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)

MEMORANDUM IN OPPOSITION TO DEFENDANTS' CROSS-MOTION FOR SUMMARY JUDGMENT AND REPLY IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

Over the past five decades, Congress has explicitly and repeatedly addressed the question of staffing levels for the more than 97% of nursing homes across the nation that participate in Medicare and Medicaid—and has repeatedly turned back efforts to impose one-size-fits-all minimum-staffing requirements on those facilities, as nursing homes face a wide variety of different staffing needs and different challenges in recruiting and retaining staff. Congress has instead set two straightforward requirements for those facilities: A nursing home "must use the services of a registered professional nurse [("RN")] for at least 8 consecutive hours a day, 7 days a week," but beyond that it need only "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).

The Centers for Medicare and Medicaid Services ("CMS") is no longer satisfied with those two statutory requirements—so it has decided to simply override them, tripling the former (from 8 hours a day to 24 hours a day), and supplanting the latter flexible, qualitative standard with rigid and impracticable quantitative mandates. *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"). That brazen departure from the statutory scheme that Congress enacted cannot stand. The onerous one-size-fits-all minimum-staffing requirements in the Final Rule exceed CMS's statutory authority, mark an arbitrary and unexplained reversal of the agency's longstanding views, and will harm countless nursing homes and their residents across the country.

CMS's summary-judgment brief fails to rescue the Final Rule from its multiple fatal flaws. As its statutory authority for the rule, CMS relies on its general authority to impose requirements relating to the health and safety of nursing home residents. But however broad that general

authority may be, it does not permit CMS to override other statutory provisions in which Congress has already addressed the topic CMS wishes to regulate. Here, Congress has specifically determined that each nursing home that participates in Medicare or Medicaid must provide at least 8 hours of RN coverage per day, so CMS has no authority to "revise[]" that statutory requirement by tripling it. 89 Fed. Reg. at 40898. Beyond that, Congress has determined that each nursing home that participates in Medicare or Medicaid need only provide nursing services that "are sufficient to meet the nursing needs of its residents," setting a flexible qualitative standard that accounts for the differences among facilities, rather than a fixed one-size-fits-all quantitative threshold that every facility must meet. 42 U.S.C. §1396r(b)(4)(C)(i); *accord id.* §1395i-3(b)(4)(C)(i). CMS has no power to supplant that qualitative standard by demanding instead that each nursing home—regardless of its residents' actual needs—provide at least 3.48 hours per resident day ("HPRD") of total nursing services, including at least 2.45 HPRD of nurse aide ("NA") services and 0.55 HPRD of RN services. It is one thing for the agency to fill gaps in the statutory regime when it comes to issues that Congress declined to address. It is another thing entirely for the agency to claim that its "gap-filling" authority empowers it to supplant explicit statutory mandates with requirements more to its liking—especially when Congress has repeatedly stepped in to *stop* the agency from imposing staffing requirements in the past.

The major questions doctrine confirms that the Final Rule exceeds CMS's authority. As the Fifth Circuit recently held, that doctrine applies whenever an agency *either* (1) "claims the power to resolve a matter of great political significance" *or* (2) "seeks to … require billions of dollars in spending by private persons or entities." *Mayfield v. U.S. Dep't of Lab.*, 117 F.4th 611, 616 (5th Cir. 2024). Meeting either prong of that disjunctive test would be sufficient to "independently trigger" the major questions doctrine, *id.*, and the Final Rule meets both:

Nationwide nursing-home-staffing requirements have long been a hotly contested political issue, and CMS itself estimates that the Final Rule will require nursing homes to spend more than *$43 billion* over the next decade on compliance. CMS's attempts to evade the binding precedents that compel application of the major questions doctrine here are unpersuasive. And under that doctrine, the Final Rule is plainly invalid, as the general provisions on which CMS relies come nowhere near the kind of clear congressional authorization that would be required to afford CMS the expansive power it claims.

Even if CMS had statutory authority to issue the Final Rule—and it does not—the rule would still have to be set aside as arbitrary and capricious. As CMS and its predecessor agencies repeatedly explained over the course of more than four decades, a one-size-fits-all approach to nursing home staffing is plainly inappropriate considering the wide variety of staffing needs different facilities may face. The Final Rule abandons that longstanding view without even acknowledging the agency's change in position, let alone adequately explaining it, in violation of settled administrative law principles. CMS's regulatory about-face was also wholly unreasonable, as it makes no sense to impose the same rigid staffing requirements on thousands of nursing homes across the country when resident needs vary dramatically from one facility to another. And it is particularly irrational to demand massive increases in RN and NA staffing at a time when many parts of the country are already experiencing a severe shortage of RNs and NAs, and to saddle nursing homes with a multi-billion-dollar unfunded mandate at a time when many of them are struggling to stay afloat.

Left standing, the Final Rule would threaten to force hundreds of nursing homes to close their doors for good, displacing thousands of vulnerable residents. It is unquestionably important for nursing homes to have adequate nursing staff, and it is unfortunately true that some facilities

fall short. But that does not remotely justify imposing nationwide staffing standards that exceed CMS's statutory authority, depart without explanation from the agency's own longstanding position, make no distinction among nursing homes with widely varying staffing needs, and require staffing levels that four out of every five nursing homes currently cannot meet. This Court should grant Plaintiffs' motion for summary judgment, deny Defendants' cross-motion, and vacate the Final Rule.

ARGUMENT

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

The most fundamental flaw in the Final Rule's minimum-staffing requirements is straightforward: The requirements exceed CMS's statutory authority. While Congress has afforded CMS general authority to administer the Medicare and Medicaid programs, that general authority emphatically does not extend to rewriting the minimum-staffing requirements for nursing homes that Congress itself enacted by statute. *See* 42 U.S.C. §1302(a) (CMS may not promulgate regulations "inconsistent with" other statutory provisions).

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

Congress has already set a specific minimum RN staffing requirement: Each nursing home that participates in Medicare or Medicaid "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 brazenly "revises" that statutory requirement by tripling it, replacing the statutory 8/7 RN requirement with a new mandate that each nursing home "must have a registered nurse (RN) onsite *24* hours per day, for 7 days a week." 89 Fed. Reg. at 40898, 40997 (emphasis added). The Final Rule further departs from the statutory text by replacing the requirement to "use the services of" an RN, which encompasses administrative and supervisory roles, with a requirement to have an RN "available to provide direct resident care." *Id.* These

changes violate "the core administrative-law principle that an agency may not rewrite clear statutory terms to suit its own sense of how the statute should operate." *In re Benjamin*, 932 F.3d 293, 300 (5th Cir. 2019) (quoting *Util. Air Regul. Grp. v. EPA*, 573 U.S. 302, 328 (2014)). CMS accordingly has no authority to replace the statutory 8/7 RN requirement with a regulatory 24/7 RN requirement. *See* ECF No. 57-1 ("Pltfs.Br.") at 27-30.

CMS has no meaningful response. CMS first asserts that it has statutory authority to issue the Final Rule under its general authority to impose "such other requirements relating to the health and safety of [nursing home] residents … as [it] may find necessary." 42 U.S.C. §1396r(d)(4)(B); *accord* 42 U.S.C. §1395i-3(d)(4)(B); *see* ECF No. 80-1 ("CMS.Br.") at 13. But as CMS acknowledges, that general authority is limited to "fill[ing] up the details of the statutory scheme," CMS.Br.13; it does not empower the agency to replace statutory requirements that Congress has enacted with different requirements that are more to the agency's liking. After all, it is well settled—and CMS does not contest—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)). That principle controls here: The general grant of regulatory authority to impose "such other requirements" with respect to nursing homes as CMS may deem necessary cannot be read as a grant of authority to modify or supersede the specific 8/7 RN staffing requirement that Congress itself imposed in a separate statutory provision.

