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

AMERICAN HEALTH CARE ASSOCIATION; LEADING AGE; TEXAS HEALTH CARE ASSOCIATION; ARBROOK PLAZA; BOOKER HOSPITAL DISTRICT; HARBOR LAKES NURSING & REHABILITATION CENTER,

Plaintiffs,

STATE OF TEXAS,

Consolidated Plaintiff,

v.

XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; CHIQUITA BROOKS-LASURE, in her official capacity as Administrator of the Centers for Medicare & Medicaid Services; CENTERS FOR MEDICARE & MEDICAID SERVICES,

Defendants.

Nos. 2:24-cv-00114-Z-BR (lead case)
2:24-cv-00171 (consolidated case)

BRIEF OF THE AMERICAN HOSPITAL ASSOCIATION AND THE TEXAS HOSPITAL ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF PLAINTIFFS

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STATEMENT OF INTEREST

The American Hospital Association represents nearly 5,000 hospitals, healthcare systems, and other healthcare organizations. Its members are committed to improving the health of the communities that they serve, and to helping ensure that care is available and affordable for all Americans.

AHA's member hospitals provide care under a wide variety of conditions, which are reflected in the different staffing mixes they employ. These hospitals have a strong interest in ensuring that the federal government does not adopt increasingly one-size-fits-all regulation of staffing in medical facilities. They also have a specific interest in the question here, because imposing inflexible numerical thresholds on long-term-care facilities will lead to worse patient outcomes and less patient-care capacity across the entire healthcare system.

The Texas Hospital Association is the principal advocate for the over 460 hospitals and hospital systems in Texas. THA and its members seek to enhance the accessibility, quality, and cost-effectiveness of healthcare throughout the State of Texas.

THA is vitally interested in the issues before this Court. The hundreds of general and special hospitals in Texas that provide a wide array of healthcare services depend on flexibility in setting appropriate staffing levels, which vary based on facility-specific attributes. If the Centers for Medicare & Medicaid Services (CMS) continues to adopt centralized mandates like those at issue here, it will negatively affect the delivery of healthcare and treatment of individuals, as well as the operation and even financial viability of Texas hospitals.

INTRODUCTION AND SUMMARY OF ARGUMENT

Healthcare is, in a word, complex. As every provider and patient knows, delivering high-quality care rarely involves a one-size-fits-all approach. Instead, resources must be allocated, and procedures adapted, to meet individuals' medical needs and the needs of the broader patient community. Congress knows this, too. Across a range of complex issues, it has sought to improve health outcomes by empowering healthcare professionals to act flexibly in accordance with their professional experience and obligations.

In the rule challenged here, CMS has jettisoned that flexible approach, imposing rules where Congress legislated in standards. Faced with an entrenched shortage of qualified nurses and other healthcare professionals in nursing homes, CMS has imposed a "minimum staffing" mandate—a command that each nursing home meet a single staffing level CMS has deemed best. That mandate is not just an overly simplistic and costly solution to the nursing shortage; it is no solution at all.

Congress and CMS have long embraced flexible staffing for healthcare providers. Hospitals must have "adequate numbers" of registered nurses (RNs), licensed practical nurses, and other personnel "to provide nursing care to all patients as needed," including an RN to "supervise and evaluate the nursing care for each patient." 42 C.F.R. § 482.23. Other programs must similarly adopt an "adequate staffing model." *See, e.g.*, *id.* § 418.110(a), (b) (hospice); *id.* § 485.717 (rehabilitation programs); *id.* § 8.12(b)(1), (d) (treatment programs for opioid use disorder); *id.* § 482.98 (organ transplant programs). Congress likewise requires nursing homes to staff "sufficient[ly] to meet the nursing needs" of each facility's residents, 42 U.S.C. § 1396r(b)(4)(C)(i)(I), and to "maintain the highest

practicable physical, mental, and psychosocial well-being of each resident," *id.* § 1396r(b)(2). Congress imposed only one numerical requirement on nursing homes: to "use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week." *Id.* § 1396r(b)(4)(C)(i)(II).

CMS's approach to nursing-home staffing changed abruptly in 2024. Under CMS's new rule, all nursing homes are required to have an RN onsite and "available to provide direct resident care" for 24 hours each day, 7 days per week. *See Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting*, 89 Fed. Reg. 40,876, 40,997 (May 10, 2024) (Final Staffing Rule). CMS's other across-the-board rules come in the form of minimum "hours per resident day" requirements: 0.55 hours for RNs, 2.45 hours for nursing assistants (NAs), and 3.48 hours for total nurse staffing. *Id.* at 40,996. These mandates carry a price tag that CMS has (under-) estimated at $4.3 billion per year, apparently to be counterbalanced with a mere $75 million in new incentives to increase the nursing workforce. *Compare* Final Staffing Rule at 40,949, *with id.* at 40,953. CMS's modest characterization of the mandate as supplying a "minimum baseline" applicable to every facility is belied by the data: 79% of long-term-care facilities will need to increase staff above current levels to meet the new thresholds, which exceed the existing requirements in "nearly all States." *Id.* at 40,877.

