pre-pandemic levels; hundreds of thousands of nurses are expected to retire or leave the profession in the coming years; and a shortage of nursing school faculty has

contributed to a decrease in nursing program enrollment for the first time in more than two decades. *See* AR_00057756; AR_00066194.

The Final Rule's adverse effects will be especially pronounced in Texas. According to CMS, "Texas will need to hire the most [additional] RNs" *of any state* to meet the new staffing standards—approximately 653 RNs to comply with the 24/7 RN requirement, plus another 1,926 RNs to comply with the 0.55 RN HPRD requirement. 89 Fed. Reg. at 40957, 40976-80. That is a *46.1%* increase in the number of RNs presently employed by nursing homes in Texas. *See id.* Texas will require approximately 7,887 additional NAs to meet the other HPRD requirements, which represents an increase of 28.4%. *See id.* at 40978, 40980. All in all, CMS acknowledges that Texas facilities alone will collectively need to spend nearly *half a billion dollars* per year to comply with these new requirements—$84 million on the 24/7 RN requirement, and another $409 million on the three HPRD requirements. *See* 89 Fed. Reg. at 40958, 40960, 40983.

Nursing homes are unable to absorb these additional costs on top of the rising costs of care, chronic underfunding of Medicaid, and ongoing inflationary factors. AR_00056961. As THCA explained in its comments, Texas simply does not have the manpower to implement these requirements, as it "is already short of thousands of RNs and []NAs." AR_00056959. And while nursing homes in Texas employ nearly 60,000 LVNs—the second largest number of any State—the Final Rule does not allow hours worked by LPNs/LVNs to be counted toward the NA HPRD requirement, even though LPNs/LVNs complete more education and training than NAs. *See supra* pp.4 & n.1; *cf.* 89 Fed. Reg. at 40897 (noting that either RNs or LPNs/LVNs—but not NAs—can be used to meet the statutory requirement of 24-hour *licensed* nursing services). As LeadingAge warned in its comments, without the opportunity to use LPNs to meet RN or NA requirements, the Final Rule "marginalizes the contributions of LPNs in the long-term care [sector]," which

"employs more LPNs than any other sector." AR_00066195.

To make matters worse, CMS is imposing these massive burdens on thousands of nursing homes that already provide high-quality care for their residents, and already comply with any state-law minimum staffing standards that their state governments have set in light of local conditions. Nursing homes use a variety of staffing blends to meet the unique needs of their resident populations, and many achieve above-average ratings on health inspections and quality measures even though they do not satisfy CMS's arbitrary new staffing requirements. The three facilities that are Plaintiffs in this case illustrate the point:

- Arbrook Plaza has a 4-star overall rating from CMS, including quality measures that are "much above average" and health inspections that are "above average." Medicare.gov, *Care Compare: Arbrook Plaza*, https://tinyurl.com/2p967zth (last visited Oct. 18, 2024).[7] It delivers these results with an average of 0.23 RN HPRD, 0.93 LVN HPRD, and 2.08 NA HPRD. *Id.* Even though Arbrook Plaza receives high marks across the board on resident care, and already complies with the minimum staffing standards set by Texas law, *see* 26 Tex. Admin. Code §554.1001-.1002, the Final Rule will force it to begin providing 24/7 RN services, nearly triple its RN HPRD, and significantly increase its NA HPRD.
- Booker Hospital District operates Twin Oaks, which has a 5-star overall rating from CMS. Medicare.gov, *Care Compare: Booker Hospital District Dba Twin Oaks Manor*, https://tinyurl.com/2tbkya7u (last visited Oct. 18, 2024). By CMS's own account, Twin Oaks' staffing is "much above average" and its health inspections are "above average." *Id.*

[7] Information from the Medicare website and the Texas State Veterans Homes website, *see infra* p.26, is subject to judicial notice. *See* Fed. R. Evid. 201(b) (authorizing judicial notice of facts that "can be accurately and readily determined from sources whose accuracy cannot reasonably be questioned").

Twin Oaks is the only Plaintiff facility that is currently in compliance with CMS's new HPRD requirements; indeed, it currently offers 7.05 HPRD of total nurse staffing, which is nearly *double* the national average. *Id.* Nevertheless, the Final Rule will require Twin Oaks to recruit and hire additional RNs to meet the 24/7 RN requirement—an extremely daunting task for a 61-bed facility located in one of the most rural parts of the Texas panhandle.

- Harbor Lakes has a 5-star overall rating from CMS, including quality measures that are "much above average" and health inspections that are "above average." Medicare.gov, *Care Compare: Harbor Lakes Nursing and Rehabilitation Center*, https://tinyurl.com/bdem8brn (last visited Oct. 18, 2024). It also meets the minimum staffing standards established by Texas law. *See* 26 Tex. Admin. Code §554.1001-.1002. Harbor Lakes is able to provide high-quality care thanks to a staffing mix that includes 0.97 HPRD of LVN services. Medicare.gov, *Care Compare: Harbor Lakes*, *supra*. But because the Final Rule irrationally discounts (indeed, largely ignores) the contributions of LVNs, Harbor Lakes would have to significantly increase its RN and NA staffing to comply. Despite its high-quality ratings, the facility does not currently meet the 24/7 RN requirement, the 0.55 RN HPRD requirement, or the 2.45 NA HPRD requirement. *Id.*

