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

AMERICAN HEALTH CARE ASSOCIATION, et al.,

Plaintiff(s),

v.

XAVIER BECERRA, et al.,

Defendant(s).

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

BRIEF OF AARP, AARP FOUNDATION, AMERICAN NURSES ASSOCIATION, CALIFORNIA ADVOCATES FOR NURSING HOME REFORM, THE CENTER FOR MEDICARE ADVOCACY, THE LONG TERM CARE COMMUNITY COALITION, JUSTICE IN AGING, AND THE NATIONAL CONSUMER VOICE FOR QUALITY LONG-TERM CARE AS AMICI CURIAE IN SUPPORT OF DEFENDANTS

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AARP and AARP Foundation

AARP is the nation's largest nonprofit, nonpartisan organization dedicated to empowering Americans ages 50 and older to choose how they live as they age. With a nationwide presence, AARP strengthens communities and advocates for what matters most to the more than 100 million Americans 50-plus and their families: health security, financial stability, and personal fulfillment. AARP's charitable affiliate, AARP Foundation, works for and with vulnerable people 50 and over to end senior poverty and reduce financial hardship by building economic opportunity.

Among other areas, AARP and AARP Foundation fight for the right of nursing facility residents to obtain judicial redress when they have been victims of abuse and neglect, and frequently appear as friends of the court on issues affecting nursing facility residents.

American Nurses Association

The American Nurses Association ("ANA") represents the interests of the nation's five million registered nurses. Founded in 1896, ANA has members in all 50 states and in U.S. territories. It is comprised of both individual nurses and state nurses associations. ANA is an advocate for improving the quality of health care for all.

California Advocates for Nursing Home Reform

California Advocates for Nursing Home Reform ("CANHR") is a non-profit organization that represents the interests of approximately 100,000 California nursing facility residents and their families. Since 1983, CANHR has been advocating for the rights of long-term care residents. CANHR and its 3,000 members have a substantial interest in ensuring that quality care be provided to persons living in nursing facilities. CANHR's efforts include aiding residents and

their families in obtaining legal services for long-term care issues; working to impose tougher sanctions on nursing facilities that abuse or neglect residents; providing consumers, attorneys, and social workers with accurate information on long-term care; and continually working to determine the root causes of poor care and developing legislation and policies to address them.

The Center for Medicare Advocacy

The Center for Medicare Advocacy is a national, private, non-profit law organization, founded in 1986, that provides education, analysis, advocacy, and legal assistance nationwide, primarily to assist the elderly and people with disabilities to obtain necessary healthcare, therapy, and Medicare. The Center for Medicare Advocacy focuses on the needs of Medicare beneficiaries, people with chronic conditions, and those in need of long-term care, and provides nationwide training regarding Medicare and healthcare rights. It advocates on behalf of beneficiaries in administrative and legislative forums and serves as legal counsel in litigation of importance to Medicare beneficiaries and others seeking healthcare coverage.

Justice in Aging

Justice in Aging is a national non-profit legal advocacy organization that fights senior poverty through law. Justice in Aging was founded in 1972 (originally under the name "National Senior Citizens Law Center") and maintains offices in Washington, D.C., and Los Angeles and Oakland, California. Justice in Aging advocates for affordable health care and economic security for older adults with limited resources, focusing especially on populations that have traditionally lacked legal protection. Justice in Aging's work includes substantial advocacy on behalf of nursing facility residents, including federal administrative and legislative advocacy.

The Long Term Care Community Coalition

The Long Term Care Community Coalition ("LTCCC") is a nonprofit organization dedicated to improving quality of care, quality of life and dignity for elderly and disabled people in nursing facilities, assisted living, and other residential settings. LTCCC focuses on systemic advocacy, researching relevant national and state policies, laws, and regulations in order to identify relevant issues and develop meaningful recommendations to improve quality, efficiency, and accountability. In addition to providing a foundation for advocacy, LTCCC uses this research and the resulting recommendations to educate policymakers, consumers, and the general public. Consumer, family, and long-term care Ombudsman empowerment are fundamental to its mission.

The National Consumer Voice for Quality Long-Term Care

The National Consumer Voice for Quality Long-Term Care ("Consumer Voice") was formed as NCCNHR (the National Citizens' Coalition for Nursing Home Reform) in 1975 due to public concern for substandard care in nursing facilities. Consumer Voice has since become the leading national voice representing consumers in issues relating to long-term care and is the primary source of information and tools for consumers, families, caregivers, ombudsmen, and other advocates to help ensure quality care for all residents. Consumer Voice is dedicated to advocating for quality care, quality of life, and protection of rights for all individuals receiving long-term services and supports.