CMS has sacrificed the flexibility that was and should remain a hallmark of appropriate healthcare staffing. Its unfunded, across-the-board mandate not only is incapable of mitigating the nursing shortage but also is counterproductive. Nursing homes

may be forced to reach compliance by increasing demands on their existing staff (fueling additional burnout), or hiring more staff from a limited labor pool (reducing the availability of qualified staff for all healthcare providers). Alternatively, many facilities will cut beds so that they can meet the prescribed ratios with existing staffing levels, leading both to less overall capacity and to more crowding in, and more staffing pressure on, other facilities. Because long-term-care facilities and hospitals operate on a healthcare continuum—drawing from the same pool of nursing professionals and providing ongoing care to many of the same acutely ill patients, *see* Nat'l Ctr. for Health Stats., *Post-acute and Long-term Care Providers and Service Users in the United States, 2017-2018*, Vital and Health Statistics ser. 3 vol. 47, at 2-3 (2022)—hospitals and their patients will suffer from these ill-advised mandates, too.

The Final Staffing Rule dismisses these predictable consequences on other healthcare providers as "not within the scope of this rule." Final Staffing Rule at 40,888. But "an agency cannot simply ignore 'an important aspect of the problem.'" *Ohio* v. *EPA*, 144 S. Ct. 2040, 2053 (2024) (quoting *Motor Vehicle Mfrs. Ass'n of U.S., Inc.* v. *State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983)). And "if there is an explanation" for why the agency believes these obvious harms to the broader healthcare system will not come to pass, "it does not appear in the final rule." *Id.* at 2054.

ARGUMENT

Under the Administrative Procedure Act, an agency must offer a "satisfactory explanation for its action," and must reckon with the "important aspect[s] of the problem" it is addressing. *Ohio*, 144 S. Ct. at 2053 (quoting *State Farm*, 463 U.S. at 43). It must also

articulate "a rational connection between the facts found and the choices made." *Id.* (quoting *State Farm*, 463 U.S. at 43); *see Americans for Beneficiary Choice* v. *HHS*, No. 4:24-cv-446-O, 2024 WL 3297527, at *5 (N.D. Tex. July 3, 2024) (finding CMS rule likely arbitrary and capricious because "CMS failed to address important problems to their central evidence"). CMS flouted these bedrock administrative-law principles in at least two ways.[1]

First, the agency ignored many of the variables that affect the staffing level needed to provide adequate patient care. Healthcare staffing is highly context-specific. Yet CMS reduces a facility's appropriate staffing levels to a ratio between the number of patients and the number of hours facility nurses spend working. This approach ignores critical, facility-specific factors in the staffing equation, including the acuity of the patient population, education and experience of the nursing staff, technological capabilities, facility layout, mix of healthcare professionals employed, and more.

Second, the consequences of CMS's new mandates are far more sweeping than it acknowledged. Facing both a nursing shortage and a punitive mandate to increase staffing, long-term-care facilities have no good options. Whether they ask more hours of their already-overextended nurses, hire nurses away from other facilities in a zero-sum exercise, or comply with the nursing-hours-to-resident ratio by cutting residential capacity, the mandate will not achieve its aim of securing more nursing care for patients. It will, however,

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[1] The mandate also exceeds CMS's statutory authority, as Plaintiffs explain. *See* Memorandum in Support of Plaintiffs' Motion for Summary Judgment, 27-35 (ECF No. 57-1). In this brief, however, *amici* focus on the Final Staffing Rule's other APA deficiencies.

hurt both hospitals and patients. Hardest hit will be hospitals in rural or vulnerable communities that already struggle to attract and retain staff. And as nursing homes cut capacity, patients will face extended hospital stays awaiting nursing-home placement. These backlogs will not only exacerbate the strain on hospital resources but also limit access to care for other patients.