CMS concedes that Congress explicitly addressed RN staffing and chose to require only that nursing homes participating in Medicare and Medicaid "must use the services of a [RN] for at least 8 consecutive hours a day, 7 days a week"—not the 24 hours a day, 7 days a week that the Final Rule requires. CMS.Br.14 (quoting 42 U.S.C. §1396r(b)(4)(C)(i)). But CMS claims that

there is no inconsistency between the 8/7 RN requirement that Congress set by statute and the Final Rule's 24/7 RN requirement, because the statutory 8/7 RN requirement says that nursing homes must use the services of an RN for "at least 8 consecutive hours a day," 42 U.S.C. §1396r(b)(4)(C)(i), and "there can be no dispute that 24 hours is 'at least 8' hours," CMS.Br.14-15. That argument fails on multiple levels.

As an initial matter, it runs afoul of the settled rule that "an agency's action must be upheld, if at all, on the basis articulated by the agency itself." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 50 (1983); *see, e.g.*, *Wages & White Lion Invs., LLC v. FDA*, 16 F.4th 1130, 1140 (5th Cir. 2021) ("[I]t is a fundamental precept of administrative law that an administrative agency cannot make its decision first and explain it later."). CMS never asserted in issuing the Final Rule that the statutory 8/7 RN requirement somehow "preserve[s] room" for a regulatory 24/7 RN requirement by using the words "at least." CMS.Br.15. On the contrary, CMS expressly disclaimed any reliance on the statutory 8/7 RN requirement as a source of authority for the rule, stating that it was "using separate authority … to establish [the 24/7 RN requirement] rather than" the statutory 8/7 RN requirement. 89 Fed. Reg. at 40891. To the extent CMS is now trying to assert that the phrase "at least" in the statutory 8/7 RN requirement somehow authorizes CMS to impose a regulatory 24/7 requirement, it cannot rely on that post hoc rationalization to defend the Final Rule. *Motor Vehicle Mfrs. Ass'n*, 463 U.S. at 50; *Wages & White Lion*, 16 F.4th at 1140.

In any event, CMS's late-breaking focus on the words "at least" in the statutory 8/7 RN requirement is meritless. CMS insists that those words must be meant to empower the agency to establish a higher minimum RN requirement than the one Congress chose because to conclude otherwise would "read the words 'at least' out of the statute entirely." CMS.Br.14. But the words

"at least" serve an obvious purpose that has nothing to do with CMS: They clarify that the statutory 8/7 RN requirement sets a floor, not a ceiling, *for nursing homes*. Each nursing home "*must* use the services of a [RN] for *at least* 8 consecutive hours a day," 42 U.S.C. §1396r(b)(4)(C)(i) (emphasis added), but remains free under the 8/7 RN requirement to use the services of an RN for more than 8 consecutive hours a day if it so chooses. Nothing about those words remotely authorizes (or leaves room for) CMS to rewrite the 8/7 RN requirement that Congress adopted by replacing it with a new regulatory 24/7 RN requirement. Indeed, the statutory provision setting forth the 8/7 RN requirement does not even mention CMS; it is by its terms directed to facilities themselves.

More fundamentally, the question is not whether there is an irreconcilable contradiction between CMS's 24/7 RN requirement and Congress's 8/7 RN requirement, CMS.Br.14-15; of course a facility can (at least in theory) comply with both. The question is whether Congress has empowered the agency to impose RN requirements of its own. And whatever may be said of CMS's power to impose "such other requirements" to address issues that Congress has not addressed, *see Biden v. Missouri*, 595 U.S. 87 (2022) (per curiam), Congress has already decided for how many "consecutive hours a day" a nursing home "must use the services of a" RN, and its answer was 8. 42 U.S.C. §1396r(b)(4)(C)(i). That forecloses CMS's effort to use its general rulemaking powers to change the number to 24. After all, statutes "are drawn not only to bar what they prohibit but to allow what they permit," *Crosby v. Nat'l Foreign Trade Council*, 530 U.S. 363, 380 (2000), and Congress chose to give nursing homes the flexibility to choose any level of RN staffing at or above 8 hours per day based on their particular staffing needs. By stripping nursing homes of the flexibility that Congress provided, and tripling the mandatory RN staffing minimum from 8 hours per day to 24 hours per day, the Final Rule's 24/7 RN requirement is

plainly inconsistent with the statute Congress wrote. And by replacing the statutory requirement to "use the services of" an RN, 42 U.S.C. §1396r(b)(4)(C)(i), with a new requirement to have an RN "available to provide direct resident care," 89 Fed. Reg. at 40997, the Final Rule only compounds the inconsistency—a problem that CMS's brief does not address at all.

CMS's attempt to defend the 24/7 RN requirement by drawing analogies to other Medicare and Medicaid regulations fails for much the same reason. *See* CMS.Br.15-16. To be sure, when Congress adopts a general requirement *without* filling in the details, such as by requiring nursing homes to "establish and maintain an infection control program," or to provide "dietary services" to meet each resident's "special dietary needs," 42 U.S.C. §1396r(b)(4), (d)(3)(A), CMS may exercise its general authority to promulgate "such other requirements" as it deems necessary, *id.* §1396r(d)(4)(B), "'fill[ing] up the details' of [the] statutory scheme" with specific requirements, *Loper Bright Enters. v. Raimondo*, 144 S.Ct. 2244, 2263 (2024). Plaintiffs thus certainly are not suggesting that CMS cannot impose any requirements that are not already "specifically set forth in statute." *Contra* CMS.Br.12. But when Congress chooses to fill in the details on a particular subject itself, CMS cannot use its general gap-filling authority to override Congress' choice, as Congress has not left any gap to fill. Indeed, even in the heyday of *Chevron* deference, it was understood that when "Congress has directly spoken to the precise question at issue … that is the end of the matter," as the agency "must give effect" to Congress' instructions, not invent its own. *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 842-43 (1984), *overruled on other grounds by Loper Bright*, 144 S.Ct. 2244.[1]

[1] CMS's citation to 42 U.S.C. §1396r(b)(7) underscores the point. That provision requires a "facility with more than 120 beds" to "have at least one social worker (with at least a bachelor's degree in social work or similar professional qualifications) employed full-time." By using the phrase "at least," §1396r(b)(7) gives *nursing homes* flexibility to hire more than one social worker,

That makes CMS's invocation of *Bostock v. Clayton County*, 590 U.S. 644 (2020), unavailing. To be sure, *Bostock* rejected the proposition that "Congress's failure to speak directly to a specific case that falls within a more general statutory rule creates a tacit exception." CMS.Br.16 (quoting *Bostock*, 590 U.S. at 669). But this is not a situation where Congress "fail[ed] to speak directly" to the issue at hand, *id.*; on the contrary, Congress *did* speak directly to the proper level of RN staffing, and it resolved that question by requiring nursing homes to use "at least 8 consecutive hours a day" of RN services, but no more. 42 U.S.C. §1396r(b)(4)(C)(i). The point thus is not that Congress "implicitly" precluded CMS from imposing a 24/7 RN requirement, *contra* CMS.Br.16; Congress *explicitly* took that question out of CMS's hands by enacting its own 8/7 RN requirement. Congress' "general delegation of authority" to CMS to implement Medicare and Medicaid "does not give [CMS] license to alter the [statute's] unambiguous terms." *Tex. Med. Ass'n v. HHS*, 120 F.4th 494, 508 (5th Cir. 2024). By CMS's logic, its gap-filling authority would override everything else Congress has said about Medicare and Medicaid save an express prohibition on the agency imposing a particular requirement. That is not a plausible reading of provisions that, by CMS's own admission, simply authorize the agency to fill in details Congress did *not* supply, not to override details Congress *did*.