The Final Rule injures not only these (and countless other) private facilities, but the State of Texas itself. First, CMS's new standards conflict with the minimum staffing standards enshrined in Texas law, overriding duly enacted State regulations and thereby reducing the State's authority and control over healthcare. *See* 26 Tex. Admin. Code §554.1002(a)(1) (setting minimum staffing levels at 0.4 "licensed-care hours per resident day"). As the Fifth Circuit has recognized, States are injured by "federal assertions of authority to regulate matters" that States would otherwise

control. *Texas v. United States*, 809 F.3d 134, 153 (5th Cir. 2015). In addition, Texas faces a direct injury due to the impact the Final Rule will have on long-term care facilities that the State owns and operates, which serve veterans, their spouses, and Gold Star parents. *See* Tex. Veterans Land Bd., *Texas State Veterans Homes*, https://vlb.texas.gov/veterans-homes/index.html (last visited Oct. 18, 2024). These State-run facilities participate in Medicare and Medicaid and are therefore subject to the Final Rule's new minimum-staffing requirements. *See, e.g.*, Medicare.gov, *Care Compare: Alfredo Gonzalez Texas State Veterans Home*, https://tinyurl.com/yc7uxvch (last visited Oct. 18, 2024) (State-owned facility with a 5-star overall rating from CMS that does not currently satisfy the 24/7 RN requirement, 0.55 HPRD RN requirement, or 2.45 HPRD NA requirement). Consequently, the Final Rule deprives Texas of vital flexibility in how it chooses to operate its own facilities, and will require Texas to absorb the costs and other adverse effects of one-size-fits all staffing levels.

And the harms imposed by the Final Rule extend even further. More than 500 nursing homes closed over the course of the COVID-19 pandemic, and very few of those have reopened or been replaced by new facilities. AR_00057756; *see also* AR_00056961 (noting that, "[s]ince March 2020, 56 skilled nursing facilities have closed" in Texas alone). By imposing a massive, unfunded staffing mandate at a time when there is already an inadequate supply of RNs and NAs, the Final Rule will force scores of additional nursing homes to reduce their capacity or even shut down entirely. AR_00057758-AR_00057759; AR_00057761; AR_00056962; AR_00066194. This would have a hugely detrimental effect on access to long-term care, in derogation of CMS's statutory charge. In fact, according to CliftonLarsonAllen's analysis, the Final Rule could cause nearly *one quarter* of nursing home residents to be displaced from their current nursing home, while forcing countless other seniors and family members to wait longer, search farther, and pay

more for the care they need. AR_00057758; *see also* AR_00056961-AR_00056962.

LEGAL STANDARD

Summary judgment is the appropriate mechanism for review of agency action under the Administrative Procedure Act. *Girling Health Care, Inc. v. Shalala*, 85 F.3d 211, 214 (5th Cir. 1996). In reviewing the agency's decision, the district court does not act as the finder of fact; the court must instead decide the case based on "the record compiled before the administrative agency." *Garcia for Cong. v. FEC*, 22 F. Supp. 3d 655, 658 (N.D. Tex. 2014). And the court must grant summary judgment to the challenger, and "set aside [the] agency action," if it determines that the action was "in excess of statutory … authority," "arbitrary," "capricious," or "otherwise not in accordance with law." 5 U.S.C. §706(2)(A), (C).

ARGUMENT

I. Each Of The New Staffing Requirements Exceeds CMS's Statutory Authority.

Like all administrative agencies, CMS is a "creature[] of statute" and "accordingly possess[es] only the authority that Congress has provided." *Nat'l Fed'n of Indep. Bus. v. Dep't of Lab.*, 595 U.S. 109, 117 (2022); *see also, e.g.*, *La. Pub. Serv. Comm'n v. FCC*, 476 U.S. 355, 374 (1986) ("[A]n agency literally has no power to act … unless and until Congress confers power upon it."). That well-established principle dooms the Final Rule, as Congress has not authorized CMS to depart from the statutory standards that Congress itself set by imposing the agency's own 24/7 RN requirement and HPRD requirements.

A. CMS Lacks Statutory Authority To Impose the 24/7 RN Requirement.

Congress has specified the minimum amount of RN staffing necessary to participate in Medicaid or Medicare: All LTC facilities "must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week." 42 U.S.C. §1396r(b)(4)(C)(i); *accord id.* §1395i-3(b)(4)(C)(i). The Final Rule impermissibly alters this statutory requirement in two

distinct ways. First, it triples the hours of mandatory RN staffing, replacing the 8 hours per day, 7 days a week ("8/7") RN requirement that Congress set with a mandate that all LTC facilities "must have a registered nurse (RN) onsite 24 hours per day, for 7 days a week." 89 Fed. Reg. at 40997. Second, the Final Rule replaces the statutory requirement to "use the services of" an RN, including in administrative or supervisory roles, with a new requirement to have an RN "available to provide direct resident care." *Id.*

CMS has no statutory authority to impose those deviations from the requirements Congress set. Indeed, the agency does not even try to argue that the statutory provisions setting forth the 8/7 requirement for RN staffing empower it to substitute a 24/7 RN requirement. *See* 89 Fed. Reg. at 40891 (disclaiming reliance on §§1395i-3(b)(4)(C) or 1396r(b)(4)(C) as source of statutory authority). That concession should come as no surprise, as even in the heyday of *Chevron* deference, a statutory requirement of X was not an invitation for the agency to require 3X. *See Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837 (1984), *overruled by Loper Bright Enters. v. Raimondo*, 144 S.Ct. 2244 (2024).