Amici are organizations that represent the interests of older adults and nursing facility residents. We submit this brief to explain why the Centers for Medicare & Medicaid Services

("CMS") nationwide mandatory minimum staffing rule ("the Final Rule")[1] is critical to protecting nursing facility residents' health and safety. Amici urge this Court to grant the Defendants' cross-motion for summary judgment, deny Plaintiffs' motion for summary judgment, and allow the U.S. Department of Health and Human Services ("HHS") and CMS to implement the rule.

INTRODUCTION AND SUMMARY OF ARGUMENT

HHS's announcement of a nationwide minimum nursing facility staffing requirement in May 2024 was a watershed moment for people living in nursing facilities. For more than 37 years, residents, their caregivers, and advocates alike have been raising the alarm that nursing facilities were dangerously understaffed, leading to devastating – and even deadly – consequences for residents. Time and time again, residents and advocates shared their experiences of unsafe and unsanitary living conditions in understaffed facilities, including:

- Residents lying in feces and urine for hours with their call lights ignored;
- Residents breaking bones from being dropped when one staff member tries to help them transfer using equipment that requires two or more people;
- Residents starving and losing weight because they are not provided meals or given needed assistance in eating;
- Residents given mind-altering antipsychotic drugs without medical justification to keep them docile;
- Residents dying after treatable illnesses were missed because no one was monitoring their condition;

[1] *Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting*, 89 Fed. Reg. 40876 (May 10, 2024) ("Final Rule").

- Residents developing life-threatening stage 4 pressure ulcers because they were never repositioned; and
- Residents in dementia units wandering away from the facility and becoming lost and dying.

The cause of these harms has been clear. In many nursing facilities nationwide, there simply are not enough staff in terms of number and skill to provide the care that the residents need. And despite the federal Nursing Home Reform Act's ("NHRA") requirement that every nursing facility provide "nursing services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident," many nursing facilities are flouting their responsibility – and getting away with it. Adding to the crisis is an influx of for-profit and private equity companies that divert money from paying workers to increase personal profits.

With these factors in mind, it is no wonder that this crisis came to a dramatic and inevitable head during the COVID-19 pandemic. More than 200,000 residents and workers died during the pandemic. Despite being only .004% of the nation's population, nursing facility residents made up 20% of all COVID-19 deaths in the United States. Numerous studies have shown that understaffing contributed to the catastrophic effects of COVID-19 on nursing facility residents.

Unable to ignore the evidence any longer, HHS had the duty to act. Since 1970, research studies have consistently shown that higher staffing levels are associated with better resident care quality across multiple measures of care, including lower mortality rates, fewer pressure ulcers, less weight loss, and less improper use of antipsychotics. HHS recognized that it had to make federal minimum staffing standards a condition of participating as a Medicare and/or Medicaid-

funded nursing facility. Nursing facilities that voluntarily choose to receive Medicare and Medicaid funding are paid over $80 billion annually in taxpayer dollars to provide quality care. High quality care requires sufficient staff to meet residents' needs.

The Final Rule fulfills HHS's statutory mandate to protect residents by requiring facilities to meet at least a minimum staffing level standard. The rule is needed because too many facilities across the country are chronically understaffed and risk residents' lives. Defendants' cross-motion for summary judgment should be granted and Plaintiffs' motion should be denied. In sum, HHS should be allowed to implement the staffing requirements of the Final Rule.

ARGUMENT

I. The Final Rule Must Be Implemented To Protect Nursing Facility Residents' Health And Safety.

A. Nursing facility residents have suffered under years of nursing facility understaffing.

To understand why the Final Rule is so important to the health and safety of nursing facility residents, we ask that the Court consider the horrible consequences that nursing facility residents suffer in understaffed nursing facilities. In 2023, more than 1.2 million nursing facility residents lived in 15,000 nursing facilities certified to participate in the Medicaid and Medicare health insurance programs. *See* Kaiser Fam. Found., *Total Number of Residents in Certified Nursing Facilities* (July 2023).[2]

When facilities are chronically understaffed, residents are put in precarious positions because residents depend on nursing facility staff for all aspects of their care. Most residents are elderly, with 82% being more than 65 years old. *Data from the 2020 National Post-Acute and*

[2] https://www.kff.org/other/state-indicator/number-of-nursing-facility-residents/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

Long-Term Care Study, Ctrs. for Disease Control & Prevention, Table 4 (2020) (detailing nursing facility residents' characteristics).[3] They depend on nursing facility staff to accomplish the most basic and intimate activities of daily living ("ADLs"), including eating, bathing, dressing, and toileting. *Id.* At least eighty-seven percent of residents need assistance with five or more ADLs. *Id.* Forty-five percent have Alzheimer's disease or other dementias resulting in cognitive impairment. *Id.* Because they reside in the facility, residents are largely isolated from their family and friends. *See* Kjersti Lisbeth Braaten and Wenche Malmedal, *Preventing Physical Abuse of Nursing Home Residents- As Seen From the Nursing Staff's Perspective*, 2017 Nursing Open 274, 278 (2017).[4] Taken together, these factors result in residents depending on nursing facility staff to meet their most basic human needs every day.