I. A FLEXIBLE NURSE-STAFFING STANDARD REFLECTS SOUND HEALTHCARE POLICY.

The nursing shortage has deeply rooted, systemic causes that were exacerbated by the COVID-19 pandemic: the aging U.S. population has increased demand for nurses but supply has not kept pace, constrained by barriers to nurse training and enrollment, visa caps, and high rates of turnover and burnout.[2] The enduring nationwide shortage of qualified nursing staff calls for a flexible regulatory approach to staffing in long-term-care facilities. As CMS previously recognized, staffing needs vary across facilities based on variables such as acuteness of patient illness, staff mix, and facility-specific technology and staffing policies. Accordingly, administrators of long-term-care facilities are best positioned to make staffing choices for their facilities, consistent with each facility's needs. Staffing under conditions of severe shortage necessarily entails making certain tradeoffs, which facility administrators are best positioned to evaluate. CMS's new mandate short-

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[2] *See, e.g.*, Josh Kelety, *Despite Surging Demand for Long-Term Care, Providers Struggle to Find Workers*, AP News (May 24, 2024), https://tinyurl.com/4xuhnrz9; Yuki Noguchi, *The U.S. Needs More Nurses, But Nursing School Don't Have Enough Slots*, NPR (Oct. 25, 2021), https://tinyurl.com/43brzuvr ("One of the biggest bottlenecks in the system is long-standing: There are not enough people who teach nursing. Educators in the field are required to have advanced degrees yet typically earn about half that of a nurse working the floor of a hospital.").

circuits administrators' ability to use their tailored judgment, and will lead to less efficient staffing as a result.

A. CMS Failed To Consider All The Ways Staffing Needs Vary Across Long-Term-Care Facilities.

Nobody disagrees with CMS's near-truism that "adequate staffing" is a crucial ingredient for providing quality care in nursing homes and other long-term-care facilities. Final Staffing Rule at 40,880. But that does not mean there is a single "adequate" level of staffing across all facilities. A wealth of academic studies—including the flagship report that CMS itself commissioned in anticipation of this rulemaking—teach that ideal staffing is complex and that "staffing levels" are only "one component of administrative practices influencing . . . quality of care." Abt Associates, *Nursing Home Staffing Study* 1 (2023) (Abt Study). Several key variables influence what staffing levels translate to quality care, including (1) patient population, (2) care-team composition, and (3) technological and physical facilities. *See id.* at 65. CMS's blunt hours-per-resident-day mandate fails to capture, or even acknowledge, these important variables.

1. *Patient population.* Patients' needs vary with the nature of their medical conditions. It is common sense that patients with more severe ailments tend to require more consistent and time-intensive nursing care. For example, as dementia advances, a patient typically becomes less independent with daily tasks such as bathing and feeding, increasing the demands on caregivers. *See* Marie-Andree Cadieux et al., *Needs of People With Dementia in Long-Term Care: A Systematic Review*, 28 Am. J. Alzheimer's Disease & Other Dementias 723, 723-24 (2013). Accordingly, the more severely impaired patients a facility cares for, the more nursing resources it requires to meet their needs. *See generally*

Charlene Harrington et al., *Appropriate Nurse Staffing Levels for U.S. Nursing Homes*, 13 Health Servs. Insights 1 (2020).

Nor is patient acuity the only patient-population characteristic relevant to assessing a facility's staffing needs. For instance, socio-demographic factors may affect the level of family involvement in caring for dementia patients alongside nursing staff, which can be part of holistic care for patients even in long-term-care facilities. *See generally* Kathryn Hoehn Anderson, et al., *Patients With Dementia: Involving Families to Maximize Nursing Care*, 18 J. Gerontological Nursing 19 (1992).

In other contexts, CMS recognizes the relevance of patient-population characteristics. It refers to the average level of acuity among patients in a given facility as the facility's "case-mix" and uses that variable to evaluate facilities' performance and needs in a variety of contexts, such as setting prospective payment rates under Medicare for skilled nursing facilities. 42 C.F.R. § 413.337(b)(4). It also adjusts for case mix when calculating individual nursing homes' staffing ratings. *See* CMS, *Design for* Care Compare *Nursing Home Five-Star Quality Rating System: Technical Users' Guide* 9-10 (2024). But not here.

CMS's failure to account for case mix here is particularly inexplicable because CMS implicitly recognized the importance of case mix to long-term-care facilities. It arrived at its across-the-board hourly requirements by consulting "*case-mix adjusted* data sources" collected from long-term-care facilities nationwide. *See* Final Staffing Rule at 40,877, 40,881 (emphasis added). In other words, it *recognized* that case mix affected each facility's staffing needs, and made adjustments to its data accordingly. It nevertheless used that

data to arrive at a single standard, which it declared "will be implemented and enforced independent of a facility's case-mix." *Id.* at 40,877. That move is difficult to understand and impossible to justify. *See, e.g.*, *Nat. Res. Def. Council* v. *Nuc. Regul. Comm'n*, 879 F.3d 1202, 1214 (D.C. Cir. 2018) ("[I]t would be arbitrary and capricious for the agency's decision making to be 'internally inconsistent.'") (citation omitted); *U.S. Sugar Corp.* v. *EPA*, 830 F.3d 579, 650 (D.C. Cir. 2016) (stating "[t]his court has 'often declined to affirm an agency decision if there are unexplained inconsistencies in the final rule,'" and collecting cases) (citation omitted).