In the end, CMS has one thing right: Courts "must presume that a legislature says in a statute what it means and means in a statute what it says there." CMS.Br.17 (quoting *Barnhart v. Sigmon Coal Co.*, 534 U.S. 438, 461-62 (2002)). That principle, however, cuts decisively against

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or to hire a social worker who has not only a bachelor's degree but a master's or doctoral degree. But it does not give *CMS* latitude to override Congress' specific commands—for instance, by demanding that every LTC facility employ five social workers who each have a doctoral degree. So too here: The phrase "at least" in the statutory 8/7 RN requirement allows nursing homes to use the services of an RN for more than 8 hours a day, but does not empower CMS to replace the statutory 8/7 RN requirement with a regulatory 24/7 RN requirement more to the agency's liking.

the Final Rule's 24/7 RN requirement. Under the 8/7 RN requirement that Congress enacted, nursing homes "must use the services of a registered professional nurse for at least 8 consecutive hours a day." 42 U.S.C. §1396r(b)(4)(C)(i); *accord id.* §1395i-3(b)(4)(C)(i). CMS has no authority to replace that express requirement with a rule that each LTC facility must instead have a registered nurse "available to provide direct resident care" for "24 hours per day." 89 Fed. Reg. at 40997. The Final Rule's 24/7 RN requirement must therefore be set aside.

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

For similar reasons, CMS lacks statutory authority to mandate that every nursing home must provide total nurse staffing of at least 3.48 HPRD, including at least 0.55 HPRD of RN staffing and 2.45 HPRD of NA staffing. As already explained, for more than half a century, Congress has repeatedly considered whether to set rigid one-size-fits-all minimum-staffing ratios for nursing homes and has repeatedly decided not to do so. *See* Pltfs.Br.6-11. Congress has instead dealt with nursing home staffing levels by adopting a qualitative, facility-specific standard, requiring that each facility "must 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).

That should resolve the matter, as, once again, CMS's general authority to administer the Medicare and Medicaid programs does not empower it to modify "matter[s] specifically dealt with in another part of the same enactment." *RadLAX Gateway Hotel*, 566 U.S. at 646; *see* 42 U.S.C. §1302(a) (prohibiting CMS from issuing regulations "inconsistent with" other statutory requirements). CMS's new HPRD requirements not only override, but directly and impermissibly conflict with the qualitative, facility-specific statutory staffing standard that Congress chose. Even if CMS determines through an individualized facility assessment that a given facility already has enough staff to meet its residents' needs, the Final Rule still requires the facility to continue adding

staff until it satisfies the fixed HPRD requirements for RN, NA, and total nurse staffing. *See* CMS.Br.17. On top of that, the 0.55 RN HPRD requirement is inconsistent with the statutory 8/7 RN requirement, as it will force many facilities to go well beyond the minimum level of 8 hours per day of RN coverage that Congress set—even if that level is more than sufficient to meet the needs of those facilities' residents. The HPRD requirements accordingly exceed CMS's statutory authority. *See* Pltfs.Br.30-32.

CMS's contrary arguments go nowhere. As with its 24/7 RN requirement, CMS contends that its HPRD requirements are a permissible exercise of its authority to set "such other requirements relating to the health and safety of [nursing home] residents … as [CMS] may find necessary," 42 U.S.C. §1396r(d)(4)(B), on the theory that those requirements merely "fill up the details of the statutory scheme," CMS.Br.17 (brackets and quotation marks omitted). Of course, CMS does not (and cannot plausibly) claim that its HPRD requirements simply elaborate on the boundaries of nursing homes' statutory obligation to "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). On the contrary, CMS concedes that its new HPRD requirements impose obligations "in addition to" that existing statutory obligation—and that the Final Rule requires nursing homes to meet the new HPRD requirements *regardless* of whether they actually need those levels of staffing to provide quality care, as assessed by CMS's own individualized facility assessments. CMS.Br.17-18. That is not gap-filling; that is imposing quantitative, one-size-fits all requirements that override the qualitative approach Congress chose.

CMS contends that although Congress chose to enact only a flexible qualitative staffing requirement, it simultaneously authorized CMS to supersede that approach by imposing the rigid quantitative HPRD requirements of the Final Rule, through its general grant of authority to issue

regulations related to the well-being of nursing home residents. But again, when Congress provides an agency with a "general delegation of authority" to implement a statutory scheme, that general delegation "does not give [CMS] license to alter the [statute's] unambiguous terms" just to "suit its own sense of how the statute should operate." *Tex. Med. Ass'n*, 120 F.4th at 508. By requiring only that each nursing home must provide nursing services that are "sufficient to meet the nursing needs" of its unique resident population, 42 U.S.C. §§1395i-3(b)(4)(C), 1396r(b)(4)(C), Congress ensured that nursing homes could use any combination of RNs, LPNs/LVNs, NAs, and other caregivers to fulfill their staffing needs and ensure that adequate care will be available. The Final Rule, by contrast, supplants that flexible system with an entirely different scheme under which nursing homes must meet fixed numerical staffing thresholds for RNs, NAs, and total staffing, regardless of whether the particular facility actually needs those staffing levels to provide adequate care (as determined by CMS's own facility assessment process). Put bluntly, the Final Rule's HPRD requirements are a thinly veiled effort to substitute CMS's policy views for Congress' considered judgment on a matter that Congress "specifically dealt with" through legislation. *RadLAX Gateway Hotel*, 566 U.S. at 646. That is impermissible.

CMS asserts that its HPRD requirements do not completely supplant Congress' flexible staffing requirement because the Final Rule requires nursing homes to meet *both* sets of standards, so a nursing home might need even *more* staff to satisfy the statute than the Final Rule demands. CMS.Br.18. That seems exceedingly unlikely for most facilities; it is far more likely that the Final Rule will demand more staffing than Congress does, since CMS's own survey data shows that "roughly 95 percent of facilities" are already "providing 'sufficient nursing staff'" even though most are not meeting the new HPRD requirements. Pltfs.Br.31-32 (quoting AR_00057776). But more to the point, Congress squarely considered the question of whether to impose rigid one-size-

fits-all staffing ratios on nursing homes, and it chose not to do so. Beyond requiring facilities to "use the services of a registered professional nurse for at least 8 consecutive hours a day," 42 U.S.C. §1396r(b)(4)(C)(i); *accord id.* §1395i-3(b)(4)(C)(i), Congress chose only to require each facility to have staffing levels "sufficient to meet the nursing needs of its residents," 42 U.S.C. §§1395i-3(b)(4)(C), 1396r(b)(4)(C), not to meet fixed numerical requirements for other staff as well.[2] Because Congress once again has spoken directly to the question at hand, CMS has no power to "rewrite clear statutory terms to suit its own sense of how the statute should operate." *Tex. Med. Ass'n*, 120 F.4th at 508. And the Final Rule's insistence that fixed HPRD requirements are "necessary" for "the health and safety of [nursing home] residents," CMS.Br.19, cannot be squared either with Congress' decision not to impose such requirements or with CMS's own survey data showing that most homes already provide sufficient staff below those levels.[3]

CMS insists that its HPRD requirements "are not a 'rigid one-size-fits-all' approach" after all, because "HPRD involves an assessment of the total number of hours worked by each type of staff compared to the actual number of residents in the facility," and so "is automatically adjusted for size of facility." CMS.Br.18 (quoting 89 Fed. Reg. at 40908). But CMS itself has previously recognized that "minimum staffing ratios" like its new HPRD requirements are "a 'one size fits all' approach," 81 Fed. Reg. 68688, 68755 (Oct. 4, 2016), and for good reason: By design, those

[2] Particularly when contrasted with the 8/7 RN requirement, the facility-specific nature of that requirement readily distinguishes it from other provisions that CMS claims could be construed to take a "qualitative" approach, as CMS identifies no other context in which Congress has affirmatively eschewed a quantitative approach. *See* CMS.Br.19. Indeed, it does not even identify any other context in which a quantitative approach would be logical.