Yet, instead of nursing facilities meeting their responsibility of providing care to their residents, for decades many nursing facility owners have consistently understaffed their facilities, leading to disastrous consequences for residents. The following examples illustrate this point.

1. Former nursing facility aide Jacinda G. described the horrible conditions that residents suffered due to the understaffing at her employer. Jayme Fraser, Nick Penzenstadler & Jeff Kelly*, Many Nursing Homes are Poorly Staffed. How Do They Get Away with it?*, USA Today, (Dec. 1, 2022, 4:02 PM).[5] When she arrived for her shift, she would often find residents who had been lying in bed, soaked in urine and feces for 8 or more hours. *Id.* Urine and stool ran up the residents' backs to their necks. *Id.* Because of inadequate staffing, she had to prioritize which residents would receive care. *Id.* Residents would be crying. *Id.*

2. An Iowa nursing facility that underwent an emergency evacuation was so short-staffed that staff had to call 911 for assistance with residents. C. Kauffman, *Report: Nursing Home Owner Balked at Hiring More Staff Before Evacuation Order*, Iowa Capital Dispatch, (Sept. 19, 2024, 3:47 PM). As a result of the understaffing, residents suffered staff-on-resident abuse, resident-on-resident sexual abuse, significant medication errors, falls, and lack of pain management. *Id.* Many residents

[3] https://www.cdc.gov/nchs/npals/webtables/overview.htm.
[4] https://pmc.ncbi.nlm.nih.gov/articles/PMC5653394/.
[5] https://www.usatoday.com/in-depth/news/investigations/2022/12/01/skilled-nursing-facilities-staffing-problems-biden-reforms/8318780001/.

had no staff assigned to their part of the facility for the evening. *Id*. One certified nursing assistant explained that the facility was so understaffed, that the only care the staff could provide was to "make sure people didn't get out of the building" by wandering away. *Id.*

3. A study by Human Rights Watch linked the understaffing of facilities to the widespread inappropriate and dangerous use of antipsychotic drugs in older people with dementia as a chemical restraint. Hannah Flamm et al., "*They Want Docile" How Nursing Homes in the United States Overmedicate People With Dementia,* Hum. Rts. Watch,(Feb. 5, 2018) ("Our research on the inappropriate use of antipsychotic medications identified the failure to ensure minimum staffing levels necessary for residents to attain their highest practicable wellbeing and the lack of explicit requirements around informed consent (or functionally equivalent legal requirements that are framed in different terms) as key gaps in existing regulations.").[6] This conduct is life-threatening abuse. The U.S. Food and Drug Administration has approved antipsychotic drugs for the treatment of psychotic conditions such as schizophrenia and bipolar disorder. *Id*. It has not approved these drugs to treat dementia. In fact, it issued its most dire warning—a black box warning— on these drugs because of the increased risk of death when administered to elderly patients with dementia. *Id.* But a shocking number of facilities use these drugs without medical justification to control residents with dementia because they do not have enough staff to properly care for them. *Id.* In short, they risk the residents' lives. *Id.*

The dire consequences for residents in these understaffed facilities are predictable given that the residents are in the facility to receive care from staff. *See* Nat'l Consumer Voice for Quality Long-Term Care, *The Impact of Understaffing on the Daily Lives of Nursing Home Residents* (2024) (reporting the results of a 2023 resident survey that detailed how understaffing impacts residents' lives).[7] After all, when there are not enough staff to help a resident safely transfer from one location to another, residents experience falls or get injured from being dropped. *See id.* at 8, 9. When there are not enough staff to help a resident eat and drink, residents experience extreme weight loss, dehydration, and related illnesses. *See id.* at 1, 4, 9. When there are not enough staff to reposition residents, residents develop dangerous pressure

[6] https://www.hrw.org/report/2018/02/05/they-want-docile/how-nursing-homes-united-states-overmedicate-people-dementia.

[7] https://theconsumervoice.org/uploads/files/general/The_Impact_of_Understaffing_on_Residents.pdf.

ulcers that become infected and cause avoidable, debilitating pain. *See* Fraser, *supra*. When there are not enough staff to monitor the residents, disoriented residents wander from the facility, fall down a flight of stairs while unsupervised, get into an altercation with a staff member or another resident, or injure themselves. *See id.* When there are not enough staff to monitor and implement residents' plans of care, residents' physical and mental functioning deteriorates. *See id.* When there are not enough staff to clean the facility, the building becomes a breeding ground for infection, bacteria, and illness.