CMS instead claims that "various provisions" elsewhere in §§1395i-3 and 1396r that have nothing to do with staffing requirements imbue it with a more sweeping "separate authority" to alter Congress' carefully crafted regime as it sees fit. *See id.* at 40879, 40890-91. In particular, CMS points to general provisions stating that:

- The Secretary may impose "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. §1396r(d)(4)(B); *accord* 42 U.S.C. §1395i-3(d)(4)(B);
- An LTC facility "must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care," 42 U.S.C. §1396r(b)(2); *accord* 42 U.S.C. §1395i-3(b)(2); and

- An LTC facility "must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident," 42 U.S.C. §1396r(b)(1)(A); *accord* 42 U.S.C. §1395i-3(b)(1)(A).

But while these provisions may give CMS some measure of authority "to 'fill up the details' of [the] statutory scheme," it remains the job of this Court to "fix[] the boundaries of [the] delegated authority." *Loper Bright*, 144 S.Ct. at 2263. And in executing that task, the Court does not defer to the agency's assessment of its own authority; instead, the Court must "independently interpret the statute" and "use every tool at [its] disposal to determine the best reading of the statute." *Id.* at 2263, 2266; *cf. Kisor v. Wilkie*, 588 U.S. 558, 576 (2019) (when interpreting an agency regulation, the court must "employ[] all its interpretive tools" to "establish the outer bounds of permissible interpretation").

Here, traditional tools of statutory interpretation make crystal clear that CMS lacks statutory authority to replace the statutory 8/7 RN requirement with a regulatory 24/7 RN requirement. It is well established that "[g]eneral language" in one part of a statute "will not be held to apply to a matter specifically dealt with in another part of the same enactment." *RadLAX Gateway Hotel, LLC v. Amalgamated Bank*, 566 U.S. 639, 645-46 (2012) (quoting *D. Ginsberg & Sons, Inc. v. Popkin*, 285 U.S. 204, 208 (1932)). Whatever the scope of the Secretary's general authority to impose "*other* requirements," 42 U.S.C. §§1395i-3(d)(4)(B), 1396r(d)(4)(B) (emphasis added), and flesh out the "services," "activities," and "care" that nursing homes must provide, *id.* §§1395i-3(b)(1)(A), (b)(2), 1396r(b)(1)(A), (b)(2), it does not include the power to modify the requirements specifically enacted by Congress.

Yet that is exactly what the Final Rule does. As CMS itself recognizes, the Final Rule "revises" the statutory 8/7 RN requirement codified at 42 U.S.C. §§1395i-3(b)(4)(C)(i) and 1396r(b)(4)(C)(i), replacing it with CMS's preferred 24/7 RN requirement. *See* 89 Fed. Reg. at

40898. That is not a decision that Congress left open for CMS to make. After all, a general grant of rulemaking power cannot sensibly be understood as an invitation to revisit decisions that Congress has reserved for itself. Indeed, the Social Security Act itself explicitly guards against that result by confirming that the Secretary may not "publish ... rules and regulations" that are "inconsistent with" provisions of the Act. 42 U.S.C. §1302(a); *see* 89 Fed. Reg. at 40897-99 (acknowledging that detailed statutory scheme for waiving the 8/7 RN requirement "can only be modified by legislation"). Because the 24/7 RN requirement plainly flunks that test, it must be set aside. *See* 5 U.S.C. §706(2).

B. CMS Lacks Statutory Authority to Impose the HPRD Requirements.

The same goes for the Final Rule's HPRD requirements. Congress has extensively considered whether to impose staff-to-patient ratios on LTC facilities, and it has repeatedly chosen not to do so. Instead of a rigid one-size-fits-all quantitative requirement, Congress opted for a flexible qualitative standard: An LTC facility must provide nursing services "sufficient to meet the nursing needs of its residents." 42 U.S.C. 1396r(b)(4)(C)(i); *accord* §1395i-3(b)(4)(C)(i).

Once again, the Final Rule impermissibly substitutes CMS's current policy views for Congress' considered judgment, replacing that flexible standard with a rule of almost comical rigidity and specificity. By requiring every nursing home in the country to provide "a minimum of 3.48 hours per resident day for total nurse staffing[,] including but not limited to—(i) [a] minimum of 0.55 hours per resident day for registered nurses; and (ii) [a] minimum of 2.45 hours per resident day for nurse aides," it replaces the adaptable standard that Congress consciously chose—which accommodates the wide variation in resident needs across different States, localities, and facilities—with an inflexible mandate that each facility must meet an arbitrary numerical staffing threshold. 89 Fed. Reg. at 40996. Making matters worse, the requirement to have RN staffing of at least 0.55 HPRD conflicts with Congress' decision to set the statutory

requirement for RN staffing at 8 consecutive hours per day. Indeed, CMS all but admitted as much by extending the statutory waiver that Congress crafted for the 8/7 RN requirement to not only its new 24/7 RN requirement but also its new 0.55 RN HPRD requirement. *See* 89 Fed. Reg. at 40997.

Once again, these are not choices Congress has authorized CMS to make. Indeed, just as with the new 24/7 RN requirement, CMS does not and cannot claim that it has discretion under §1395i-3(b)(4)(C) and §1396r(b)(4)(C) themselves to replace the qualitative standard Congress adopted with quantitative requirements of the agency's own making. Instead, CMS once again invokes only the Secretary's general authority to impose "necessary" requirements relating to residents' health and safety, as well as provisions requiring nursing homes to "provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident," and "promote maintenance or enhancement of the … quality of life of each resident." 89 Fed. Reg. at 40879, 40890-91; *see* 42 U.S.C. §§1395i-3(b)(1)(A), (b)(2), (d)(4)(B); 1396r(b)(1)(A), (b)(2), (d)(4)(B).