[3] CMS also invokes the "at least" language to argue in a footnote that its 0.55 HPRD RN requirement does not conflict with the statutory 8/7 RN requirement. CMS.Br.18 n.5. That is wrong for all the reasons already explained with respect to the 24/7 RN requirement. *See supra* pp.6-8.

fixed ratios 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. 2238, 2239 (Jan. 17, 1974)). That makes them nothing like the flexible qualitative standard Congress chose.

CMS's analogy to the "infection control program" requirement of 42 U.S.C. §1396r(d)(3), and its reliance on *Biden v. Missouri*, CMS.Br.19-20, are once again misplaced. *Biden v. Missouri* upheld CMS's imposition of a COVID-19 vaccination mandate for nursing home workers in the face of statutory *silence* about vaccination requirements, and against a backdrop of decades of agency regulation of infection control measures, as well as a statutory command to "establish and maintain an infection control program," 42 U.S.C. §1396r(d)(3). *See* 595 U.S. at 90-91, 94-95. In other words, the vaccination mandate was not an "additional" vaccination requirement imposed "on top of those articulated by Congress," CMS.Br.19; it filled gaps in an area that Congress had not directly addressed at all. Here, by contrast, CMS does not—and cannot—claim that its HPRD requirements somehow implement the qualitative, facility-specific staffing approach Congress chose. To the contrary, CMS openly admits that it has imposed new regulatory requirements "in addition to" the statutory standard, and that compliance with one does not necessarily ensure compliance with the other. CMS.Br.17. *Biden v. Missouri* in no way suggests that the agency's power to impose "such other requirements relating to the health and safety of [nursing home] residents … as [it] may find necessary," 42 U.S.C. §1396r(d)(4)(B); *accord* 42 U.S.C. §1395i-3(d)(4)(B), is so sweeping as to empower the agency to override specific requirements that Congress has already established.

The existing Medicare and Medicaid staffing regulations that CMS invokes are thus a far cry from the rigid HPRD requirements that the Final Rule imposes. It is one thing for CMS to

specify that the statutory requirement to "establish and maintain an infection control program" requires employment of a credentialed "[i]nfection preventionist"; the statutory requirement to provide "dietary services" requires employment of a "qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis"; and the statutory requirements for nursing facility administration require the employment of administrative professionals. *See* CMS.Br.5-6, 12, 15-16; 42 U.S.C. §1396r(b)(4)(A)(iv), (d)(1)(A)-(C), (d)(3); 42 C.F.R. §§483.60(a)(1), 483.70(d)-(e), 483.80(b). And CMS undisputedly has some authority to define what types of training and experience qualify someone to serve as an infection preventionist, dietician, or nursing home administrator. *See* 42 C.F.R. §§483.60(a)(1)-(2), 483.70(d)(2), 483.80(b). But it is quite another thing to attempt to use general, gap-filling authority to impose blanket quantitative mandates for RN, NA, and total nurse staffing per resident—particularly when Congress has set a different minimum level for RN staffing and adopted a qualitative total staffing standard, which recognizes that staffing needs vary greatly based on facility-specific factors such as residents' diagnoses and acuity.

The history of congressional action in this area confirms what the statutory text makes clear. CMS does not dispute that Congress "has extensively considered whether to impose staff-to-patient ratios on LTC facilities, and has repeatedly chosen not to do so." CMS.Br.20 (brackets omitted); *see* Pltfs.Br.6-11. Faced with that reality, CMS resorts to asserting that Congress' "decision not to impose different staffing standards in the past provides no indication as to whether CMS possesses the authority to do so today." CMS.Br.20. But for more than half a century, Congress has repeatedly chosen to regulate staffing requirements for nursing homes directly—and has repeatedly intervened whenever CMS or any of its predecessors tried to assert the power to set those requirements itself. *See* Pltfs.Br.6-11. That history leaves little doubt that Congress has

repeatedly and consistently reserved this issue for itself, and has never authorized CMS to impose staffing requirements more to its liking.

CMS claims that Congress' repeated past decisions not to impose rigid one-size-fits-all staffing requirements were just "motivated by a lack of available data." CMS.Br.20. Of course, even if that were true, it would only underscore that Congress has kept for itself the decision of whether adequate data were available to justify such requirements, rather than delegating that decision to CMS. *See* Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, §4801(e)(17)(B), 104 Stat. 1388, 1388-218 to -219 (Nov. 5, 1990) (limiting the agency's role to compiling data and recommendations *for Congress* to consider). In any event, the purported "legislative history" that CMS cites is the Institute of Medicine's 1986 report on nursing homes, which suggested that the Executive Branch might someday impose HPRD requirements. *See* CMS.Br.20-21. That offhand remark by a private, non-profit entity says nothing about whether Congress intended to grant CMS the authority it now asserts. And while CMS claims that its own "longstanding position" is consistent with the Institute of Medicine's, CMS.Br.21, its sole evidence for that assertion is the fact that CMS has consistently *declined* to impose any such requirements in the past. That is hardly persuasive evidence that Congress actually granted CMS the remarkable power to replace Congress' own qualitative, facility-specific staffing standard with the kind of rigid quantitative standards that Congress itself has repeatedly declined to adopt.

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

If there were any remaining doubt that the Final Rule is unlawful, the major questions doctrine would resolve it. Under Fifth Circuit precedent, that doctrine applies whenever an agency (1) "claims the power to resolve a matter of great political significance'" or (2) "seeks to … require billions of dollars in spending by private persons or entities." *Mayfield*, 117 F.4th at 616. Either

indicator "independently trigger[s] the doctrine," *id.*, and both are present here. First, Congress has repeatedly demonstrated the political significance of nationwide nursing-home-staffing requirements by taking high-profile legislative action in this area, *see* Pltfs.Br.6-11, and has "conspicuously and repeatedly declined to enact" a 24/7 RN requirement or one-size-fits-all HPRD requirements, *West Virginia v. EPA*, 597 U.S. 697, 724 (2022); *see* Pltfs.Br.33-34. Second, by CMS's own estimate, the Final Rule will require $43 billion in spending by private persons or entities over the coming decade. 89 Fed. Reg. at 40970-71 & tbl.22. Because the Final Rule's political and economic significance plainly triggers the major questions doctrine, CMS must identify "clear congressional authorization" to impose the challenged minimum-staffing requirements. *Mayfield*, 117 F.4th at 616. And the Secretary's general power to impose "necessary" requirements related to resident health and safety comes nowhere close to supplying the requisite clear delegation of authority. *See* Pltfs.Br.35.

CMS begins its response by badly misstating the test for when the major questions doctrine applies, claiming that it is limited to cases in which *both* (1) an agency is claiming "extravagant statutory power over the national economy," *West Virginia v. EPA*, 597 U.S. at 723-24, *and* (2) the claimed power would reflect "a fundamental revision of the statute, changing it from one sort of scheme of regulation into an entirely different kind," CMS.Br.22 (brackets, ellipsis, and quotation marks omitted) (quoting *Biden v. Nebraska*, 143 S.Ct. 2355, 2373 (2023)). That is wrong at every turn. While *West Virginia v. EPA* involved (and held invalid) an agency's assertion of "extravagant statutory power over the national economy," 597 U.S. at 724, nothing in that decision declared such an assertion a necessary condition for applying the major questions doctrine. *Contra* CMS.Br.22. And while *Biden v. Nebraska* rejected the Biden Administration's sweeping student-loan-forgiveness program in part because it would have effected a "fundamental revision of the

statute," 143 S.Ct. at 2373, nothing in that case held that a fundamental revision along those lines is necessary to trigger the major questions doctrine. *Contra* CMS.Br.22. On both counts, CMS's assertion that "[u]nless both criteria are met, the major questions doctrine does not apply," CMS.Br.22, has no basis in Supreme Court or Fifth Circuit precedent.