Several studies confirm that staffing levels are a critical indicator of a nursing facility's quality and safety. *See, e.g.*, John F. Schnelle et al., *Relationship of Nursing Home Staffing to Quality of Care,* 39 Health Serv. Res. 225 (2004) (finding that the highest-staffed facilities provided significantly better care than lower-staffed facilities);[8] Jane E. Bostick et al., *Systematic Review of Studies of Staffing and Quality in Nursing Homes*, 7 J. Am. Med. Dirs. Ass'n 366 (2006) (finding that studies establish a proven association between higher total staffing levels and improved quality of care and a significant relationship between high staff turnover and poor resident outcomes).[9] Studies show that nursing facilities with more nursing staff have better results in quality, on-site governmental survey scores, and resident quality outcome measures. *Id.* On the other hand, when staffing is inadequate, residents suffer grave harm, including painful pressure wounds, injuries from falls, weight loss, depression, hospitalizations, and even death. *See, e.g.*, Charlene Harrington & Toby Edelman, *Failure to Meet Nurse Staffing Standards: A Litigation Case Study of a Large US Nursing Home Chain*, 5 Inquiry 1 (2018).[10]

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[8] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361005/.
[9] https://www.jamda.com/article/S1525-8610(06)00051-X/fulltex.
[10] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6055099/.

Despite overwhelming evidence of the palpable dangers of understaffing, several factors have resulted in the crisis not being addressed without federal intervention. First, while the residents have been experiencing harm from understaffing, nursing facilities have been experiencing booming profits. A 2023 study found that nursing facilities make about $11 billion in profits annually. Charlene Harrington et al., *United States' Nursing Home Finances: Spending, Profitability, and Capital Structure,* 54 Int'l J. Soc. Determ. Health & Human Servs. 131, 135 (2023).[11] The study authors analyzed the 2019 Medicare cost reports of 11,752 nursing facilities. *Id.* at 132. They found that facilities made $126 billion in net revenue. *Id.* at 134. The facilities' profit margins were about nine percent when the authors excluded disallowed costs and depreciation. *Id.* at 135.

In addition, facilities collectively paid $11 billion to "related parties," which are companies that have a shared financial interest with the nursing facility owners. *Id.* at 138. Earlier this year, researchers from UCLA and Lehigh University released a study finding that many nursing facilities were extracting substantial profits by overcharging related parties for inflated rents and management fees. Ashvin Gandhi & Andrew Olenski, *Tunneling and Hidden Profits in Health Care*, 10 (Nat'l Bureau of Econ. Rsch., Working Paper No. 32258, 2024) (showing facility rents and management fees are 43.1% and 34.2%, respectively, of all related party spending).[12]

Second, the influx of for-profit facilities and private equity firms owning facilities has greatly impacted the industry. Nursing facilities have a strong profit incentive to keep staffing low because payments to staff are a key driver of overall costs. Nina A. Kohn, *Nursing Facilities,*

[11] https://pubmed.ncbi.nlm.nih.gov/38115716/.
[12] https://www.nber.org/papers/w32258.

COVID-19, and the Consequences of Regulatory Failure, 110 Geog. L. J. Online 1, 6 (Spring 2021). For-profit nursing facilities, which comprise 70% of the industry, are particularly susceptible to the pressure to understaff for higher profits. *Id.* These facilities frequently have lower staffing levels and more deficiencies than non-profit facilities. *Id.* For example, amicus Consumer Voice analyzed staffing levels at for-profit nursing facilities and compared them with those of not-for-profit facilities. Nat'l Consumer Voice for Quality Long-Term Care, *Better Staffing is Achievable: A Look at For-Profit versus Non-Profit Nursing Homes* (2023).[13] On average, for-profit facilities provided 23% less staff than non-profit facilities. *Id.*

Knowledgeable investors, including real estate investment trusts, private equity firms, and other sophisticated enterprises, see nursing facilities as a profitable investment. Sadly, understaffing is particularly common in facilities that private equity firms have taken over. Atul Gupta et al., *Incentives and Performance in Healthcare: Private Equity Investment in Nursing Homes* (Nat'l Bureau of Econ. Rsch., Working Paper No. 28474, 2021) (showing that facilities run by private equity firms have increased mortality likely due to lower staffing levels and less compliance with care standards).[14] Private equity firms often have complex ownership structures with less transparency. Therefore, there is less information on how funds are used, including the extent to which funds are diverted from resident care and staffing.