2. *Care-team composition.* Just as patients have unique needs, not all nurses have the same level of experience and clinical expertise. For instance, all else being equal, a nurse with 20 years of experience is better able to meet the complex needs of a patient with diabetes and dementia than a recently graduated nurse. *See* Mary A. Blegen et al., *Nurse Experience and Education: Effect on Quality of Care*, 31 J. Nursing Admin. 33, 38 (2001). In addition, a nurse familiar with a specific facility's procedures and patients is able to deliver care more efficiently than a nurse who rotates among multiple facilities. *See* Ashvin Gandhi et al., *High Nursing Staff Turnover in Nursing Homes Offers Important Quality Information*, 40 Health Affairs 384, 384 (2021). The aggregate experience and tenure of a facility's care team thus significantly affects its staffing needs. CMS's exclusive focus on credentials—whether a nurse is qualified as an RN or NA—ignores these differences and requires organizations to staff nurses based on the number of patients alone. *See* Final Staffing Rule at 40,895.

Nor do CMS's uniform hourly rules account for care models that employ other professionals in conjunction with RNs and NAs, including therapists, behavioral health specialists, activities staff, medical directors, pharmacy staff, licensed vocational nurses, and licensed practical nurses. *See* Abt Study 16, 124. The Final Staffing Rule pays lip service to the contributions of these other professionals, mentioning the "important services" that licensed vocational nurses and licensed practical nurses provide, and the "integral" nature of "[b]ehavioral health services." Final Staffing Rule at 40,881, 40937. But the mandates do not actually account for the contributions of these professionals. To the contrary, because staffing budgets are constrained, a mandate that long-term-care facilities hire more nurses will inevitably lead those facilities to cut back on other professional staff. In some cases, that may mean losing the professionals best suited to meet the specific needs of a particular facility's patients.

In response, CMS fights a straw man. It insists that focusing on RN and NA hours is key because "the RN's education, training, and scope of practice, especially in nursing assessment," "is missing from resident care when an RN is not readily available." Final Staffing Rule at 40,896. True enough. But nobody is contending that other professionals can do an RN's job. The point is that other staff members can do the jobs for which they are best qualified, and free up time for RNs to do the same. When support from other professionals is available, nurses can more efficiently allocate their own time, focusing on the upper end of the care only they are licensed to provide; in the absence of supporting staff, nurses must spend time on tasks for which their qualifications are unnecessary. Thus, for instance, nurses will spend time tracking and administering patients' medications, which

could otherwise be delegated to properly trained (but unlicensed) assistive personnel. *See* Asa Gransjon Craftman et al., *Registered Nurses' Experience of Delegating the Administration of Medicine to Unlicensed Personnel in Residential Care Homes*, 25 J. Clinical Nursing 3189, 3189-92 (2016); Am. Nurses Ass'n, *Registered Nurse Utilization of Nursing Assistive Personnel in All Settings* (2007). In short, the level of support staffing affects nurses' ability to care for patients in ways that do not register in an hours-per-resident-day metric, which captures only *how much* time nurses spend and not *how* they spend it.

The resulting inefficiencies will only exacerbate the problems that CMS sought to solve. When nurses must spend time completing tasks at the lower end of their qualifications, that fuels burnout and turnover. *See* Megha K. Shah et al., *Prevalence of and Factors Associated with Nurse Burnout in the US*, JAMA Network Open 4, at 6 (2021). The loss of experienced nursing professionals, in turn, puts more pressure on those who remain and shrinks the pool of available nurses. This shortage adds to burnout and ultimately harms patients.

3. *Facility-specific capabilities.* Finally, even holding case mix and staff mix constant, nursing needs vary depending upon facility-specific variables such as the technology and resources employed in delivering care. For example, the adoption of advanced information and communication technologies reduces time spent on documentation and paperwork, freeing nurses to spend more time with patients. *See* Geneviève Rouleau et al., *Impact of Information and Communication Technologies on*

Nursing Care: Results of an Overview of Systematic Reviews, 19 J. Med. Internet Rsch. 4, e122 (2017).

Even an individual facility's physical layout matters. *See* Christine Mueller, *A Framework for Nurse Staffing in Long-Term Care Facilities*, 21 Geriatric Nursing 262, 265-66 (2000). For example, the distance a nurse must travel between patients' rooms naturally affects how many patients (of a given acuity) the nurse (with a given skill level) can care for in an hour. Facility size can also affect staffing needs because of task-specific economies of scale. Some larger facilities, for instance, allow nurses to concentrate on smaller numbers of tasks, whereas small facilities may ask nurses to perform a greater variety of tasks. *See generally* Dennis Moeke et al., *Scale and Skill-mix Efficiencies in Nursing Home Staffing: Inside the Black Box*, 3 Health Sys. 18 (2014). CMS's mandate does not account for any of these facility-specific variables, which can have a significant aggregate effect.