CMS's assertion that "the economic and political significance of an agency action alone cannot trigger the major questions doctrine," CMS.Br.22-23, is also squarely contrary to the Fifth Circuit's recent and binding decision in *Mayfield*. To quote *Mayfield*: "There are three indicators that each *independently* trigger the [major questions] doctrine: (1) when the agency 'claims the power to resolve a matter of great political significance'; (2) when the agency 'seeks to regulate a significant portion of the American economy or require billions of dollars in spending by private persons or entities'; and (3) when an agency 'seeks to intrude into an area that is the particular domain of state law.'" 117 F.4th at 616 (emphasis added). That language makes crystal clear that either political *or* economic significance alone—and certainly both—can "independently trigger" the major questions doctrine. *Id.* To be sure, whether the challenged agency action "aligns with the agency's established role," or "whether the agency has previously claimed the authority at issue," CMS.Br.23, are *additional* considerations that may come into play. But *Mayfield* makes clear beyond cavil that they are not preconditions to application of the doctrine.

Once again, CMS's reliance on *Biden v. Missouri* is unavailing. To be sure, that case involved an invocation by CMS of the same statutory grants of authority. But whether the major questions doctrine applies depends on the nature of the power the agency is asserting, not on what statutory provision the agency invokes. So whether *Biden v. Missouri* implicated the doctrine says little, if anything, about whether this case does, as what CMS claimed the power to do there (impose vaccination requirements) is entirely different from what CMS claims the power to do

here (impose rigid, nationwide minimum-staffing ratios). As explained, moreover, in *Biden v. Missouri* the agency was acting in an area where Congress had *not* spoken, and where the agency had instead taken the primary role for decades. *See supra* pp.7-8, 14. Here, by contrast, Congress has long reserved for itself the power to impose staffing requirements and has jealously guarded that power whenever the agency has even contemplated encroaching on it. The two situations could not be more different. In all events, *Biden v. Missouri* never so much as mentioned the major questions doctrine, leaving it unclear whether the Court thought it was inapplicable or thought it was satisfied. That makes the case an exceedingly poor candidate for trying to discern how the doctrine applies here.

CMS's effort to downplay the Final Rule's political significance, *see* CMS.Br.24, likewise blinks reality. Over the past half-century, Congress has repeatedly demonstrated the political significance of nursing home staffing by taking it upon itself to enact specific staffing requirements and to specify the circumstances under which those requirements may be waived. *See* Pltfs.Br.6-13. In so doing, Congress has made clear that, while it is open to considering CMS's recommendations, it intends to deal with this weighty political issue itself through legislation. *See* Pltfs.Br.7-11. And to the extent Congress has allowed CMS to "fill up the details" of how to *enforce* its statutory standards, CMS.Br.24—for instance, through regulations governing facility assessments—that in no way diminishes the political significance of the minimum-staffing standards themselves.

That leaves CMS insisting that the Final Rule lacks political significance because (CMS says) it is not a novel assertion of agency power, but merely an exercise of "CMS's long-recognized authority." CMS.Br.24. Nonsense. While the fact that an agency has *wielded* a particular power for many decades may undercut the political significance of a subsequent invocation of that power,

see Mayfield, 117 F.4th at 617, the Executive Branch has *never* enacted nationwide minimum-staffing mandates for nursing homes in the six decades since Medicare and Medicaid began, and Congress has *never* recognized any power to do so. To the contrary, Congress has stepped in and halted even *suggestions* that the Executive Branch might try to exercise that power itself. The best CMS can muster is the Institute of Medicine's passing reference to hypothetical future regulatory action a full 200 pages into its 1986 report. *See* CMS.Br.24. That does not come close to constituting congressional "recognition" that CMS actually possesses the sweeping power it now claims. *See* Pltfs.Br.33-34. *Contra* CMS.Br.24.

CMS's contention that the Final Rule lacks the requisite economic significance, CMS.Br.25, is weaker still. CMS does not (and cannot) dispute that the Final Rule will "require billions of dollars in spending by private persons or entities," which "independently trigger[s]" the major questions doctrine under controlling Fifth Circuit precedent. Pltfs.Br.33-34 (quoting *Mayfield*, 117 F.4th at 616). CMS just insists that the Final Rule's projected $43 billion price tag over the coming decade—which CMS itself predicts will be paid almost entirely by nursing homes, with no additional support from Medicare and Medicaid, *see* 89 Fed. Reg. at 40970-71—is too small to trigger the major questions doctrine because it is smaller than the estimated impact of the regulations in *Biden v. Nebraska* and *West Virginia v. EPA*. CMS.Br.25. But neither of those cases purported to set any fixed economic-impact threshold—and more important, neither involved an agency action mandating billions of dollars in new spending *by private actors*, as opposed to government spending or less direct economic consequences. *See Mayfield*, 117 F.4th at 616 (recognizing that the major questions doctrine is "independently trigger[ed]" when an agency "seeks to … require billions of dollars in spending *by private persons or entities*" (emphasis added)). Instead, the most relevant Supreme Court comparator is *Alabama Association of Realtors*

v. Department of Health and Human Services, which ascribed "vast 'economic … significance'" to a regulation expected to cost private landlords about $50 billion. 594 U.S. 758, 764 (2021). The Final Rule's projected $43 billion impact is on par with that figure and is more than *fourteen times* the estimated ten-year impact of the regulation that the Fifth Circuit considered in *Mayfield*. *See* 84 Fed. Reg. 51230, 51286-87 (Sept. 27, 2019). Under the clear and binding language of *Mayfield*, an unfunded government mandate requiring private actors to pay more than $43 billion for additional staff suffices to trigger the major questions doctrine.

And under the major questions doctrine, it is clear that the Final Rule cannot stand. That doctrine requires an agency seeking to resolve a major question to demonstrate "'clear congressional authorization' for the power it claims." *West Virginia v. EPA*, 597 U.S. at 723. Even under ordinary principles of statutory interpretation, the general statutory provisions authorizing CMS to set requirements relating to the health and safety of nursing home residents do not allow the agency to override the staffing requirements that Congress itself has enacted by statute. *See supra* pp.4-16. These general statutory provisions certainly do not provide the kind of clear authorization that the major questions doctrine requires. *See, e.g.*, *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." (quotation marks omitted)). Indeed, even CMS does not seriously contend that the Final Rule can survive if the major questions doctrine applies; it instead argues only that the doctrine should not apply. *See* CMS.Br.22-26. Because Congress has never empowered CMS to supersede the governing statutory minimum-staffing requirements for nursing homes by issuing different regulatory

requirements—and has certainly never provided the kind of clear congressional authorization that CMS would need to resolve that major question—the Final Rule exceeds CMS's statutory authority and cannot stand.

II. The Final Rule Is Arbitrary And Capricious.

Even if CMS had statutory authority to issue the Final Rule, the rule would still be arbitrary and capricious. In issuing the rule, CMS failed to even acknowledge that its adoption of the 24/7 RN requirement and HPRD requirements marked a dramatic shift from longstanding agency policy, let alone explain why the reasons it has previously given for rejecting such policies should no longer control. That dramatic shift in CMS's position is not only unacknowledged but unreasonable, as nationwide, one-size-fits-all staffing ratios do not adequately account for the extensive variation among nursing home resident populations and other location- and facility-specific factors—which is precisely why Congress has eschewed them. Especially at a time when many nursing homes already cannot find qualified candidates to fill open positions and are facing severe financial constraints, the imposition of rigid, unfunded staffing requirements is arbitrary and irrational. The Final Rule accordingly fails the basic requirements of reasoned administrative decisionmaking.