Private equity ownership of nursing facilities has been associated with higher costs and increases in emergency department visits and hospitalizations for ambulatory-sensitive conditions. *See, e.g.*, Robert Tyler Braun et al., *Association of Private Equity Investment in US Nursing Homes with the Quality and Cost of Care for Long-Stay Residents.* JAMA Health F. 1

[13] https://theconsumervoice.org/uploads/files/issues/Better_Staffing_Is_Achievable.pdf.
[14] https://www.nber.org/papers/w28474.

(2021) (finding that private equity acquisition of nursing facilities was associated with higher costs and increased emergency department visits and hospitalizations for ambulatory care sensitive conditions).[15] It also has been associated with higher short-term mortality, lower measures of well-being, and lower total nurse staffing ratios (i.e., fewer nursing hours per resident per day). Nat'l Acad. of Sci., Eng'g & Med., *The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families, and Staff* 430 (2022).[16]

Third, federal and state regulatory enforcement alone has been ineffective in remedying understaffing. Despite having statutory authority, regulators rarely impose penalties for deficiencies that would have substantial financial implications for facilities. 42 U.S.C. § 1396r(h)(1)-(2) (authorizing termination from the Medicare and Medicaid programs, denial of payment, civil monetary fines, and appointment of a temporary manager as penalties for nursing facility deficiencies). For most types of violations, no monetary fines are levied. *See, e.g.*, U.S. Gov't Accountability Off., *Nursing Homes: Improved Oversight Needed to Better Protect Residents from Abuse* 17-18 (2019) (finding that penalties were implemented in less than 8% of cases where facilities were cited for abuse deficiencies).[17] As a result, too many nursing facilities understaff and flout federal and state requirements with impunity.

Finally, the lack of a national mandatory minimum staffing standard means that some facilities operate with even less than bare-bones staff. Residents and their advocates have long called for a national minimum staffing standard to protect the health and safety of residents. In 2001, CMS commissioned a years-long staffing study to determine nurse staffing thresholds

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15 https://doi.org/10.1001/jamahealthforum.2021.3817.
16 https://doi.org/10.17226/26526.
17 https://www.gao.gov/assets/gao-19-433.pdf.

minimally necessary to provide care consistent with the NHRA. Abt Associates Inc., *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Report to Congress: Phase II Final Volumes I-III* (2001).[18] The study found that, to meet the care requirements of the NHRA, each resident needed at least 4.1 hours of direct care to avoid having their care compromised. *Id.* at 5. But CMS never implemented that standard. As a result, nursing facility residents across the country have experienced grossly inadequate staffing levels for decades.

Thus, the perfect storm of (1) the financial incentive to understaff to save money; (2) for-profit and private equity companies increasing their percentage of the nursing facility market; (3) the lack of effective regulatory enforcement; and (4) the lack of a national minimum staffing requirement worked to create an environment where understaffing would continue for years. And it may have continued indefinitely if the pandemic had not thrust the staffing crisis into the forefront of our national consciousness.

The shocking number of people who lost their lives in nursing facilities exposed the devastating consequences of understaffing to the world. COVID-19 caused the deaths of more than 200,000 nursing facility residents and staff. Priya Chidambaram, *Over 200,000 Residents and Staff in Long-Term Care Facilities Have Died From COVID-19*, KFF (Feb. 3, 2022). These deaths have made it impossible for policymakers and the public to ignore facilities' longstanding crisis in understaffing. Numerous studies and reports linked higher direct care staffing levels to fewer COVID-19 outbreaks and resident deaths. *See* Jose F. Figueroa et al., *Association of Nursing Home Ratings on Health Inspections, Quality of Care, and Nurse Staffing with COVID-*

[18] https://theconsumervoice.org/uploads/files/issues/CMS-Staffing-Study-Phase-II.pdf.

19 Cases, 324 JAMA 1103–1105 (2020) (finding that across 8 states, high-performing nursing facilities for nurse staffing had fewer COVID-19 cases than low-performing nursing facilities).[19]

The government had to take long overdue action to protect nursing facility residents from the avoidable danger that understaffing poses. It did so by imposing the mandatory minimum staffing standard in the Final Rule.

B. Implementing the CMS minimum staffing rule will protect residents' health and safety.

1. The federal Nursing Home Reform Act gives HHS the duty and authority to protect residents' health and safety.

As noted above, chronic understaffing, while exacerbated during the pandemic, has long plagued nursing facilities. After recognizing that staffing levels were critical to ensuring that residents get the care they need, the government had a statutory duty to protect residents' health and safety. It did so by establishing a mandatory minimum staffing standard that each nursing facility must meet.