B. Administrators Of Long-Term-Care Facilities Are Best Positioned To Meet Their Facilities' Individual Staffing Needs.

Because staffing needs vary so significantly across long-term-care facilities, the administrators in each facility, rather than regulators in Washington, D.C., are best positioned to make staffing choices that ensure adequate care. Under a flexible standard, administrators of long-term-care facilities can take account of the aforementioned facility-specific variables when choosing and implementing a staffing model. And while that flexibility is prudent at any time, it is critical in light of today's nursing shortage.

Administrators have more granular knowledge about the case and staff mix in their facilities and can adapt staffing levels and procedures in response to those variables. They

can—and, as a matter of course, do—make predictive judgments about how the patient population's needs will change with time and deploy real-time clinical judgment and expertise in evaluating staffing needs. They talk to staff and know how teams are working (or not working) together. Because they are closest to the action, they are the first to notice signs that a particular staffing arrangement is not working. Administrators know, for instance, that when a longtime experienced nurse departs, staffing needs increase significantly. Conversely, they are able to gauge when a particular staff mix that may not meet the hourly minimum rules set by CMS nonetheless works well for patients.

Administrators of long-term-care facilities also have flexibility to respond to differences in state licensing requirements. In practice, CMS's minimum NA requirement means something different depending on the State because States authorize NAs to perform varying tasks. For example, 11 States permit certified nursing aides to engage in "expanded care tasks" beyond those identified in 42 C.F.R. § 483.152. *See* Tara L. McMullen et al., *Certified Nurse Aide Scope of Practice: State-by-State Differences in Allowable Delegated Activities*, 16 J. Soc'y for Post-Acute & Long-Term Care Med. 20, 22 (2015). In States that allow NAs to perform more complicated or time-intensive tasks—including medication administration, wound care, catheter care, and managing medical information, *see id.*—long-term-care facilities may require a different mix of NAs and RNs than facilities in States where only RNs perform such tasks.

With respect to other facility-specific variables—including technologies, procedures, and organizational techniques—the gap between administrators and regulators is even larger. Administrators have both superior *knowledge* of facilities' capabilities and the

ability to *change* them. For instance, administrators can experiment with different team structures or compositions, or with tools that automate staffing arrangements based on certain inputs about the facility and its patients, testing whether reliance on these automated processes generates better outcomes than staffing based principally on persons' judgments. Peter Griffiths et al., *Nursing Workload, Nurse Staffing Methodologies and Tools: A Systematic Scoping Review and Discussion*, 103 Int'l J. Nursing Studs. 103487 (2020). But CMS's rigid mandates short-circuit this process by diminishing facility administrators' ability and incentive to experiment with new and more efficient staffing models. Worse still, CMS's numerical thresholds typically are anchored in "older care models that do not consider advanced capabilities in technology or the interprofessional team care model that supports data-driven decision-making and collaborative practice." Am. Hosp. Ass'n, *Comment Letter on Minimum Staffing Standards for Long-Term Care Facilities*, 4 (Oct. 26, 2023) (AHA Cmt. Letter). Stripping facility administrators of the authority to tailor staffing to facility needs will lead to inefficiency, stymie innovation in care delivery, and result in a misallocation of nurses and more nurse burnout.

II. THE HARMFUL CONSEQUENCES OF CMS'S STAFFING RULES WILL RADIATE ACROSS THE HEALTHCARE CONTINUUM.

The harmful effects of CMS's mandates are not limited to the facility-level inefficiencies described above. They ripple outward from there. Nursing-home administrators have only a few undesirable options to comply: (1) impose greater demands on existing staff, (2) hire additional staff from an already-constrained labor pool, or (3) cut beds to meet CMS's hours-per-resident ratios. Each approach has serious consequences not just for long-term-care facilities but also for patients and other acute-care facilities like

hospitals, which are part of the same healthcare continuum. In particular, the staffing mandates will fuel nurse turnover and burnout, and will increase labor costs for already-strained hospitals without addressing the bottleneck on supply. All of that will reduce the system-wide capacity to offer quality care, in ways that CMS's half-hearted attempts to mitigate any adverse consequences for long-term-care facilities do not address.