But none of those provisions empowers CMS to impose rigid HPRD requirements for RNs, NAs, and total nursing staff. Again, CMS's general authority over Medicare and Medicaid does not permit it to modify "matter[s] specifically dealt with in another part of the same enactment." *RadLAX Gateway Hotel*, 566 U.S. at 646; *see also* 42 U.S.C. §1302(a) (CMS may not promulgate regulations that are "inconsistent with" statutory requirements). Congress squarely considered the question of whether to impose rigid one-size-fits-all staffing requirements on nursing homes, and other than the 8/7 RN requirement, it chose to require only that each facility maintain staffing levels "sufficient to meet the nursing needs of its residents." 42 U.S.C. §§1396r(b)(4)(C), 1395i-3(b)(4)(C). That language itself leaves no room for CMS to supersede Congress' judgment with its own numerical requirements. Indeed, the Secretary's insistence that one-size-fits-all HPRD

levels "are necessary for resident health, safety, and well-being," 89 Fed. Reg. at 40890, is flatly at odds with Congress' determination that sufficient staffing levels should be determined by reference to the particularized needs of each facility, based on its unique mix of residents with varying needs and levels of acuity. The Secretary's claim is also belied by the agency's own survey process, which indicates that "roughly 95 percent of facilities" are already "providing 'sufficient nursing staff'" without its arbitrary new staffing requirements. AR_00057776.

Nevertheless, the Final Rule makes clear that it will no longer be sufficient for a nursing home to satisfy the statutory requirement that Congress set by "provid[ing] 24-hour licensed nursing services which are sufficient to meet the nursing needs of its residents," 42 U.S.C. §1396r(b)(4)(C), through any suitable combination of RNs, NAs, LPNs/LVNs, and other caregivers and support staff—as Congress envisioned, and as Plaintiffs Arbrook Plaza, Twin Oaks, and Harbor Lakes all currently do. Instead, all nursing homes will now be required to comply with CMS's rigid HPRD requirements, even if "the facility assessment indicates that a lower HPRD [is sufficient] or that a 24/7 RN is not required to care for their resident population." 89 Fed. Reg. at 40908. That is flatly contrary to the approach that Congress adopted, and CMS has no power to override Congress' judgment. Because the Final Rule exceeds CMS's authority by rewriting the requirements that Congress set, it must be set aside.

C. The Major Questions Doctrine Confirms That Congress Did Not Grant CMS the Sweeping Authority It Now Claims.

To the extent there were any doubt about whether CMS has the authority it claims, the major questions doctrine eliminates it. When (as here) a court interprets a statute "that confers authority upon an administrative agency," the court's analysis "must be shaped, at least in some measure," by "whether there are 'reason[s] to hesitate before concluding that Congress meant to confer [the] authority'" the agency seeks to wield. *Texas v. Nuclear Regul. Comm'n*, 78 F.4th 827,

844 (5th Cir. 2023) (quoting *West Virginia v. EPA*, 597 U.S. 697, 721 (2022)). Those principles are given effect through the major questions doctrine, which "counsels skepticism" toward expansive assertions of agency power. *West Virginia*, 597 U.S. at 732; *see id.* at 723-24. As the Fifth Circuit recently held, that doctrine comes into play whenever an agency "claims the power to resolve a matter of great political significance'" or "seeks to … require billions of dollars in spending by private persons or entities." *Mayfield*, 2024 WL 4142760, at *2 (quoting *West Virginia*, 597 U.S. at 743-44 (Gorsuch, J., concurring)). Either of those two indicators "independently trigger[s] the doctrine," *id.*, and both are present here.

First, nationwide nursing-home-staffing requirements are an issue of great political significance, as evidenced by the considerable attention Congress has given the matter over the past several decades. For more than half a century, Congress—not CMS or its predecessors—has taken the lead in setting staffing requirements for nursing homes that participate in the Medicare and Medicaid programs. *See supra* pp.6-11. And on the rare occasions when CMS has tried to usurp that power, Congress has stepped in. Most notably, Congress has *twice* acted to block major regulatory changes that could have forced nursing homes to comply with one-size-fits-all staffing requirements—first in 1980, when it prohibited HHS from using appropriated funds to publish final regulations, Pub. L. No. 96-536, §119, 94 Stat. at 3172, and again in 1987, when it extensively amended the statute to terminate a rulemaking that proposed new staffing standards, Pub. L. No. 100-203, 101 Stat. 1330; *see supra* pp.7-10. A few years later, Congress underscored its intent to govern nursing home staffing through legislation—not agency regulation—by specifically instructing HHS to *study* potential minimum staffing requirements for nursing homes and provide a report with recommendations for *Congress* to consider. *See* Pub. L. No. 101-508, §4801(e)(17), 104 Stat. at 1388-218 to -219. Congress has not altered the statutory staffing requirements for

LTC facilities since 1990, and the relevant agency regulations have mirrored those statutory standards for well over three decades. *See supra* pp.11-14. That history of repeated legislative action on this sharply contested issue belies any assertion that Congress authorized CMS to impose its own solution. Yet by promulgating the Final Rule, CMS has "adopt[ed] a regulatory program that Congress ha[s] conspicuously and repeatedly declined to enact itself," in an area where Congress has made clear that it, not CMS, should be the primary regulator. *West Virginia*, 597 U.S. at 724.