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

1. Over the past half-century, CMS and its predecessors have repeatedly rejected calls to impose a 24/7 RN mandate and minimum-staffing ratios on nursing homes that participate in Medicare or Medicaid (as nearly all do), opting to instead retain the 8/7 RN requirement and facility-specific determination of "sufficient staffing" established by Congress. *See, e.g.*, 39 Fed. Reg. at 2239; 45 Fed. Reg. 47368, 47371 (July 14, 1980); 52 Fed. Reg. 38582, 38586-87 (Oct. 16, 1987); 81 Fed. Reg. 68688, 68754-56 (Oct. 4, 2016); Pltfs.Br.36. In rejecting these proposals, the

agency has repeatedly reaffirmed that it would be unreasonable to impose nationwide minimum-staffing ratios because nursing homes across the country serve a diverse array of residents and thus have dramatically divergent staffing needs. *See, e.g.*, 81 Fed. Reg. at 68758; 39 Fed. Reg. at 2239; *accord* Inst. of Med., *Improving the Quality of Care in Nursing Homes* 102-03 (1986), https://archive.ph/KFNCi ("Institute of Medicine Study") ("Because of the complexities of case mix … prescribing simple staffing ratios clearly is inappropriate."). The Final Rule reflects a 180-degree departure from that longstanding agency position, taking the exact minimum-staffing-ratio approach that the agency repeatedly rejected in the past—with no meaningful acknowledgment of that striking change. *See* Pltfs.Br.36-40.

CMS insists that there has been "no departure at all" from the agency's prior position, and that CMS's previous rejections of minimum-staffing proposals turned solely on a "lack of data" about where to set and how to enforce minimum-staffing standards. CMS.Br.30-31. That is revisionist history in the extreme. While the agency has occasionally cited insufficient data as one reason for rejecting calls to impose minimum-staffing standards, it has also provided a host of substantive reasons. As early as 1974, CMS 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" the adoption of "a specific ratio of nursing staff to patients." 39 Fed. Reg. at 2239. CMS attempts to spin the 1974 rule as rejecting only an "*optimal or required* staffing ratio for every facility" as opposed to a *minimum* staffing ratio, CMS.Br.31, but that is simply incorrect. The 1974 rule expressly rejected comments that requested "[a] *minimum* ratio" of "nursing staff to patients" because of "the variation from facility to facility," and the risk that some facilities would inappropriately "striv[e] only to reach that *minimum*" while others would be forced to "hir[e] unneeded staff." 39 Fed. Reg. at 2239 (emphasis added). Even CMS thus is

ultimately forced to concede (with considerable understatement) that the 1974 rule "expressed some skepticism about a minimum standard." CMS.Br.31.

When confronted with similar minimum-staffing proposals in the ensuing decades, the agency steadfastly adhered to its position that they were not appropriate. *See* Pltfs.Br.7-11. And as recently as less than a decade ago, CMS provided a detailed reaffirmation of its substantive concerns about such proposals. *See* 81 Fed. Reg. at 68754-58; 80 Fed. Reg. 42168, 42201 (July 16, 2015). The agency reiterated "that a mandated ratio could result in unintended consequences, such as staffing to the minimum, input substitution (hiring for one position by eliminating another), and task diversion (assigning non-standard tasks to a position)," and "would not result in … improved quality and person-centered care." 81 Fed. Reg. at 68754. The agency also reiterated that "LTC facilities are varied in their structure and in their resident populations." *Id.* at 68758. Some "focus on short term rehabilitation services," while others have "primarily long-stay residents"; some "specialize in dementia care," while others "have pediatric residents, young adult residents, or ventilator dependent residents." *Id.* Because of those differences, CMS rejected rigid "minimum staffing ratios" in favor of a more "flexib[le]" approach that determines "sufficient staff" by considering "facility- and resident-specific factors," including "residents' acuity and diagnoses." 81 Fed. Reg. at 68756; *accord* 80 Fed. Reg. at 42201. And CMS expressly rejected a 24/7 RN requirement, explaining that "imposing such a requirement could negatively impact the development of innovative care options, particular[ly] in smaller, more home-like settings," and expressing skepticism about whether compliance with such a mandate would be feasible, particularly in "rural and underserved areas." 81 Fed. Reg. at 68755.

The Final Rule is thus a dramatic reversal of the agency's longstanding prior position. *Contra* CMS.Br.29-32. In issuing the Final Rule, CMS not only adopted the very requirements it

had previously rejected, but also jettisoned most of the underlying reasons it had given for rejecting them. In 2016, for example, CMS described "minimum staffing ratios" as "a 'one size fits all' approach" because they fail to account for facility-specific variables such as layout and resident acuity. 81 Fed. Reg. at 68755. The Final Rule, by contrast, asserts that minimum-staffing ratios are *not* a "one-size-fits-all" approach, despite their failure to account for those same facility-specific variables. *See* 89 Fed. Reg. at 40908-09. The Final Rule likewise rejects or ignores CMS's prior determinations that imposing nationwide minimum-staffing requirements will cause some facilities to inappropriately staff to the minimum, force other facilities to hire more staff than they need, lead facilities to fill new mandated positions (such as additional NAs) by eliminating other positions (such as LPN/LVNs), cause facilities to assign tasks to nurses that could more efficiently be handled by non-nurses, and stifle innovation. *See* 39 Fed. Reg. at 2239; 81 Fed. Reg. at 68754. By embracing positions that CMS had previously rejected and discarding or ignoring the bulk of its prior reasoning, the Final Rule plainly departs from the agency's prior views.

2. It is black-letter law that, "[w]hen an agency changes its existing position, it … must at least display awareness that it is changing position." *R.J. Reynolds Vapor Co. v. FDA*, 65 F.4th 182, 189 (5th Cir. 2023) (alterations in original) (quoting *Encino Motorcars, LLC v. Navarro*, 579 U.S. 211, 221 (2016)). The Final Rule does not even do that. Its short discussion of its most recent rulemaking on this issue never mentions that the agency expressly rejected both a 24/7 RN requirement and HPRD requirements less than a decade ago; nor does it address the agency's prior explanation that such "one size fits all" requirements inappropriately ignore facility-specific considerations such as resident acuity. *See* 89 Fed. Reg. at 40879-80; *cf.* 81 Fed. Reg. at 68755, 68758; 80 Fed. Reg. at 42201. The Final Rule likewise never mentions any of the other times the agency has rejected similar minimum-staffing requirements. *See* 52 Fed. Reg. 38582, 38586-87

(Oct. 16, 1987) (not cited in Final Rule); 39 Fed. Reg. at 2239 (same); 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 (same). Indeed, the agency still insists to this day that there has been "no departure at all" from its prior position. CMS.Br.31. Given CMS's (inexplicable) belief that it has *not* changed position, "[it] would be impossible for [CMS] to display awareness that it was changing position." *Wages & White Lion*, 16 F.4th at 1141; *see Louisiana v. U.S. Dep't of Energy*, 90 F.4th 461, 469 (5th Cir. 2024).

CMS's arguments that it "fully explained" its change in position, CMS.Br.32-34, are likewise unavailing. Contrary to what CMS now suggests, the Final Rule gives no indication that CMS chose to "reassess its … prior policy" because of "lessons learned from the [COVID-19] pandemic," CMS.Br.32-33. Quite the opposite: The Final Rule states that the pandemic simply "highlighted and exacerbated long-standing concerns about inadequate staffing," without ever explaining why those "long-standing concerns" should now warrant measures that the agency firmly rejected in the past as counterproductive. 89 Fed. Reg. at 40880; *cf. Motor Vehicle Mfrs. Ass'n*, 463 U.S. at 50 ("[A]n agency's action must be upheld, if at all, on the basis articulated by the agency itself[.]"); *Louisiana*, 90 F.4th at 469 (recognizing that "the grounds upon which an administrative order must be judged are those upon which the record discloses [the agency's] action was based," not "convenient litigating positions and *post hoc* rationalizations" (brackets and quotation marks omitted)). CMS's claim that the Final Rule adequately justified its change in position by citing new data is equally unpersuasive; while the Final Rule mentions the agency's

post-2016 collection of "PBJ System data" and purported "new evidence from the literature," CMS.Br.30, it does not (and cannot) explain how that data could alter its longstanding prior view that inflexible one-size-fits-all staffing requirements are not appropriate. *Compare* 81 Fed. Reg. at 68754-55, 68758, *with* 89 Fed. Reg. at 40908-09. Because the Final Rule "depart[s] from [CMS's] prior policy *sub silentio*" and without rational explanation, it is arbitrary and capricious and must be set aside. *Louisiana*, 90 F.4th at 469 (quoting *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009)).