This massive collateral damage is "an important aspect of the problem," *State Farm*, 463 U.S. at 43, which CMS openly declined to consider. It simply dismissed concerns about effects on "other healthcare settings" as "not within the scope of this rule." Final Staffing Rule at 40,888. But the APA's requirements are not so easily avoided. "Failure to adequately consider the costs" imposed on hospitals—the obvious collateral damage of the new rule[3]—"constitutes arbitrary and capricious decisionmaking." *Texas* v. *Biden*, 646 F. Supp. 3d 753, 780 (N.D. Tex. 2022) (Kacsmaryk, J.).

A. CMS's Mandate Will Harm Acute-Care Hospitals.

The Final Staffing Rule leaves long-term-care facilities with no good options for compliance. As one nursing home executive put it, "[t]here just aren't enough staff. . . . [W]e're all competing for the same quality staff to run a good facility." Ashley Milne-Tyte, *In Nursing Homes, Staff Are Key. But Is Biden's Boost for the Workforce Realistic?*, NPR (June 6, 2024), https://tinyurl.com/5fxspbdt. Because hiring their way into compliance is

[3] Several commenters warned of the negative consequences for hospitals of staffing mandates on long-term-care facilities. *See, e.g.*, AHA Cmt. Letter 7-8; Loretto Mgmt. Corp., *Comment Letter on Minimum Staffing Standards for Long-Term Care Facilities* 2 (Nov. 6, 2023); Fla. Hosp. Ass'n, *Comment Letter on Minimum Staffing Standards for Long-Term Care Facilities* 3 (Nov. 6, 2023); Dr. Jonathan Romanyshyn, *Comment Letter on Minimum Staffing Standards for Long-Term Care Facilities* 1 (Oct. 27, 2023).

unrealistic, long-term-care facilities will be forced instead to ask more of existing staff, engage in zero-sum hiring of other long-term-care facilities' or hospitals' nurses, or reduce bed capacity so that existing staffing levels will suffice. Each of these bad options will cause negative consequences for long-term-care facilities, hospitals, and patients alike, including worsening the burnout that has fueled the nursing shortage, increasing costs for already-imperiled hospitals, and reducing healthcare providers' capacity to offer care along the healthcare continuum. The Final Staffing Rule inadequately explained why these consequences for long-term-care facilities are worth it, and it declined altogether to consider these consequences from hospitals' perspective.

1. *Nurse burnout.* CMS's mandates will worsen the problems of burnout and job dissatisfaction that are causing the nursing shortage to begin with. As CMS itself acknowledged, 79% of long-term-care facilities currently fall short of the Final Staffing Rule's prescribed staffing level. Final Staffing Rule at 40,877. Because hiring sufficient additional staff will often be infeasible, some nursing homes may ask nurses already on staff to work more hours. When demands on nurses increase, burnout increases, and nurses leave their job or abandon the profession entirely. *See* McKinsey & Company, *Nursing in 2023: How Hospitals Are Confronting Shortages* 3 (2023) (citing "unmanageable workloads" as a top reason nurses leave their jobs). Nurse burnout and turnover are associated with negative patient outcomes. For example, there is a well-documented relationship among long working hours, patient safety, and provider errors. *See* Sung-Heui Bae, *Relationships Between Comprehensive Characteristics of Nurse Work Schedules and Adverse Patient Outcomes: A Systemic Literature Review*, 30 J. Clinical Nursing 2202,

2209 (2021). Moreover, nurse turnover decreases patient satisfaction. Sung-Heui Bae, *Noneconomic and Economic Impacts of Nurse Turnover in Hospitals: A Systematic Review*, 69 Int'l Nursing Rev. 392, 399 (2022).

Burnout and turnover caused by increasing nurses' hours can spiral from there. A smaller and less experienced pool of remaining nurses must then work still harder to meet a facility's needs (and potentially CMS's mandates if the facility is a nursing home)—causing further burnout and turnover. Over time, then, CMS's mandate can be expected to exacerbate the nursing shortage, with predictable adverse results for the well-being of nurses, patients, and healthcare providers.

Hospitals can be expected to feel the consequences of burnout especially severely. Although many nurses prefer to work in hospitals due to more challenging work and higher pay, those that are asked to work even harder may flee for facilities with lower patient acuity. *See* Amy Stulick, *As Acuity Rises, Nursing Homes Gain Ability to Outcompete Hospitals for Nurses*, Skilled Nursing News (Mar. 17, 2023), https://tinyurl.com/2s4ke95k. Consequently, the cycle of burnout-induced shortages will be particularly harmful for hospitals and for the patients needing the highest level of care.