The second major questions trigger is even more clearly satisfied, as CMS openly acknowledges that the Final Rule would "require billions of dollars in spending by private persons or entities.'" *Mayfield*, 2024 WL 4142760, at *2. After its initial phase-in period, the Final Rule would cost over $5 billion per year (in CY 2021 dollars)—nearly all of which would be borne by nursing homes, with no additional support from the Medicare and Medicaid programs they service. *Id.* at 40970, tbl.22; *see id.* at 40970-71 ("This final rule does not include any provisions requiring Medicare, Medicaid, or other non-Medicare/Medicaid payors to increase payment rates to providers to meet any or all of the costs of [its] requirements"); *id.* at 40949 ("[O]ur cost estimates assume that LTC facilities and not payors will bear the rule's costs."). By CMS's own estimate, the Final Rule would require more than 79% of LTC facilities—nearly *four out of every five* facilities in the country—to increase their staffing levels. 89 Fed. Reg. at 40877. All told, facilities would need to hire approximately 15,906 additional RNs (a staffing increase of about 11.8%) and 77,611 additional NAs (a staffing increase of about 17.2%). *See* 89 Fed. Reg. at 40958, tbl.16; *id.* at 40977-80, tbls.25 & 26. These massive burdens could force many facilities to limit their capacity or close entirely, threatening to displace tens if not hundreds of thousands of nursing home residents. *See, e.g.*, AR_00057813 (projecting that if all LTC facilities complied with the final rule

by keeping existing staff but reducing occupancy, 287,524 residents would be displaced); 89 Fed. Reg. at 40953 (recognizing risk of "closure of facilities due to inadequate staff availability").

Because the Final Rule's substantial political and economic significance triggers the major questions doctrine, CMS "must point to clear congressional authorization for the power it claims." *Mayfield*, 2024 WL 4142760, at *2 (quoting *West Virginia*, 597 U.S. at 723). None of the vague, general provisions that CMS invokes remotely fits the bill. *See Texas v. United States*, 50 F.4th 498, 527 n.208 (5th Cir. 2022) ("A vague statutory grant is not close to the sort of clear authorization required by our precedents." (brackets omitted)); *Texas v. United States*, 809 F.3d 134, 183 (5th Cir. 2015) ("[B]road grants of authority … cannot reasonably be construed as assigning 'decisions of vast "economic and political significance,"' … to an agency."). The major questions doctrine accordingly confirms that the Final Rule exceeds CMS's statutory authority.

II. The Final Rule Is Arbitrary And Capricious.

Even when an agency's actions may fall within the scope of its statutory authority, they still must be "reasonable and reasonably explained." *E.g.*, *Texas v. United States*, 40 F.4th 205, 226 (5th Cir. 2022) (quoting *FCC v. Prometheus Radio Project*, 592 U.S. 414, 423 (2021)). This standard "is not toothless"; on the contrary, "it has serious bite." *Id.* The court "must set aside any action premised on reasoning that fails to account for relevant factors or evinces a clear error of judgment." *Id.* The court must also set aside agency action when the agency "fail[ed] to respond to 'significant points' ... raised by the public comments." *Huawei Techs. USA, Inc. v. FCC*, 2 F.4th 421, 449 (5th Cir. 2021) (quoting *Carlson v. Postal Regul. Comm'n*, 938 F.3d 337, 344 (D.C. Cir. 2019)). And when, as here, an agency changes a longstanding policy, it must "show that there are good reasons for the new policy" and "be cognizant that longstanding policies may have 'engendered serious reliance interests that must be taken into account.'" *Encino Motorcars, LLC v. Navarro*, 579 U.S. 211, 221-22 (2016) (quoting *FCC v. Fox Television Stations, Inc.*, 556 U.S.

502, 515 (2009)). CMS's adoption of the Final Rule violated these settled requirements several times over.

A. The Final Rule Unreasonably Departs from CMS's Longstanding Position by Imposing Arbitrary, One-Size-Fits-All Standards.

Over the past 50 years, CMS and its predecessors have consistently rejected calls to deviate from the plain text of the Social Security Act by requiring nursing homes to provide "a specific ratio of nursing staff to patients." 39 Fed. Reg. at 2239. In 1974, the Social Security Administration explained that "the variation from facility to facility in the composition of its nursing staff, physical layout, patient needs[,] and the services necessary to meet those needs precludes setting such a figure." *Id.* In 1980, when HHS took over the administration of Medicare and Medicaid, it expressly declined to propose "any nursing staff ratios or minimum number of nursing hours per patient per day." 45 Fed. Reg. at 47371. In 1986, an HHS-commissioned study concluded that "prescribing simple staffing ratios clearly is inappropriate," observing that individuals within a single facility have "widely differing needs," and some facilities have a much "larger proportion of heavy-care residents" than other facilities. Institute of Medicine Study at 102-03. In 2002, the Secretary of HHS informed Congress that after studying the issue for several years, it was not recommending the imposition of minimum staffing ratios on nursing homes. Thompson Letter at 1-2. And as recently as 2016, CMS again rejected requests to adopt minimum staffing rules, reiterating that it is not reasonable to adopt "a 'one size fits all' approach" toward nursing homes that care for a wide range of resident populations with greatly divergent health care needs. 81 Fed. Reg. at 68755; *see id.* at 68754-56, 68758.