The rule falls directly within HHS's duty and authority to protect residents under the NHRA. Congress passed the NHRA in 1987 after an Institute of Medicine study found that in too many nursing facilities, residents were being abused and neglected, and receiving "very inadequate - sometimes shockingly deficient - care." Comm. on Nursing Home Regul., Inst. of Med., *Improving the Quality of Care in Nursing Homes* 2 (1989).

The NHRA implemented significant protections for nursing facility residents, including requiring that every skilled nursing facility provide "nursing services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and

[19] https://jamanetwork.com/journals/jama/fullarticle/2769437?guestAccessKey=258f9d19-b7c2-43e2-9218-55c23d3914bc&utm_source=silverchair&utm_medium=email&utm_campaign=article_alert-jama&utm_content=olf&utm_term=081020.

psychosocial well-being of each resident." 42 U.S.C. § 1395i-3(b)(4)(A)(i). The NHRA requires nursing facilities receiving federal funds to "meet such other requirements relating to the health, safety, and well-being of residents or relating to the physical facilities thereof as the Secretary may find necessary." 42 U.S.C. §§ 1395i–3(d)(4)(B), 1396r(d)(4)(B). It defined the Secretary's "duty and responsibility" to ensure that requirements of care and their enforcement "are adequate to protect residents' health, safety, welfare, and rights and to promote the effective and efficient use of public moneys." 42 U.S.C. §§ 1395i–3(f)(1), 1396r(f)(1).

Nowhere does the NRHA prohibit the Secretary from adopting additional Requirements of Participation. To the contrary, the law advises nursing facilities that voluntarily choose to participate in the Medicare and Medicaid programs that they must "meet such other requirements relating to the health, safety, and well-being of residents . . . as the Secretary may find necessary." 42 U.S.C. §§ 1395i-3(d)(4)(B), 1396r(d)(4)(B).

Thus, the Final Rule is part and parcel of the Secretary's responsibility to protect residents' health, safety, and well-being. Key provisions of the Final Rule require:

1. Nursing facilities to have a minimum of 3.48 hours per resident per day (HPRD), with each resident receiving at least .55 hours of care from a registered nurse (RN) per day and at least 2.45 hours of care from a nursing aide (NA) per day;
2. An RN on-site at facilities 24 hours a day, seven days a week to provide direct patient care;
3. A staggered timetable for implementation;
4. A proposal for hardship exemptions from the minimum staffing standards for HPRD and the 24/7 on-site RN requirements. The hardship exemptions are limited to facilities in geographic areas where the provider-to-population ratio for

nursing workforce is 20% below the national average after a showing of good faith; and

5. Continued finalization of facility assessment requirements.

89 Fed. Reg. 40876, 40877-40879 (May 10, 2024).

As outlined in the rule, CMS's decision regarding the provisions was not arbitrary. 89 Fed. Reg. 40876, 40877 (May 10, 2024). Instead, it issued the Rule after thoroughly considering voluminous materials, including comments from more than 46,000 people and organizations. *Id.* Residents of facilities and nurses supported the need for a mandatory minimum staffing rule with harrowing stories about conditions inside understaffed facilities. Jordan Rao, *Biden's Nursing Home Staffing Rule Surfaces Horror Stories*, KFF Health News (May 8, 2024).[20] Geriatric experts and scientists submitted evidence from more than 100 research articles and reports from 1977 to 2022 documenting better care for residents in facilities with higher staffing levels. Charlene Harrington et al., *Comment Letter on the Proposed Rule on Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting* (Oct. 24, 2023).[21]

The Final Rule is a major step forward because it is an evidence-based solution that will protect residents. It is essential for the residents' safety and should be allowed to proceed.

2. Research studies support the benefits of mandatory staffing minimums for residents, including saving lives.

Research studies show that implementing a mandatory minimum staffing standard would help protect residents. In a literature review of the relationship between nursing facility staffing

[20] https://kffhealthnews.org/news/article/health-202-biden-nursing-home-staffing-rule-horror-stories/.

[21] https://www.regulations.gov/comment/CMS-2023-0144-9587.

and quality outcomes dating back to 1977, researchers identified several quality outcomes that depend on adequate staffing. Adequate staffing is here defined as not only the number of staff required, but the skill-mix (ratios between RN; Licensed Professional Nurse ("LPN"); Certified Nurse Aide ("CNA") of those staff.