2. *Increased labor costs.* Asking nurses to work more hours (if feasible)[4] or hiring more nurses to meet CMS's mandates comes with a large price tag. As a matter of basic economics, too, increased demand for nurses without increased supply will inflate

[4] It is far from clear that a long-term-care facility *could* comply with the mandates by asking more of its existing staff. Nursing organizations have taken the position that "[m]andatory overtime is an unacceptable solution to achieve appropriate nurse staffing." Am. Nurses Ass'n, *Principles for Nurse Staffing* 10 (2d ed. 2012), https://tinyurl.com/y8w9rkzn.

wages and threaten the viability of both long-term-care facilities and hospitals. *See* Final Staffing Rule at 40,956. Importantly, bottlenecks on supply mean that rising wages are unlikely to lead to more nurses to alleviate the nursing shortage. *See* Peter I. Buerhaus, *Economic Determinants of Annual Hours Worked by Registered Nurses*, 29 Medical Care 1181 (1991); Am. Ass'n of Coll. of Nursing, *New AACN Data Points to Enrollment Challenges Facing U.S. Schools of Nursing* (Apr. 15, 2024), https://www.aacnnursing.org/news-data/all-news/article/new-aacn-data-points-to-enrollment-challenges-facing-us-schools-of-nursing (cataloguing rejection of "thousands of qualified applications" because of shortage of nursing faculty and other resources).

Wage pressures will place a strain on acute-care hospitals that they may not be able to bear. Labor costs for acute-care hospitals increased 15.6% during the pandemic, from 2019 to 2021. *Data Brief: Health Care Workforce Challenges Threaten Hospitals' Ability to Care for Patients*, Am. Hosp. Ass'n 2 (2021). Hospitals have not fully recovered from that financial shock. *See* Kaufman Hall, *April 2024 National Hospital Flash Report* 11. The burden is not equally distributed, as hospitals in the Great Plains and Midwest have been hit hardest with cost increases and nursing shortages. *Id.* at 10-21. And hospitals serving rural or disadvantaged communities have been thinly stretched, leading 136 rural hospitals and health systems to close between 2010 and 2021. Am. Hosp. Ass'n, *Rural Hospital Closures Threaten Patient Access to Care* 3 (2022); *see* David Kendall et al., *Revitalizing Safety Net Hospitals: Protecting Low-Income Americans from Losing Access to Care*, Third Way 10 (2023).

CMS estimates that the Final Staffing Rule will cost long-term-care facilities $5.76 billion per year by its tenth year in effect. Final Staffing Rule at 40,949. But even that staggering number fails to account for the costs borne by other participants in the same labor market, including acute-care hospitals—let alone the costs to patients of shuttered hospitals or reduced services.

3. *Capacity reductions*. For some long-term-care facilities, simply hiring more nurses—in the face of a nationwide nursing shortage and already-slim margins—is not an option. That is not for lack of effort: one recent report found that 99% of nursing homes are actively hiring, 80% take at least one month to fill a position, and 90% have increased wages to recruit and retain staff within the past six months. Am. Health Care Ass'n, *State of the Sector: Nursing Home Labor Staffing Shortages Persist Despite Unprecedented Efforts to Attract More Staff* 5-8 (2024). Unable to hire their way into compliance with CMS's mandate, those facilities will be forced to reduce their bed capacity to hit the numerical targets in a different way. Indeed, 46% of nursing homes are *already* limiting admissions due to labor shortages. *See id.* at 9. Some long-term-care facilities in rural areas may even close entirely. *See* AHA Cmt. Letter 7.

The Final Staffing Rule's draconian penalties all but guarantee that result. Compliance will be infeasible for many facilities, as it has been in States that have imposed stringent minimum staffing requirements. *See* Jordan Rau, *Why Nursing Home Residents Still Suffer Despite Tough State Laws*, N.Y. Times (July 12, 2024), https://tinyurl.com/2ert4ck2. But CMS has indicated that noncompliance with its new staffing requirements will be met with "stiff fines or losing the ability to participate in

Medicare"—a consequence that is existential for most, if not all, nursing homes. AHA Cmt. Letter 5.

Reduced nursing-home capacity will also affect acute-care hospitals in the same healthcare ecosystem. For example, it will increase the wait time for transfers from hospitals to long-term-care facilities. CMS obliquely acknowledged as much, noting that "staffing needs in one provider setting can impact other provider settings." Final Staffing Rule at 40,877; *see* AHA Cmt. Letter 8-9. Already, "[p]atients requiring additional care after hospitalization," including "skilled nursing," "face growing delays in accessing that care," Am. Hosp. Ass'n, *Issue Brief: Patients and Providers Faced with Increasing Delays in Timely Discharges* 1 (2022) (AHA Issue Brief), as the average length of stay for patients discharged from acute-care hospitals to skilled nursing facilities increased more than 20% from 2019 to 2022, *see* AHA Cmt. Letter 8.