3. Even leaving aside CMS's failure to acknowledge or explain its change in position, the agency's imposition of one-size-fits-all staffing requirements is unreasonable. Given the extensive variation among nursing homes' resident populations, it makes no sense to impose a 24/7 RN requirement and rigid HPRD mandates that all nursing homes must follow regardless of their individual staffing needs. Pltfs.Br.36-37; *see* Institute of Medicine Study at 102-03 (recognizing that "prescribing simple staffing ratios clearly is inappropriate" in light of "the complexities of case mix," including the "widely differing needs" of different residents and different facilities). A facility that "specialize[s] in dementia care" will have staffing needs that are nothing like one that "focus[es] on short term rehabilitation services" for "pediatric residents" or "young adult[s]." 81 Fed. Reg. at 68758. Consequently—as CMS observed all the way back in 1974, and reiterated in 2016—a rule that sets rigid one-size-fits-all staffing requirements will lead to overstaffing in some facilities and understaffing in others. *See* 39 Fed. Reg. at 2239; 81 Fed. Reg. at 68754-58.

Indeed, even the 2022 Abt Associates study commissioned by CMS illustrates the problems with trying to set one-size-fits-all staffing requirements. While the Abt Associates study reached the unremarkable (and undisputed) conclusion that increased staffing is generally correlated with better outcomes, one of its "key findings" was that there is "no obvious plateau at which quality

and safety are maximized or 'cliff' below which quality and safety steeply decline." AR_00069993. For that reason, the Abt Associates study—like the many prior studies on the subject—was unable to identify any optimal, generally applicable minimum staffing threshold, and instead presented a range of "options" without endorsing any specific standard. *See* AR_00069994-AR_000700003. The study thus provides further confirmation that it is not reasonable to replace the flexible, facility-specific inquiry contemplated by Congress with the nationwide quantitative minimum staffing standards adopted by the Final Rule.

The Final Rule's nationwide staffing mandates also fail to take account of the extensive variation among the States. Pltfs.Br.37-38. "[D]ifferent local circumstances"—including vast differences in state Medicaid rates and supply of RNs and NAs—"make different staffing levels appropriate (and higher levels impracticable) in different areas of the country." AR_00057757; *see* 81 Fed. Reg. at 68755; AHA.Amicus.Br.7-14. By ignoring those local differences—and setting fixed nationwide requirements that "exceed the existing minimum staffing requirements in nearly all States," 89 Fed. Reg. at 40877—the Final Rule defies rationality.

CMS again has no persuasive response. It asserts that the Final Rule "is not a rigid prescription" but only a "floor," and that nursing homes will "maintain flexibility" to staff at levels even higher than the Final Rule requires. CMS.Br.34-35. But allowing nursing homes the "flexibility" to hire even more staff than the Final Rule requires, CMS.Br.35, cannot justify the irrationality of setting an inflexible nationwide floor that ignores varying local conditions, is higher than existing staffing requirements in practically all of the 38 States that already have such requirements, and will require nearly four out of every five nursing homes in the country to hire additional staff—all competing with each other to do so at the same time, no less. *See* 89 Fed. Reg. at 40877. The agency's assertion that the Final Rule's requirements represent a "minimum

standard necessary for resident health and safety," CMS.Br.35, is irreconcilable with the judgment of both Congress and state governments (including Plaintiff State of Texas) in setting their own standards. *See* Pltfs.Br.25-26, 37-38, 40. Indeed, far from disputing that its new standards exceed the minimum staffing levels deemed appropriate by practically all of the 38 States that have set such requirements, CMS openly admits that overriding those states' judgments about appropriate staffing levels "is precisely the point." CMS.Br.45-46.

CMS's claim that its new standards are necessary for resident health and safety also contravenes CMS's own survey findings, which indicate that "roughly 95 percent of facilities" are "providing 'sufficient nursing staff'" even though most of them do not meet one or more of the new requirements, AR_00057776, and with CMS's acknowledgment that nursing homes will be required to meet the Final Rule's new requirements even if CMS's own individualized 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; *see* Pltfs.Br.38-39. CMS has no answer to those glaring irrationalities.

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

That is far from the end of the Final Rule's defects. The Final Rule will require LTC facilities to massively increase their nursing staff, to the tune of approximately 15,906 RNs and 77,611 NAs nationwide, and 2,579 RNs and 7,887 additional NAs in Texas alone. *See* 89 Fed. Reg. at 40957-58, 40976-80. Many nursing homes will find it simply impossible to comply with these mandates—whether because they are not able to find qualified candidates to fill the new positions, due the ongoing nationwide shortage of RNs and NAs, or because they simply cannot afford the cost of so many additional staff on top of the rising costs of care, underfunding of Medicaid, and ongoing inflation. *See* Pltfs.Br.22-23, 40-43. On top of that, the Final Rule irrationally encourages nursing homes to replace experienced LPNs/LVNs with less-qualified NAs

and irrationally ignores the contributions of numerous other non-nursing professionals who provide vital care to nursing home residents. Pltfs.Br.41-42.

CMS's effort to defend the Final Rule by downplaying the significant workforce shortage falls flat. To begin, CMS impermissibly relies on an HHS report that is not in the administrative record and on which the agency could not have relied in issuing the Final Rule. *See* CMS.Br.36-37 & n.12; *cf. Harris v. United States*, 19 F.3d 1090, 1096 n.7 (5th Cir. 1994) ("[W]e may not consider evidence outside the administrative record when determining whether to uphold agency action."). In any event, that report does not help CMS. Its proffered statistic about how many facilities provide "at least 24 hours of total RN staffing per day" says nothing about how many provide "24/7 'around the clock' RN coverage," as the Final Rule requires. ASPE, *Nurse Staffing Estimates in US Nursing Homes, May 2024* 1 (June 28, 2024), https://tinyurl.com/bdfe4e3k. And the report confirms that *70%* of the nursing homes across the country do not currently meet the NA HPRD requirement, CMS.Br.36, which is in line with CMS's own estimate that some 79% of all nursing homes would have to hire additional staff to comply with the Final Rule, *see* 89 Fed. Reg. at 40877. By any measure, the Final Rule's total impact on nursing home staffing—including the need to increase RN staffing by about 11.8% nationwide (and 46.1% in Texas), and to increase NA staffing by about 17.2% nationwide (and 28.4% in Texas)—will be enormous.

CMS's blithe assurance that it "seriously grappled with the concerns about nursing availability raised during the rulemaking process" is cold comfort. CMS.Br.37. In adopting the Final Rule's sweeping mandates, CMS gave short shrift to the reality that many nursing homes simply will not be able to find enough qualified staff to meet one or more of the new requirements—forcing facility closures that could displace thousands of vulnerable residents. *See* AR_00057756 (explaining that "hundreds of thousands are expected to retire or leave the health

care profession entirely in the coming years"); AR_00068969 ("Recommending a staffing requirement that something like 80% of facilities cannot comply with is … the definition of policy insanity."); *see also* Pltfs.Br.26-27, 34-35, 40-44. Merely "nodding to [stakeholders'] concerns" that the Final Rule's requirements will be impossible to meet due to the nationwide absence of qualified staff does not satisfy the Administrative Procedure Act ("APA"). *Texas v. Biden*, 10 F.4th 538, 556 (5th Cir. 2021) (per curiam).