CMS did not come close to providing a reasoned explanation for departing from its longstanding position that fixed numerical staffing requirements are inappropriate. As AHCA explained in its comments on the proposed rule, and CMS nowhere denied, the agency's basic, oft-

reiterated reason for rejecting prior calls to impose blanket minimum staffing ratios—that "LTC facilities are varied in their structure and in their resident populations," *id.* at 68758—remains equally true today. *See* AR_00057757; AR_00057760-AR_00057761; AR_00057764-AR_00057765; AR_00057767; *accord* AR_00070006 (Abt Associates: "Nursing homes with higher-acuity or more clinically complex residents can require a higher level of staffing to meet resident needs."); AR_00070015 (similar); AR_00070022 (similar). Indeed, the Abt Associates study commissioned by CMS itself concluded that the literature on nursing home staffing "has not identified a minimum staffing level required for adequate care quality." AR_00070015. That is hardly surprising. To give just one example, nursing homes that specialize in serving especially vulnerable populations, such as individuals with dementia or Alzheimer's disease, naturally require more staffing than facilities serving individuals with far lower levels of acuity. *See* AR_00070015-AR_00070016; *see also* 81 Fed. Reg. at 68755 (explaining that such ratios "could negatively impact the development of innovative care options"). Yet despite its repeated recognition that "case-mix" matters—including in this very rulemaking, *see* 89 Fed. Reg. at 40877, 40881—CMS has now embraced rigid standards that "will be implemented and enforced independent of a facility's case-mix." *Id.* at 40877. Given the extensive variation among nursing home populations, CMS's one-size-fits-all approach effectively mandates unreasonable over- and under-staffing at facilities across the country.

It also ignores major differences among the States. State Medicaid rates for nursing home services vary from $170 per day to over $400 per day. AR_00057757. Some States have a relatively good supply of RNs and NAs, while others—such as Texas—are facing a massive shortage. *See, e.g.*, 89 Fed. Reg. at 40957, 40976; 81 Fed. Reg. at 68755 (noting "geographic disparity in supply" of nursing staff). Far from "highlight[ing] the need for national minimum

staffing standards," the "widespread variability in existing minimum staffing standards" adopted by 38 States and the District of Columbia, 89 Fed. Reg. at 40880, underscores that "different local circumstances ... make different staffing levels appropriate (and higher levels impracticable) in different areas of the country," AR_00057757. By imposing fixed nationwide requirements that "exceed the existing minimum staffing requirements in nearly all States," 89 Fed. Reg. at 40877, CMS cast aside not only Congress' clear command and the agency's own longstanding approach, but also the considered judgments of state lawmakers who are much closer to their nursing homes and the vulnerable populations they serve.

CMS's attempts to justify its novel and irrational approach are woefully insufficient. CMS concedes that its 24/7 RN requirement imposes a "one-size-fits-all" requirement, 89 Fed. Reg. at 40908, but tries to avoid that characterization for its HPRD requirements, on the ground that the HPRD ratio "is automatically adjusted for size of facility." *Id.* But CMS itself previously described "minimum staffing ratios" as "a 'one size fits all' approach," 81 Fed. Reg. at 68755, and rightly so: As the Final Rule makes clear, and as commenters underscored, the new HPRD requirements—unlike the qualitative standard that Congress chose—do not account for "the variation from facility to facility in the composition of its nursing staff, physical layout, patient needs[,] and the services necessary to meet those needs." AR_00057760 (quoting 39 Fed. Reg. at 2239); *see, e.g.*, AR_00057757; AR_00057764-AR_00057765; AR_00057767; AR_00057770; AR_00057773; *accord* 81 Fed. Reg. at 68758-59 (denying requests to "utiliz[e] a minimum staffing standard" because "LTC facilities are varied in their structure" and in their residents' "acuity and diagnoses").

CMS asserts that it no longer needs to "account[] for resident acuity" because the new requirements are "minimum baseline standards for safety and quality." 89 Fed. Reg. at 40887; *see*

id. at 40877, 40891-95. But CMS took the position for decades is that there *is* no "minimum" baseline that applies equally to every facility in the country. And far from providing a basis to reverse that judgment, the Abt Associates study reinforced it, finding no support for a one-size-fits-all "minimum staffing level required for adequate care quality." AR_00070015. In all events, the 24/7 RN requirement cannot be plausibly described as a minimum-necessary "baseline" when it *triples* the statutory requirement that has been in place for half a century. So too for the new HPRD requirements, which CMS itself admits "exceed the existing minimum staffing requirements in nearly all States" that have any. 89 Fed. Reg. at 40877; *see* 88 Fed. Reg. at 61359; AR_00057759; AR_00066196. And CMS acknowledges that "more than 79 percent of nursing facilities nationwide" cannot meet the new requirements with their current staff. 89 Fed. Reg. at 40887. CMS cannot seriously mean to suggest nearly four out of every five nursing homes in the country are failing to provide their residents with care of even the "minimum" "safety and quality." As noted, CMS's own survey process indicates otherwise. *See supra* p.32 (citing AR_00057776).

Ultimately, CMS's explanation for abandoning its decades-old rejection of one-size-fits-all staffing requirements boils down to this: Some nursing homes are chronically understaffed, and "evidence demonstrates the benefits of increased nurse staffing in these facilities." 89 Fed. Reg. at 40881; *see id.* at 40893-94. But the general (and undisputed) proposition that increased staffing in understaffed facilities can lead to better outcomes does not begin to justify mandating a blanket 24/7 RN requirement and three rigid HPRD requirements for all nursing homes nationwide—especially in the face of a dramatic shortage of qualified applicants. In short, CMS has not offered any reasonable explanation for reversing its longstanding position that the high degree of "variation from facility to facility ... precludes setting" any generally applicable "ratio of nursing staff to patients." 39 Fed. Reg. at 2239; *accord* 81 Fed. Reg. at 68755. That is because there *is no*

reasonable explanation for mandating 24/7 RN coverage and rigid HPRD ratios in all cases. The agency's decision to impose one-size-fits-all staffing standards on LTC facilities was arbitrary and capricious and must be set aside.