These studies show that a higher ratio and higher skilled nurse staffing levels, as well as adequate CNA staffing, are associated with better resident care quality. *See, e.g.*, Susan D. Horn et al., *RN Staffing Time and Outcomes of Long-Stay Nursing Home Residents*, 105 Am. J. Nursing 58 (2005) (less prevalence of pressure ulcers);[22] Dana. B. Mukamel et al., *Dementia, Nurse Staffing, and Health Outcomes in Nursing Homes*, 59 Health Servs. Res. 4 (2024) (less hospitalizations and emergency rooms visits):[23] Victoria Chappell et al., *Association Between Long-Term Care Facility Staffing Levels and Antipsychotic Use in US Long-Term Care Facilities*, 23 J. Am. Med. Dir. Ass'n 1787 (2022) (decreased inappropriate use of antipsychotic drugs).[24]

Not only does the research show that minimum staffing standards would yield better outcomes, but it also shows that the standards in the Final Rule could save lives. In July 2024, researchers at the University of Pennsylvania concluded that "enforcing CMS' new rule on minimum staffing levels would save approximately 13,000 lives per year." Norma Coe & Rachel M. Werner, Penn., Univ. of Penn. Leonard Davis Inst. Of Health Econ., *Briefing: The Impact of Repealing the Centers for Medicare and Medicaid Services Minimum Staffing Rule on Patient Outcomes* 1 (2024).[25]

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[22] https://pubmed.ncbi.nlm.nih.gov/16264305/.
[23] https://pubmed.ncbi.nlm.nih.gov/38156513/.
[24] https://pubmed.ncbi.nlm.nih.gov/35926573/.
[25] https://ldi.upenn.edu/our-work/research-updates/comment-the-impact-of-repealing-the-centers-for-medicare-and-medicaid-services-minimum-staffing-rule-on-patient-outcomes/.

This estimate corroborates research findings that higher nurse staffing levels saved lives during the pandemic. A study of Connecticut's 215 nursing facilities found that 20 additional minutes of RN coverage per resident per day was correlated with 22% fewer COVID-19 cases and 26% fewer COVID-19 deaths. Yue Li, et al., *COVID-19 Infections and Deaths Among Connecticut Nursing Home Residents: Facility Correlates*, 68 J. Am. Geriatrics Soc'y 1899 (2020).[26] A separate study found that facilities that self-reported staffing shortages had a 10.5% increase in resident death during the pandemic, from both COVID-19 and non-COVID-19 causes. Sushant Joshi, *Staffing Shortages, Staffing Hours, and Resident Deaths in US Nursing Homes During the COVID-19 Pandemic*, 24 J. Am. Med. Dir. Ass'n 1114 (2023).[27] The New York Attorney General's analysis of staffing levels during the early months of the pandemic found that the highest rates of resident deaths occurred in nursing facilities with the lowest staffing levels. N.Y. Off. of the Att'y Gen., *Nursing Home Response to Covid-19 Pandemic* (Revised Jan. 30, 2021).[28]

Research studies also show that the presence of an RN makes a huge difference in resident quality outcomes. RNs have a critical role in every nursing facility. They provide expertise – infection control planning and management, resident assessment and care planning, and the identification and treatment of chronic and acute conditions - to help ensure every resident's clinical, emotional, and psychosocial needs are met.

Thus, experts have strongly advocated for 24/7 on-site RN years before HHS included it in the Final Rule. Most recently, in 2022, the National Academy of Sciences, Engineering, and Medicine, Committee on the Quality of Care in Nursing Homes (NASEM) called for on-site

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[26] https://pubmed.ncbi.nlm.nih.gov/32557542/.
[27] https://pubmed.ncbi.nlm.nih.gov/37253431/.
[28] https://ag.ny.gov/sites/default/files/2021-nursinghomesreport.pdf.

direct care RN coverage 24/7, "with additional RN coverage that reflects resident census, acuity, case mix, and the professional nursing needs for residents as determined by the residents' assessments and care plans." Nat'l Acads. of Sci., Eng'g & Med., supra at 510. The NASEM report noted that a 1996 Institute of Medicine ("IoM") report, *Nursing Staff in Hospitals and Nursing Homes*, recommended a requirement that there be 24-hour RN coverage seven days a week in nursing facilities on or before the year 2000. *Id.* The recommendation was endorsed by IoM in 2001 and in a 2004 IoM report, *Keeping Patients Safe. Id.*

Even the legislation jointly released in 2021 by Plaintiffs American Health Care Association and Leading Age, the Care for Our Seniors Act, called for "a new federal requirement" of 24 hours a day of RN coverage. Am. Health Care Ass'n & Leading Age, *The Care for Our Seniors Act*, 4 (2021).[29]

3. The mandatory minimum staffing standard will protect residents by requiring that facilities use federal funding to hire staff.

Requiring nursing facilities to spend money on direct care to meet a mandatory minimum staffing standard is a critical step to protect residents' health and safety. It forces nursing facilities to spend Medicare and Medicaid dollars on direct care workers instead of retaining that money as profits. Nursing facility owners who divert money away from workers cause poverty-level wages and high turnover. This ultimately results in poor and missed care for residents.