Delayed discharges have serious consequences for patients and providers. For patients, delays can include "slow[er] recovery" and greater risk of adverse health events. AHA Issue Brief 1. On the providers' side, delayed discharges result in needlessly occupied beds, increasing the "costs of caring for patients [awaiting discharge] without appropriate reimbursement." *Id.* Ultimately, these resource strains lead to delays in other care settings at the hospital, including increasing waiting times for emergency care "because hospitals are unable to move current patients out of inpatient beds." AHA Cmt. Letter 8.

Despite that chain of consequences, CMS inexplicably declined to analyze "potential bed losses" from the rule, *i.e.*, the prospect that the rule will lead "some facilities to close and other facilities to limit the numbers of residents they admit due to insufficient nurse

staff to accept more residents." Final Staffing Rule at 40,952. CMS noted this concern, *id.* at 40,952-53, but any explanation for dismissing it "does not appear in the final rule," *Ohio*, 144 S. Ct. at 2054. Even assuming that CMS expected hiring gains bolstered by its paltry $75 million to eliminate bed loss, that expectation is unjustified for all the reasons described herein. Indeed, it is unrealistic that a substantial percentage of facilities will react to the mandates by hiring their way into compliance—let alone that additional hiring will be so universal that "potential bed losses" can be ignored altogether. Final Staffing Rule at 40,952. Nor did CMS address the impact of reduced long-term-care capacity on "other health care facilities," despite being alerted to these potential consequences as well. *Id.* at 40,952-53. Of course, the costs and benefits of the Final Staffing Rule "would shift" substantially if it caused significant closures or bed reductions. *Ohio*, 144 S. Ct. at 2051. CMS's refusal to engage with these concerns is paradigmatic arbitrary-and-capricious agency action. *See id.* at 2053-54.

B. The Rule Does Not Mitigate These Adverse Consequences For Hospitals.

The Final Staffing Rule does not account for any costs to acute-care hospitals or to patients. CMS has provided some limited mitigation for long-term-care facilities, including a narrow "hardship exemption" and phased implementation. Neither of those mechanisms is sufficient to mitigate the harms for nursing homes themselves, as Plaintiffs explain. *See* Amend. Compl. ¶¶ 58-60. But just as importantly, neither gives *any* reprieve to hospitals. Because CMS has treated "the practices of other healthcare settings" as lying outside "the scope of" the Final Staffing Rule, *id.* at 40,888, hospitals cannot take advantage of even the agency's inadequate mitigation.

1. *Hardship exemption.* CMS provides a "limited" exemption from the 24-7 RN staffing requirement and certain of the hours-per-resident-day requirements. That exemption applies when, among other factors, facilities are located in an area where the "provider to population ratio for [the] nursing workforce" is "20 percent below the national average." Final Staffing Rule at 40,894, 40,953, 40,998. As Plaintiffs explain, this is not adequate for nursing homes because they cannot proactively request the exemption but rather must wait to be cited for failure to comply with the new rules. Amend. Compl. ¶ 96. Regardless, the exemption is entirely unresponsive to the interplay between nursing homes and hospitals. Hospitals will be most affected in areas where nursing homes *have* managed to meet the requirements—by hiring away nurses from other healthcare settings or by cutting beds. Thus, in any given geographic area, the Final Staffing Rule can be expected to impose unaccounted-for hardships on either nursing homes or hospitals, or both.

2. *Phased implementation.* Second, CMS lauds its "phased-in approach," which applies the new requirements gradually—and differently in urban and rural areas. Final Staffing Rule at 40,953. In urban areas, the phase-in occurs over three years; in rural areas, five years. *Id.* Because there is no reason to expect the fundamental problem—the nursing shortage—to diminish in the interim, this phase-in solves little. At most, it provides nursing homes with an opportunity to delay the inevitable operational changes or downsizing that will accompany implementation of the mandates. And again, hospitals are not guaranteed even those modest benefits. They are left in a purely reactive posture, not knowing whether local nursing homes will cut beds, attempt to hire their nurses, or wait and hope that CMS changes its mind again.

* * *

The Final Staffing Rule tries to mandate an acute nursing shortage to disappear. As welcome as that result would be, it cannot be achieved by a government directive. Experience tells us as much: States that have implemented minimum staffing rules generally have not managed to alleviate the shortfalls—in part because the minimums are impossible to meet without more systemic reforms. *See* Jordan Rau, *Why Nursing Home Residents Still Suffer Despite Tough State Laws*, N.Y. Times (July 12, 2024), https://tinyurl.com/2ert4ck2. Before CMS forges ahead anyway with ill-fitting mandates, the APA requires it to at least consider the many adverse consequences that it ignored here.

CONCLUSION

For the foregoing reasons, the Court should set aside the Final Staffing Rule.

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Respectfully submitted,

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