B. The Final Rule Is Manifestly Unreasonable for Several Additional Reasons.

Making matters worse, the Final Rule imposes a wholly unfunded mandate that will be virtually impossible for many (if not most) nursing homes to meet, forcing them to reduce capacity or even close entirely. A rule that will have the practical effect of depriving large numbers of Medicare and Medicare recipients of the very care CMS is charged with ensuring they can obtain is the model of arbitrary and capricious agency action.

As detailed in countless comments on the proposed rule, the wholly inadequate supply of RNs and NAs will leave many nursing homes with no realistic way to meet CMS's new minimum staffing requirements. *See, e.g.*, AR_00057752-AR_00057753; AR_00057756; AR_00057762-AR_00057765; AR_00057769; AR_00066194-AR_00066195; AR_00066197; AR_00056959-AR_00056960. As CMS itself acknowledges, its new requirements "exceed the existing minimum staffing requirements in nearly all States" and will require increased staffing "in more than 79 percent of nursing facilities nationwide." 89 Fed. Reg. at 40877. CMS accordingly estimates that nursing homes will need to hire an additional 15,906 additional RNs to meet the 24/7 RN requirement and 0.55 RN HPRD requirement (a staffing increase of about 11.8%), plus an additional 77,611 NAs to meet the 2.45 NA HPRD requirement and 3.48 total nurse HPRD requirement (a staffing increase of about 17.2%). *See id.* at 40958, 40977-80. In Texas alone, facilities will need to hire about 2,579 additional RNs (an increase of *46.1%*) and 7,887 additional NAs (an increase of 28.4%). *Id.* at 40957, 40976-79.

Those increases are beyond impossible at a time when many nursing homes are already experiencing extreme difficulty finding qualified RNs and NAs to fill vacant positions, and when

the need for nursing home services remains high and staffing shortages are expected only to worsen. *See, e.g.*, AR_00055756; AR_00066194. After all, "staffing mandates do not create more caregivers, nor do they drive caregivers to work in long term care." AR_00055752. Stated bluntly, "[r]ecommending a staffing requirement that something like 80% of facilities cannot comply with is … the definition of policy insanity." AR_00068969 (quoting MedPAC Commissioner Dr. Brian Miller, of Johns Hopkins University); *see* AR00033170 n.1 (link to article quoting Dr. Miller's remarks).

The Final Rule also irrationally discounts the vital role of LPNs/LVNs, who hold nearly 230,000 jobs in nursing homes across the country and who CMS admits "provide important services to [their] residents." 89 Fed. Reg. at 40881; *see* AR_00055757; AR_00066195. As numerous commenters pointed out, the Final Rule creates a perverse incentive for facilities "to terminate LPN/LVNs and replace them with ... [less qualified] nurse aides" in order to meet the 2.45 NA HPRD requirement. 89 Fed. Reg. at 40893 (summarizing comments); *see, e.g.*, AR_00057956; AR_00053474; AR_00051308; AR_00061450; AR_00048021-AR_00048022; AR_00031137; AR_00018497; AR_00008724; AR_00011447. Commenters likewise raised concerns about the Final Rule's failure to account for the contributions of other, non-nursing professionals employed by nursing homes, such as activities staff, administrative staff, social workers, therapists, dieticians, and behavioral health specialists who are part of person-centered, team-based staffing models that enhance quality of care and enrich the quality of life for residents. *See, e.g.*, AR_00062299; AR_00066770; AR_00066131; AR_00067479; AR_00068015; AR_00069013; AR_00069055.

CMS acknowledged the danger of ignoring LPNs/LVNs, but bizarrely posited that "[a] total nurse staffing standard [will] guard[] against" it. 89 Fed. Reg. at 40893; *see* 88 Fed. Reg. at

61366, 61369. That makes no sense. To take an example, a facility that already provides high-quality care through average staffing of 0.55 RN HPRD, 1.25 LVN/LPN HPRD, and 1.7 NA HPRD would satisfy the 3.48 total nurse HPRD requirement but would need an additional 0.75 NA HPRD to satisfy the 2.45 NA HPRD requirement. *See, e.g.*, AR_00060019 (discussing "five-star facility" that provides high-quality care through relatively high levels of LPN staffing). The Final Rule thus pressures nursing homes to replace experienced LPNs/LVNs with less-qualified new hires just to meet CMS's arbitrary quota of 2.45 NA HPRD. Moreover, CMS failed to meaningfully engage with the numerous comments urging it to account for the contributions of non-nursing staff; the agency acknowledged that non-nursing staff "provide important services for resident well-being" but summarily declared them "outside the scope of th[e] final rule." 89 Fed. Reg. 40888. "Nodding to concerns raised by commenters only to dismiss them in a conclusory manner is not a hallmark of reasoned decisionmaking." *Texas v. Biden*, 10 F.4th 538, 556 (5th Cir. 2021).

The staggering costs of the Final Rule underscore its arbitrary and capricious nature. By CMS's own estimate, the Final Rule will cost over $5 billion per year to implement once fully phased in, *see* 89 Fed. Reg. at 40949, 40970, while other estimates place the costs as high as $7 billion per year, *see id.* at 40950. The Final Rule does not provide any additional funding for Medicare or Medicaid, so CMS "assume[s] that LTC facilities ... will bear the[se] costs." *Id.* at 40949. As AHCA, LeadingAge, and THCA explained in their comments, nursing homes are in no position to take on this huge financial burden. AR_00057756; AR_00066194-AR_00066195; AR_00056961. Nearly 60% of all nursing homes already have negative operating margins; more than 500 facilities closed over the course of the pandemic; and the costs associated with these new staffing mandates would likely force many more to do so. AR_00057756; *see* AR_00066194-AR_00066195. Imposing a staffing mandate that is impossible to satisfy and that will shut down

nursing homes across the country, leaving their residents stranded, is not a rational approach to improving care.