CMS's only substantive attempt to address the dire workforce shortage—$75 million in incentives for nursing careers, 89 Fed. Reg. at 40887—will come nowhere near generating the tens of thousands of additional nursing staff that the Final Rule demands, or offsetting its $43 *billion* in additional costs. *See* AR_00057774; AR_00066194-AR_00066195; Pltfs.Br.43; AHA.Amicus.Br.14-23 (detailing how mandating large increases in nursing home staffing will have harmful effects on other healthcare institutions). *Contra* CMS.Br.36, 38. And CMS's contention that some nursing homes may be in a position to absorb the massive costs imposed by the Final Rule, CMS.Br.38 (citing 89 Fed. Reg. at 40880), is no answer for the undisputed evidence that nearly 60% of all nursing homes already have negative operating margins, making it impossible for them to face the additional cost of the Final Rule's new $43 billion unfunded mandate. AR_00057756.

Nor will the Final Rule's delayed implementation timeline remedy the ongoing shortage in nursing staff or lack of available funding. *See* Pltfs.Br.43-45. *Contra* CMS.Br.38-39. On the contrary, the nationwide staffing shortage is only growing over time, *see* Pltfs.Br.43-44, and the staggered implementation timeframe risks "pit[ting] urban and rural areas against each other" as the Final Rule's requirements come into effect in each area. Pltfs.Br.44 (quoting AR_00066200). CMS's assertion that "if a demand for nursing staff in urban areas were to draw nurses away from

rural areas, that phenomenon would already be occurring," CMS.Br.45, simply ignores the *new* demand that the Final Rule will create, and the different timing of that demand in urban and rural areas in light of the Final Rule's staggered implementation. *See* Pltfs.Br.20-21. And CMS's assertion that the Final Rule's "delayed implementation schedule" means "there will be plenty of time for the workforce to replenish in the intervening years between urban and rural deadlines," CMS.Br.45, is supported by nothing but wishful thinking.

The hardship exemption process in the Final Rule is an equally inadequate response to the nationwide staffing shortage that nursing homes face. *Contra* CMS.Br.39. CMS admits that a facility cannot request that exemption until it has been cited for noncompliance, effectively forcing nursing homes to violate the standards before they can determine whether they are exempt. CMS.Br.41-42; *see* 89 Fed. Reg. at 40902; Pltfs.Br.44-45. And while CMS claims that a "significant number of facilities are likely to meet the workforce availability criterion of the exemption, CMS.Br.42—because facilities across the country all face a massive workforce shortage—its assurance that the exemption will be "sufficiently available" for those facilities, CMS.Br.42, simply ignores its own contrary assertions that the exemption will be provided only in "limited circumstances" and that many facilities will not meet the "other requirements" necessary "to obtain an exemption," 89 Fed. Reg. at 40894, 40953.

CMS acknowledges that the $43 billion cost to nursing homes of the Final Rule is "not insignificant," but claims that cost is small relative to the total amount that Medicare and Medicaid spend on nursing home care, and that the additional expense "will be factored into Medicare and Medicaid reimbursement." CMS.Br.39-41. Those assurances are hardly comforting when nearly 60% of nursing homes already have negative operating margins, AR_00057756, and average

Medicaid rates already "cover approximately only 84% of the cost of care," AR_00066194; *see* Pltfs.Br.21-22. Again, CMS has no meaningful response.

Finally, CMS cannot defend the Final Rule's treatment of LPNs/LVNs. *See* Pltfs.Br.41-42. CMS claims that it set HPRD requirements for RNs and NAs because it found those categories "had the biggest impact on health and safety outcomes of residents," while "increased staffing of LPN/LVNs was found to have negligible impact." CMS.Br.44. But by setting no LPN/LVN HPRD requirement at all, and setting the NA HPRD requirement at a level that some 70% of the nursing homes in the country do not currently meet, *see* CMS.Br.36, the Final Rule creates a perverse incentive for nursing homes "to terminate LPN/LVNs and replace them with … [less qualified] nurse aides." 89 Fed. Reg. at 40893 (summarizing comments); *see* Pltfs.Br.41-42. CMS has no answer whatsoever to that obvious problem. *See* CMS.Br.44. Nor does CMS have any answer to the Final Rule's irrational treatment of the contributions of non-nursing staff, which its inflexible requirements likewise ignore. *See* Pltfs.Br.41-42.

While everyone agrees that all nursing homes need adequate staffing, and that some nursing homes are understaffed, imposing a blanket 24/7 RN requirement and three rigid HPRD requirements—amidst a long-term workforce shortage, without any additional funding—is not a rational solution to these challenges. The Final Rule contravenes not only Congress' statutory minimum staffing standards for nursing homes, but the broader and fundamental requirements of rational administrative decisionmaking. It must therefore be set aside as arbitrary and capricious.

III. Vacatur Is The Appropriate Remedy.

The proper remedy for all of these flaws in the Final Rule is to vacate the 24/7 RN requirement and all three HPRD requirements. *See* Pltfs.Br.5; CMS.Br.47-48. The Fifth Circuit has repeatedly held that vacatur is "the 'default' remedy for unlawful agency action" under the APA. *Braidwood Mgmt., Inc. v. Becerra*, 104 F.4th 930, 952 (5th Cir. 2024) (quoting *Data Mktg.*

P'ship, LP v. U.S. Dep't of Lab., 45 F.4th 846, 859 (2022)). While Defendants seek to "preserve" an argument that the APA "does not authorize *any* particular form of relief," they correctly acknowledge that this argument is foreclosed by binding precedent. CMS.Br.46-47. Indeed, the Fifth Circuit recently stated that vacatur is not only "statutorily permissible" but "required." *Tex. Med. Ass'n*, 110 F.4th at 780. And rightly so: "Vacatur is the only statutorily prescribed remedy for a successful APA challenge to a regulation," *Franciscan All., Inc. v. Becerra*, 47 F.4th 368, 374-75 (5th Cir. 2022), and the APA uses mandatory language ("shall") in directing courts to vacate unlawful agency actions, *see* 5 U.S.C. §706; *Braidwood Mgmt.*, 104 F.4th at 952.[4]

Defendants assert that "any relief should be limited, at most, to facilities operated by Plaintiffs and their members." CMS.Br.48. That argument is likewise foreclosed by binding precedent. Earlier this year, the Fifth Circuit reiterated that "setting aside agency action under § 706 has 'nationwide effect,' is 'not party-restricted,' and 'affects persons in all judicial districts equally.'" *Braidwood Mgmt.*, 104 F.4th at 951 (quoting *In re Clarke*, 94 F.4th 502, 512 (5th Cir. 2024); *Career Colls. & Schs. of Tex. v. U.S. Dep't of Educ.*, 98 F.4th 220, 255 (5th Cir. 2024)). "That is because, unlike an injunction, which operates *in personam*, vacatur operates on the status of agency action in the abstract." *Id.* (footnote omitted). Cases involving an injunction—such as *Gill v. Whitford*, 585 U.S. 48, 73 (2018) (cited at CMS.Br.46, 48), and *Madsen v. Women's Health Ctr., Inc.*, 512 U.S. 753, 765 (1994) (same)—are therefore inapposite. Indeed, the Fifth Circuit has expressly rejected the notion that district courts should consider "the various equities at stake

[4] "In rare cases," some courts "do not vacate the action but instead remand for the agency to correct its errors." *United Steel v. Mine Safety & Health Admin.*, 925 F.3d 1279, 1287 (D.C. Cir. 2019). But CMS's brief does not argue for the unorthodox remedy of remand without vacatur, so any such argument is forfeited. In all events, that unorthodox remedy would be inappropriate here, given the "seriousness of the deficiencies" in the Final Rule and the disruptive consequences that would follow from denying vacatur. *Id.*

before determining that a party is entitled to vacatur." *Braidwood Mgmt.*, 104 F.4th at 952. In short, nationwide vacatur is not only the default remedy under the APA but also the appropriate remedy in this case.

CONCLUSION

This Court should grant Plaintiffs' motion for summary judgment, deny Defendants' cross-motion, and set aside the 24/7 RN requirement and the HPRD requirements.

Respectfully submitted,

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