Plaintiffs have emphasized the challenges that workforce shortages pose in the nursing facility sector. (Pl. Br. 3, 4, 37, 40-41). However, a closer look reveals that nursing facilities are experiencing a job quality crisis because of unaddressed turnover and low wages. According to CMS data, in 2022, the average annual turnover of direct care staff was over 52%. Centers for

[29] https://www.ahcancal.org/Advocacy/Documents/Care%20for%20Our%20Seniors%20Act%20-%20Overview.pdf.

Medicare & Medicaid Servs., *Nursing Home Care Compare* (2022); Nat'l Consumer Voice for Quality Long-Term Care, *High Staff Turnover: A Job Quality Crisis in Nursing Homes* 1 (2022).[30] The factors contributing to high staff turnover in nursing facilities are well documented. They include poor wages and benefits, lack of training, bad management, lack of career advancement, unsafe work environments, and impossible workloads. Nat'l Consumer Voice for Quality Long-Term Care, *supra* at 6-9.

Poor job quality has plagued nursing facility workers for years. The effects of poor job quality and low wages fall largely on women and people of color because they make up 90% of the certified nurse assistants. *Id.* at 6. Yet the nursing facility industry has done little to address these underlying problems. The bottom line is that it is dangerous for both residents and staff to operate in an understaffed facility. Simply put, workers do not want to remain in settings where they are in danger or place residents in danger.

In addition, nursing facility industry claims that a mandatory minimum staffing requirement will lead to facility closures are exaggerated and unsupported. Facilities close for a variety of reasons unrelated to any staffing mandate. Sometimes they provide very poor care and the government closes them, such as Special Focus Facilities and other low-quality facilities. Toby Edelman & Dara Valenejad, *What's Causing Nursing Home Closures*, Ctr. for Medicare Advoc. (April 4, 2019).[31] Sometimes, facilities make a business decision to close. *Id.* And finally, sometimes they close because people who would be their consumers prefer to receive services in their homes instead. States have enacted deliberate policies to shift Medicaid reimbursement from nursing facilities to home and community-based care and services. The U.S. Supreme Court

[30] https://theconsumervoice.org/uploads/files/issues/High_Staff_Turnover-A_Job_ Quality_ Crisis_in_Nursing_Homes.pdf.
[31] https://medicareadvocacy.org/whats-causing-nursing-home-closures/.

decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999), established the right of people with disabilities to live in the least restrictive setting. The more that people choose to receive care in their homes, the less there is a need for nursing facilities.

In sum, requiring nursing facilities to spend money on direct care to meet a minimum staffing standard is a critical step in creating better jobs and reducing turnover. With the mandatory minimum staffing standard, nursing facilities will be forced to spend Medicare and Medicaid dollars on workers to reduce staff turnover and meet the residents' care needs.

4. The mandatory minimum staffing standard will help combat disparities in health care.

Finally, having a mandatory minimum staffing standard will help combat the longstanding, systemic disparities in quality of care in nursing facilities, including staffing levels. For example, the AARP LTSS State Scorecard found that residents of the nursing facilities with the most Black and Latino resident admissions received between 157 and 197 fewer hours of nursing care compared to residents of other nursing facilities. *See* AARP, *Long-Term Services and Supports State Scorecard 2023 Edition*, 52 Exhibit 14 (2024).[32] During the pandemic, nursing facilities with the highest proportions of residents of color experienced COVID-19 death counts that were 3.3 times higher than other facilities. Rebecca J. Gorges & R. Tamara Konetzka, *Factors Associated With Racial Differences in Deaths Among Nursing Home Residents With COVID-19 Infection in the US,* JAMA Network Open 1, 2 (Feb. 10, 2021*).*[33] Having a mandatory minimum staffing requirement will ensure that all residents receive appropriate care, regardless of their race or ethnicity and where they live.

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[32] https://ltsschoices.aarp.org/sites/default/files/documents/doi/ltss-scorecard-2023-innovation-and-opportunity.doi.10.26419-2Fppi.00203.001.pdf.

[33] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2776102.

In the end, the Final Rule creates a federal minimum staffing standard that requires America's nursing facilities to have enough staff to provide the hands-on care that our most vulnerable older adults need. Inadequate staffing in nursing facilities is the fundamental driver of poor and often dangerous health outcomes for residents. HHS and CMS took critical action with the Final Rule to prevent this country from experiencing another devastating pandemic. Nursing facilities that voluntarily choose to receive taxpayer dollars should be required to ensure quality care through minimum staffing standards. HHS should proceed with the Final Rule.

CONCLUSION

For the reasons stated above, Defendants' cross-motion for summary judgment should be granted and Plaintiffs' motion for summary judgment should be denied.

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