CMS's decision to impose this massive, unfunded staffing mandate, despite the ongoing workforce crisis and economic realities, is neither "reasonable" nor "reasonably explained." *Cf. Texas*, 40 F.4th at 226. CMS did not dispute in the Final Rule that there are not nearly enough RNs and NAs available to enable the 79% of nursing homes that are not presently in compliance to satisfy the agency's new mandates. It instead just touted a new initiative that seeks to encourage people to pursue careers in nursing by "investing over $75 million in financial incentives such as tuition reimbursement." 89 Fed. Reg. 40894. But as AHCA and LeadingAge have explained, this "one-time workforce effort" is "a drop in the bucket compared to the funding that will be needed to train [the] additional nursing staff" necessary to meet the new mandates. AR_00057774; AR_00066194-AR_00066195. It "is not going to fix the workforce crisis," and $75 *million* in incentives for new nursing careers does practically nothing to offset the *$5 billion to $7 billion per year* in costs that the Final Rule imposes on nursing homes. AR_00057774; AR_00066194-AR_00066195.

CMS claims that the Final Rule's phase-in period will "allow all facilities the time needed to prepare and comply with the new requirements specifically to recruit, retain, and hire nurse staff as needed." 89 Fed. Reg. 40894. But delaying the deadline for compliance does nothing to fix the underlying problems. Regardless of whether it goes into effect tomorrow or two or three years from now, the Final Rule is still a multi-billion-dollar unfunded mandate that many nursing homes will have no realistic way to meet. And there is no reason to think that the shortage of RNs and NAs will ease over the next two to three years; to the contrary, it is projected to become even worse, as "hundreds of thousands are expected to retire or leave the health care profession entirely

in the coming years." AR_00057756; *see* AR_00057753 ("The phase-in provisions are frankly meaningless considering the growing caregiver shortage."); AR_00066200 (similar).

CMS blithely assures stakeholders that it "fully expect[s] that LTC facilities will be able to meet [the Final Rule's] requirements," 89 Fed. Reg. at 40894, but it fails to cite any evidence to support that wishful thinking. There is every reason to expect that artificially increasing the demand for the number of hours RNs and NAs must work will exacerbate, rather than ameliorate, the problem of burnout. *See* AR_00057764; *see also, e.g.*, AR_0002289; AR_00023374; AR_00021114; AR_00021336; AR_00045826; AR_00064396; AR_00064611; AR_00067911; AR_00067922; AR_00069057. And CMS offers no meaningful response to public comments explaining that the Final Rule will force nursing homes that cannot find enough staff to reduce their bed counts, and will adversely affect other healthcare facilities (e.g., hospitals and inpatient rehabilitation centers) by "exacerbat[ing] severe long-term shortages of nursing staff across the care continuum." *Compare, e.g.*, AR_00022868-AR_00022869 (AHA's comments), *with* 89 Fed. Reg. at 40952 (CMS's non-response). Moreover, the staggered implementation timeframe risks "pit[ting] urban and rural areas against each other as staff are first recruited away from rural areas to fulfill the needs of urban nursing homes, then 1-2 years later rural areas are scrapping to bring staff back." AR_00066200.

Finally, CMS's "hardship exemption" process is a wholly inadequate response to the staffing shortage and economic constraints facing LTC facilities. For one thing, those exemptions are available only to facilities that have been surveyed and cited for failure to meet the new staffing standards—and "facilities cannot request" (or receive) "a survey specifically for the purpose of [obtaining] an exemption." 89 Fed. Reg. at 40902. Thus, instead of being able to proactively explain why they should be entitled to an exemption, facilities that cannot meet CMS's arbitrary

requirements will face a perpetual risk of being sanctioned for non-compliance. *See* AR_00057757; AR_00057784-AR_00057785; AR_00066199 (criticizing CMS's approach as "unnecessarily punitive"). In all events, the waivers are "no solution for the ongoing nationwide shortage in nursing staff" or the lack of funds available to implement the new requirements. AR_00057758. Indeed, CMS repeatedly emphasizes that the hardship exemption is meant for "limited circumstances," 89 Fed. Reg. at 40894, and that many facilities in areas of the country with severe shortages of available RNs and NAs would not qualify for an exemption because there are so many "other requirements" that must be met "to obtain an exemption." *Id.* at 40953. An exception that even CMS admits will benefit very few facilities does not begin to fix the problems with the rule.

* * *

The Final Rule is textbook unlawful agency action. It exceeds CMS's statutory authority, rewrites Congress' chosen approach, and improperly tries to wrest control over a major political and economic issue without congressional authorization. And even if CMS had statutory authority to replace Congress' staffing requirements with mandates more to its own liking, the agency has no reasonable explanation for departing from its longstanding position and imposing a one-size-fits all staffing mandate that ignores the varying needs of nursing homes across the Nation, imposes billions of dollars in unjustified costs, and will be impossible for many facilities to satisfy. For all of those reasons, CMS's unauthorized and arbitrary Final Rule cannot stand.

CONCLUSION

This Court should grant Plaintiffs summary judgment and set aside the Final Rule.

Respectfully submitted,

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October 18, 2024